DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB I	NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			ATE SURVEY OMPLETED
		345336	B. WING			C 10/19/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/10/2010
SIGNATU	RE HEALTHCARE OF RO			305 FOURTEENTH STREET		
SIGNATOR	TE HEALTHCARE OF RC	JANORE RAFIDS		ROANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	D		
F 156 SS=C	the complaint investig Event ID # OXWE11. NC00121386 and NC 483.10(b)(5) - (10), 4	:00121659 83.10(b)(1) NOTICE OF	F 15	6		11/4/16
	and in writing in a lan understands of his or regulations governing responsibilities during facility must also prov notice (if any) of the S §1919(e)(6) of the Ac made prior to or upor resident's stay. Rece	m the resident both orally guage that the resident her rights and all rules and resident conduct and the stay in the facility. The vide the resident with the State developed under t. Such notification must be a admission and during the sipt of such information, and t, must be acknowledged in				
	entitled to Medicaid b of admission to the ner- resident becomes elig- items and services the facility services under which the resident ma- other items and servi- and for which the resi- the amount of charge inform each resident the items and service (i)(A) and (B) of this service	m each resident who is enefits, in writing, at the time ursing facility or, when the gible for Medicaid of the at are included in nursing r the State plan and for ay not be charged; those ces that the facility offers ident may be charged, and is for those services; and when changes are made to as specified in paragraphs (5) section.				
	at the time of admissi	ion, and periodically during services available in the				
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	 [TITLE		(X6) DATE
Electroni	cally Signed					11/04/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES			CONSTRUCTION		FORM OMB NC	0: 11/22/2016 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION			
		345336	B. WING			_		_ 19/2016
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST			
SIGNATUR	RE HEALTHCARE OF RO	ANOKE RAPIDS			05 FOURTEENTH STREET OANOKE RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 156	under Medicare or by The facility must furni- legal rights which incl A description of the m funds, under paragraf A description of the re- for establishing eligibit the right to request an 1924(c) which determ non-exempt resource- institutionalization and spouse an equitable s cannot be considered toward the cost of the medical care in his or down to Medicaid elig A posting of names, a numbers of all pertine groups such as the St agency, the State lice ombudsman program advocacy network, an unit; and a statement complaint with the Sta agency concerning re misappropriation of re facility, and non-comp directives requiremen	is for those services, for services not covered the facility's per diem rate. sh a written description of udes: anner of protecting personal oh (c) of this section; equirements and procedures lity for Medicaid, including assessment under section ines the extent of a couple's is at the time of d attributes to the community share of resources which available for payment institutionalized spouse's her process of spending ibility levels. ddresses, and telephone nt State client advocacy tate survey and certification nsure office, the State , the protection and d the Medicaid fraud control that the resident may file a ate survey and certification sident abuse, neglect, and esident property in the bliance with the advance ts. m each resident of the way of contacting the	F 1	56		JEFICIENCY)		
	physician responsible	IN HIS OF HER CARE.						

Facility ID: 923216

If continuation sheet Page 2 of 13

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/22/2016 // APPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		LETED
		345336	B. WING				C 19/2016
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF RO			3	05 FOURTEENTH STREET		
SIGNATO				R	COANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 156	written information, and applicants for admiss information about how Medicare and Medicar receive refunds for pro- such benefits. This REQUIREMENT by: Based on observation failed to post names, numbers of state clien protection and advoca also failed to promine information about how Medicare and Medicar the survey. The findings include: During an observation there was no information on how to apply for all benefits and there was State client advocacy licensure and certifica and advocacy networ	ninently display in the facility nd provide to residents and ion oral and written w to apply for and use aid benefits, and how to revious payments covered by ⁻ is not met as evidenced ns and interviews, the facility addresses and telephone nt advocacy groups, the acy network and the facility	F	156	Upon notification of findings related to failure to post advocacy network and Medicare and Medicaid application information, the facility Social Service: Director immediately posted the requi information in the hallway near the fro entrance of the center on 10/19/16. The Administrator of the facility has al provided notification to new admission that date back to September 1, 2016, whether they have discharged or are presently in the center. This notification was mailed to each responsible party November 4, 2016. Social Services Director as well as Admissions has been educated on importance of making residents aware advocacy groups that are available for	s red nt so is n by	
	there was no informat how to apply for and benefits and there was State client advocacy	n on 10/18/2016 at 9:49 AM tion posted in the facility on use Medicare/Medicaid as no contact information for groups, the protection and d the Medicaid fraud control			support both in the center as well as community once they are discharged. This education was completed on 10/20/16 by the Administrator. This citation will be reviewed and presented to the facility QAPI meeting		

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/22/2016 MAPPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345336	B. WING			C 19/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUE	RE HEALTHCARE OF RO			305 FOURTEENTH STREET		
SIGNATOR	E HEALTHCARE OF RC	JANORE RAFIDS		ROANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 156	Continued From page	e 3	F 15	6		
	unit posted in the fac	ility. n on 10/18/2016 at 12:38 PM		monthly for 3 months by the Adm Any issues or trends identified wi addressed by the QAPI committee	ill be	
	there was no contact facility on how to app Medicare/Medicaid b	information posted in the ly for and use enefits and there was no		arise and the plan will be revised ensure continued compliance. Th committee consists of the Admini	to ne QAPI	
	groups, the protection	or State client advocacy n and advocacy network and ontrol unit posted in the		DON, SDC, MDS Coordinator, Admissions Coordinator, Medical Director of Social Services, Quali Director, Chaplain, and Environm Services.	ity of Life	
	there was no contact facility on how to app Medicare/Medicaid b contact information for groups, the protection	n on 10/19/2016 at 3:18 PM information posted in the ly for and use enefits and there was no or State client advocacy n and advocacy network and ontrol unit posted in the				
	the facility Social Work where the information	n 10/19/2016 at 3:26 PM, rker looked at the area n was supposed to be during renovations the e been taken down.				
F 253 SS=E			F 25	53		11/4/16
		vide housekeeping and s necessary to maintain a comfortable interior.				
	This REQUIREMENT	is not met as evidenced				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345336	B. WING		C 10/19/2016
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CODE	10/10/2010
SIGNATU	RE HEALTHCARE OF RO	DANOKE RAPIDS		305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
F 253		e 4	F 25	3	
	review of housekeep facility failed to clean systems for the follow 39, 40, 43, 48, 50, 53 failed to clean a when room 47 for 1 or 4 ha The findings included On 10/ 17/16 at 2:32 conditioning system i a large volume of gra with food and trash o On 10/19/16 7:59 AM she wiped down all s rooms and the heatin She further stated tha out the units when th On 10/19/16 at 11:27 conditioning system i	PM the heating and air n room18 was observed with y dust on the front panels n the inside of the unit. I housekeeping staff stated urfaces in the residents ' ing and air conditioning vents. at housekeeping would wipe ey saw trash. AM the heating and air n room18 was observed with t panels with dried food and		 Housekeeping was immediately s rooms 18, 11, 37, 39, 40, 43, 48, 4 and 55 to clean the vents and filte Heating Ventilation and Air Condit units on October 19, 2016. Addition housekeeping was sent to clean the cushion and wheelchair in room 4 October 19, 2016. A house sweep was conducted for Heating Ventilation and Air Condit units, wheelchairs, and cushions the housekeeping, maintenance, and administrator. Each room was ins and cleaned by November 3, 2010 Education will be provided by the Administrator on the importance of maintaining a clean environment residents to insure that the center free of odors and pests. Housekee was in-serviced on how to propert the HVAC units and on how to ap deep clean schedule to insure the is maintained. This will be complet 11/3/16. 	50, 53, rrs in the ioning onally, he 7 on r ioning by the pected 6. of for our remains eping y clean ply the facility
	that the heating/air co food had dropped into be cleaned. On 10/ 17/16 at 2:25 conditioning system i a large volume of gra	AM the administrator stated onditioning unit looked like o the vents and needed to PM the heating and air n room11 was observed with ay dust on the front panels n the inside of the unit.		Rounds to be made by the Admin or the Administrator in Training on 10% of the center. These rounds documented on the audit tool and monitored for five days per week weeks, then weekly for two weeks monthly for two months. All data we summarized and presented to the QAPI meeting monthly by the DO SDC. Any issues or trends identifi	at least will be for two s, then vill be facility N or

Facility ID: 923216

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	OF DEFICIENCIES			LE CONSTRUCTION		<u>0. 0938-039</u> E SURVEY
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			PLETED
			-			С
		345336	B. WING			/19/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
SIGNATU	RE HEALTHCARE OF RO	DANOKE RAPIDS		305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 253	Continued From page	e 5	F 25	3		
 F 253 Continued From page 5 she wiped down all surfaces in the residents ' rooms and the heating and air conditioning vents. She further stated that housekeeping would wipe out the units when they saw trash. On 10/19/16 at 11:28 AM the heating and air conditioning systems in room11 was observed with gray dust on the front panels with food and trash on the inside of the unit. On 10/19/16 at 11:43 AM the administrator stated that the heating and air conditioning unit looked like food had dropped into the vents and needed to be cleaned. On 10/17/16 at 9:37 AM the heating and air conditioning system in room 40 was observed with a large volume of gray dust on the front panels with food 			they arise and the plan will I ensure continued complianc committee consists of the A DON, SDC, MDS Coordinat Admissions Coordinator, Me Director of Social Services, Director, Chaplain, and Env Services.	ce. The QAPI dministrator, cor, edical Director, Quality of Life		
	conditioning system i with a large volume of panels. On 10/17/16 at 2:24 conditioning system i with a large volume of panels. On 10/17/16 at 3:02 conditioning system i	de of the unit. AM the heating and air n room 37 was observed of gray dust on the front PM the heating and air n room 53 was observed of gray dust on the front PM the heating and air n room 48 was observed of gray dust on the front				

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/22/2016 MAPPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345336	B. WING					C 19/2016
	ROVIDER OR SUPPLIER	DANOKE RAPIDS			STREET ADDRESS, CITY, STATE, ZIP (305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD B		(X5) COMPLETION DATE
F 253	conditioning system in with a large volume of panels. On 10/ 18/16 at 2:19 conditioning system in with a large volume of gray dust of and trash on the insid On 10/18/16 at 2:21 F conditioning systems with a large volume of gray dust of On 10/18/16 at 2:23 F conditioning systems with a large volume of gray dust of On 10/18/16 at 2:26 F conditioning systems with a large volume of gray dust of On 10/18/16 at 2:27 F conditioning systems with a large volume of gray dust of On 10/18/16 at 2:27 F conditioning system in with a large volume of gray dust of and trash on the insid On 10/18/16 at 2:28 F conditioning systems with a large volume of gray dust of and trash on the insid On 10/18/16 at 2:28 F conditioning systems with a large volume of gray dust of and trash on the insid	n room 50 was observed f gray dust on the front PM the heating and air n room 48 was observed on the front panels with food le of the unit. PM the heating and air in room 40 was observed on the front panels. PM the heating and air in room 39 was observed on the front panels. PM the heating and air in room 37 was observed on the front panels. PM the heating and air in room 43 was observed on the front panels with food le of the unit. PM the heating and air n room 43 was observed	F	25	3			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
			A. BUILDII	NG _			C
		345336	B. WING			10/	19/2016
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF RO	ANOKE RAPIDS			05 FOURTEENTH STREET		
				R	COANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From page	27	F 2	253			
	volume of gray dust o						
	.	······					
	-	ith the housekeeping staff she stated that 1st she					
		rs, clean the bathroom and					
		n she would wipe down					
	-	om including the dresser, Ible, closet door, window					
		saw trash in the heater					
	vents she would wipe						
		40 AM the administrator					
		iditioner looked like food had s and needed to be cleaned.					
	conditioning systems	AM the heating and air in room 50 was observed					
	with a large volume of gray dust o	n the front panels.					
		AM the heating and air in room was observed with					
	a large volume of gray dust o	n the front panels.					
		AM the heating and air n room 40 was observed					
		n the front panels with food le of the unit.					
		AM the heating and air in room 39 was observed on the front panels					
	On 10/19/16 at 8:17 A	AM the heating and air in room 37 was observed					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/22/2016 APPROVED D: 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>				(X3) DATE COMF	SURVEY PLETED
		345336	B. WING					C 19/2016
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE		
SIGNATUR	RE HEALTHCARE OF RO				305 FOURTEENTH STREET			
SIGNATO		ANORE NAFIDS			ROANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BI		(X5) COMPLETION DATE
F 253	Continued From page	<u>2</u> 8	F	25	3			
. 200	volume of gray dust of		· ·	20	5			
	volume of gray dust of	n me nom paneis.						
	conditioning systems with a large	AM the heating and air in room 55 was observed						
	volume of gray dust of	on the front panels.						
		AM the heating and air in room 53 was observed						
	with a large volume of gray dust c	on the front panels.						
		AM the heating and air in room 43 was observed on the front panels.						
	was cleaned daily usi included sweeping, d	ger stated that each room ing a 7 step process that usting, moping, clean and						
	bags and wipe down	n, change out the trash the exterior of the heating ystems. She indicated that						
	she would have staff conditioning systems	clean the heating and air						
	that the heating and a should be cleaned an	air conditioning system Id wiped down daily and						
	conditioning system c cleaned.	o cleaned the heating and air covers are taken off and						
		AM the Administrator stated						
		er looked like food had s and needed to be cleaned.						
		PM the wheel chair in room ed with a thumb size tear in						

Facility ID: 923216

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	11/22/2016 APPROVED 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPLI	ETED	
		345336	B. WING		C	9/2016	
	ROVIDER OR SUPPLIER	DANOKE RAPIDS	STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 253 F 371 SS=E	the wheel chair was of stains and food debri On 10/19/16 at 8:20 / 47 bed A was observe the left armrest. The stains and food debri During an interview w 10/19/16 at 8:02 AM were not on a cleanin housekeeping, staff of could bring dirty when be cleaned. 483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	frame and cushion seat of observed with spilled drink s. AM the wheel chair in room ed with a thumb size tear in frame and cushion seat of observed with spilled drink s. with housekeeping staff on she stated that wheelchairs og schedule but or anyone in management elchairs to the wash area to OCURE, ERVE - SANITARY	F 25		1	1/4/16	
	by: Based on observatio policy review the facil equipment clean and prevent the cross cor to clean 2 of 5 range	is not met as evidenced ins, staff interviews and lity failed to maintain kitchen in a sanitary condition to ntamination of food by failing hood filters, remove peeling and failed to clean the		The Nutrition services manager cl the underside of the steam table a fan on 10/19/16. Additionally, thes were added to the weekly deep cle schedule for the dietary staff. The also arranged for the hood to be d	nd the e items ean facility		

Event ID: OXWE11

Facility ID: 923216

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RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Lenon	IDENTIFICATION NOMBER.	A. BUILDING		C
	345336	B. WING		10/19/2016
ER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ALTHCARE OF RO	ANOKE RAPIDS		305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLETIO
tinued From page	10	F 37	1	
erside of 1 of 2 the ings included: ing the initial kitche 2 of the 5 range f ered with golden g ling paint was obs k bottom rim of the 10/16/16 at 1:05 F observed. The 6 am table shelf was dark dried food p 10/18/16 at 8:24 A observed. The 6 am table shelf was dark dried food p d filters was obser ase and a 4 inch p erved hanging fror range hood. 10/18/16 at 3:04 F observed. The 6 am table shelf was dark dried food p d filters was obser ase and a 4 inch p erved hanging fror range hood. 10/18/16 at 3:04 F observed. The 6 am table shelf was dark dried food p d filters was obser ase and a 4 inch p erved hanging fror range hood. 10/19/16 at 9:52 A chine area was obser mounted fan was ume of gray dust a ving onto the clear chine. n interview on 10/	e steam table shelves. The en tour on 10/16/16 at 1:02 nood filters was observed rease and a 4 inch piece of erved hanging from the e range hood. 20 M the 6 well steam table 5 foot underside of the observed to be covered articles. 30 M the 6 well steam table 5 foot underside of the observed to be covered articles. 2 of the 5 range rved covered with golden iece of peeling paint was in the back bottom rim of 20 M the 6 well steam table 5 foot underside of the observed to be covered articles. 2 of the 5 range rved covered with golden iece of peeling paint was in the back bottom rim of 20 M the 6 well steam table 5 foot underside of the observed to be covered articles. 2 of the 5 range rved covered with golden iece of peeling paint was in the back bottom rim of 30 M the fan in the dish served. The cage of the observed cover with a ind dust strings. The fan was in dishes exiting the dish 19/16 the Certified Dietary		 cleaned by an outside contractor at the secured for 11/07/16 - follow this process, Plant ops will paint the exterior of the hood no later than 11/12/16. The Nutrition Services may removed the chipping paint on 10/1 prevent further risk of contamination Education completed with dietary s the responsibility of cleaning all iter the deep clean schedule completed Nutrition Services Manager and Administrator by 11/03/16. Also rev with dietary staff was how to place maintenance items for repair in the Maintenance repair log for review b Plant Ops Director. Deep clean schedules will be review the Nutrition Services manager mor forward as well as inspection of the and other food storage and prepara areas to insure no further risk of contamination. Review of the deep clean schedule completion as well as weekly round the Nutrition Services Manager or Administrator. This review will be documented on the deep clean schedule completion as well as weekly round the Nutrition Services Manager or Administrator. This review will be monthly for two months. All data will be summarize presented to the facility QAPI meet monthly by the Nutrition Services 	ving e anager 9/16 to n. taff of ns on d by the iewed vy the wed by ving hood ation ls by edule o d and ing
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L and the second of the secon	ER OR SUPPLIER SALTHCARE OF ROANOKE RAPIDS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Attinued From page 10 erside of 1 of 2 the steam table shelves. The ings included: ing the initial kitchen tour on 10/16/16 at 1:02 2 of the 5 range hood filters was observed ered with golden grease and a 4 inch piece of ling paint was observed hanging from the k bottom rim of the range hood. 10/16/16 at 1:05 PM the 6 well steam table o bserved. The 6 foot underside of the am table shelf was observed to be covered 10/18/16 at 8:24 AM the 6 well steam table o bserved. The 6 foot underside of the am table shelf was observed to be covered 10/18/16 at 3:04 PM the 6 well steam table o bserved. The 6 foot underside of the am table shelf was observed to be covered 10/18/16 at 3:04 PM the 6 well steam table 10/18/16 at 3:04 PM the 6 well steam table 10/19/16 at 9:52 AM the fan in the dish 10/19/16 at 9:52 AM the fan in the dish chine area was observed. The cage of the mounted fan was observed cover with a 100/19/16 at 9:52 AM the fan in the dish chine area was observed. The cage of the mounted fan was observed cover with a 100/19/16 at 9:52 AM the fan in the dish chine area was observed. The cage of the mounted fan was observed cover with a 100 f gray dust and dust strings. The fan was ving onto the clean dishes exiting the dish	ER OR SUPPLIER SALTHCARE OF ROANOKE RAPIDS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID trained From page 10 F 37 erside of 1 of 2 the steam table shelves. The ings included: F 37 ing the initial kitchen tour on 10/16/16 at 1:02 2 of the 5 range hood filters was observed ered with golden grease and a 4 inch piece of ling paint was observed hanging from the k bottom rim of the range hood. F 37 10/16/16 at 1:05 PM the 6 well steam table observed. The 6 foot underside of the im table shelf was observed to be covered dark dried food particles. 10/18/16 at 8:24 AM the 6 well steam table observed. The 6 foot underside of the im table shelf was observed to be covered dark dried food particles. 2 of the 5 range d filters was observed covered with golden ase and a 4 inch piece of peeling paint was erved hanging from the back bottom rim of range hood. 10/18/16 at 3:04 PM the 6 well steam table observed. The 6 foot underside of the im table shelf was observed to be covered dark dried food particles. 2 of the 5 range d filters was observed covered with golden ase and a 4 inch piece of peeling paint was erved hanging from the back bottom rim of range hood. 10/18/16 at 3:04 PM the 6 well steam table observed. The 6 foot underside of the im table shelf was observed covered with golden ase and a 4 inch piece of peeling paint was erved hanging from the back bottom rim of range hood. 10/19/16 at 9:52 AM the fan in the dish chine area was observed. The cage of the mounted fan was observed cover with a ime of gray dust and dust strings. The fan was ving o	ER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE SALTHCARE OF ROANOKE RAPIDS STREET ADDRESS. CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY UNST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETRX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Unit of the company of the second of the second for 110/16/16 at 1:02 2 of the 5 range hood filters was observed ared with golden grease and a 4 inch piece of the bod mo later than 111/12/16 at 1:05 PM the 6 well steam table observed. The 6 foot underside of the the table shelf was observed to be covered dark dried food particles. 2 of the 5 range difficit food particles. 2 of the 5 range difficers was observed to be covered dark dried food particles. 2 of the 5 range difficers was observed to be covered dark dried food particles. 2 of the 5 range end hanging from the back bottom rim of range hood. F ange hood. D10/18/16 at 3:04 PM the 6 well steam table observed. The 6 foot underside of the im table shelf was observed to be covered dark dried food particles. 2 of the 5 range end hanging from the back bottom rim of range hood. Deep clean schedules will be review bilant condor gervices manager mo forward as well as inspection of the and other food storage and prepara areas to insure no further risk of contamination. Review of the deep clean schedules will be review thine area was observed covered with other area was observed covered with phine. Review of the deep clean schedule completion as well as weekly rounou the Nutrition Services Manager or Administrator. This review will be documented on the deep clean schedule completion as well as weekly rounou the Nutrition Services Manager or Ad

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/22/20 [.] MAPPROVE D. 0938-039
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345336	B. WING				C / 19/2016
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
SIGNATU	RE HEALTHCARE OF RO	DANOKE RAPIDS			5 FOURTEENTH STREET DANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 371 F 514 SS=D	day. In an interview on 10, administrator stated t on contacting a servir facility range hood. S would add the fan an table shelf to the wee 483.75(I)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practic accurately document systematically organi The clinical record m information to identify resident's assessmen services provided; the preadmission screen and progress notes. This REQUIREMENT by: Based on record rev facility failed to have the chart for 2 of 14 of #8) reviewed for phy The findings includeo 1. Resident #90 was 8/5/16 and readmitter	those areas cleaned that /19/16 at 11:13 AM the that she had been working ce to clean and service the the stated that the CDM d underside of the steam ekly cleaning schedule. ETE/ACCURATE/ACCESSIB ntain clinical records on each ce with accepted professional ces that are complete; ed; readily accessible; and zed. ust contain sufficient / the resident; a record of the nts; the plan of care and e results of any ing conducted by the State; T is not met as evidenced iew and staff interviews the current physician's orders on charts (Resident #90 and rsician's orders.		514	Upon notification of missing physician order summaries, medical records re-printed and had physicians sign the orders and added them to the medical record on 10/20/2016.	1	11/4/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345336					(X3) DATE SURVEY COMPLETED
		345336	B. WING		C 10/19/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ROANOKE RAPIDS			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
F 514	failure, hypertension, Review of the medica updated copy of the F (POS) on the chart w On 10/19/16 at 2:11 F that the POS should the 15th of the month stated that they had a employee in August 2	malnutrition and anemia, al record revealed the most Physician Order Summary as September 2016. PM the Administrator stated be on the chart no later than a. The Administrator further a transition of medical record 2016 and some of the always as prompt in signing	F 514	other residents were found to be aff Education will be provided by the D of Nurses or Staff Development Coordinator moving forward to insur administrative nursing staff are awa Physician order Summaries are to b reviewed and forwarded to the med records clerk to insure an audit can completed monthly. This education include new administrative nursing upon orientation as well as annually through skills review. This will be completed by 11/03/16.	irector re that be ical be is to hires
	4/3/2015 with diagno disease, encephalopa anemia, and pressure On 10/18/2016 a revi resident's medical rev most updated copy o Summary (POS) was An interview was con Administrator on 10/1 Administrator stated to Summary (POS) sho than the 15th of the n indicated they had a employee in August 2	ew was conducted of the cord, which revealed the f the Physician Order September 2016. ducted with the 9/2016 at 2:11 PM. The		Review of POS is completed by the medical records clerk monthly and v recorded on a census board for the to indicate in-house completion and physicians have returned them time are placed on the medical record by 15th of each month. This review wil documented on the census board re monthly for three months. All data w summarized and presented to the fa QAPI meeting monthly by the DON SDC. Any issues or trends identified be addressed by the QAPI committee they arise and the plan will be revise ensure continued compliance. The committee consists of the Administr DON, SDC, MDS Coordinator, Admissions Coordinator, Medical D Director of Social Services, Quality Director, Chaplain, and Environments	will be center ly and v the l be eports vill be acility or d will ee as ed to QAPI ator, irector, of Life

Event ID: OXWE11

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