PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345311	B. WING _		05/04/2017
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER			•	STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573	, , , , , , , , , , , , , , , , , , , ,
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
F 241 SS=D	(a)(1) A facility must the resident in a manner promotes maintenancher quality of life reconstruction individuality. The faci promote the rights of This REQUIREMENT by: Based on observation review, the facility fail for the urinary cathetes sampled resident with (Resident #151). The findings included Resident #151 was a diagnoses included, and the finding with activity in the quarterly Minimus dated 3/3/17, indicated cognitive impairments assistance with activity in the position on the floor at tubing were lying best at the same level as the sa	the resident. T is not met as evidenced In, staff interview and record led to provide privacy cover ler drainage bag for 1 of 1 In an indwelling catheter It: It: It: It: It: It: It: It	F 2	F241 STANDARD DISCLAIMER: The Plan of Correction for this a deficient practice is provided as necessary requirement for cont participation in the Medicare an program(s) and does not, in any constitute an admission to the value the alleged deficient practice(s). Resident #151 was given a prive for their urinary catheter drainary. For those residents having the be affected by the same alleged practice(s), the facility has in-senursing staff on the enhancemed quality of life and how to protect promote the residents rights with Similarly, licensed nurses were by the Assistant Director of Nurfacility sexpectation specific to provision of Catheter care protects.	s a sinued and Medicaid by manner, validity of solution. vacy cover ge. potential to deficient erviced all ent of set and the dignity. instructed sing on the solution of the country of the pocol.
	#2 confirmed Resider on the floor and the u	nt 151 ' s bed was positioned rinary drainage bag was out privacy cover. Nurse #2		To ensure compliance the direct workers will complete a daily roworksheets for those residents indwelling Foley catheter systems.	ounding with
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE

Electronically Signed 05/26/2017

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345311	B. WING			05/	04/2017	
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 315 SS=D	Nurse Aide (NA #3) of bed was positioned of drainage bag was lying resident without private the urinary drainage on the floor. NA #3 stowered the bed and uncovered or on the floor of the floor of the floor of expectation was for the bag over the drainage. During an interview of Assistant Director of expectation was for the bag over the drainage. During an interview of Administrator stated for provide a privacy of 483.25(e)(1)-(3) NO RESTORE BLADDEI. (e) Incontinence. (1) The facility must expect the facility must expect the drainage. (2) For a resident without the resident's comfacility must ensure the indwelling catheter is	on 5/2/17 at 3:34 PM, the confirmed Resident #151 's in the floor and the urinarying on the floor next to the acy cover. NA #3 emptied bag while the bed remained atted he was unaware of who left the drainage bag floor. In 5/3/17 at 2:53 PM, the Nursing (ADON) stated the ne staff to provide a privacy e bag. In 5/4/17 at 9:15 AM, the the expectation was for staff cover over the drainage bag. CATHETER, PREVENT UTI, Resident who is and bowel on admission disassistance to maintain as or her clinical condition is to continence is not possible a urinary incontinence, based aprehensive assessment, the		315	privacy cover over the drainage bag. Description of the charge nurse(s) shall make direct observations and monitor completion of the daily rounding worksheet each shift. The Director of Nursing or designee stream conduct weekly audits for one month at then quarterly audits thereafter. The Director of Nursing shall present any identified findings/observed discrepancies, to the Assurance Committee monthly for one month and quarterly thereafter.	the nall nd	5/26/17	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	345311	B. WING	 	05/	/04/2017		
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAE	3 CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573		<u> </u>	03/04/2017		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
is assessed for removal as possible unless the demonstrates that cath and (iii) A resident who is in receives appropriate the prevent urinary tract into continence to the exter (3) For a resident with on the resident's compliant facility must ensure that incontinent of bowel retreatment and services bowel function as possible. This REQUIREMENT by: Based on observation, and record review, the drainage bag off the flot for 1 of 1 sampled resident #15. The findings included: Resident #151 was addiagnoses included, urulcer and neuromuscul The quarterly Minimum.	ers the facility with an subsequently receives one all of the catheter as soon resident's clinical condition reterization is necessary accontinent of bladder eatment and services to fections and to restore at possible. fecal incontinence, based rehensive assessment, the at a resident who is ceives appropriate to restore as much normal sible. is not met as evidenced , staff and family interviews facility failed to keep the for and below the bladder dent with an indwelling and the start of th	F 31	F315 STANDARD DISCLAIMER: The Plan of Correction for th deficient practice is provided necessary requirement for coparticipation in the Medicare program(s) and does not, in constitute an admission to the the alleged deficient practice. Resident #151 s catheter wand reposition for proper plathe bladder.	I as a continued and Medicaid any manner, ne validity of e(s).			

Facility ID: 923437

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NI IMBED:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345311	B. WING _			05/04/2017	
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	•		
DOVEOD	OUEALTHOADE & DELL	AD CENTED		901 RIDGE ROAD			
ROXBORG	O HEALTHCARE & REH	AB CENTER		ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 315	Continued From pag	e 3	F 3	15			
F 315	identified the history infection and cathete pressure ulcer on corresident would have tract infection, reduce antibiotics and would. The interventions incorrowide catheter care and symptoms of del notify family of change. During an observation Resident #151 was by drainage bag on the lowest position on the and tubing was lying floor at the same level been lowered to the floor and the been lowered to the floor and the bed was lowed by the bed was lowed by the same level been lowered to the floor and the bed was lowed by the bed was lowed by the same level been lowered to the floor and the bed was on the floor and the bed was on the same level below the urinary buring an interview of the bed was positioned to bed was positioned to bed was positioned to bed was positioned of the bed was positioned to be and the bed was positioned to bed was positioned to be and the bed was positioned to be a believe to be and the bed was positioned to be a believe to	of recurrent urinary tract or present due to stage IV occyx. The goal included the reduced symptoms of urinary ed adverse effects from I be clean, dry, free of odors. Eduded encourage fluids, as indicated, report signs hydration to physician and ges. In on 5/2/17 at 3:25 PM, ying in bed with urinary floor. The bed was at the effoor and the drainage bag beside the resident on the el as the urinary bladder. In 5/2/17 at 3:25 PM, the d Resident 151 's bed had floor by the aide, but was ad lowered the bed. The en lying beside the resident wered. In 5/2/17 at 3:34 PM, Nurse in 151 's bed was positioned urinary drainage bag was I the urinary drainage bag should by bladder and off the floor. In 5/2/17 at 3:34 PM, the onfirmed Resident #151 's bed not floor.	F3	practice(s), all licensed nurs direct care staff have been in the Assistant Director of Nur to the correct Foley catheter management, proper placen prevention of infection and protocol. To ensure compliance, direct workers will complete a daily worksheets for those resider indwelling Foley catheter systemake direct observations be observe the proper placemedrainage bag and monitor the of the daily rounding worksheets for or then quarterly audits for or then quarterly audits thereaf Director of Nursing shall precidentified findings/observed discrepancies, to the Quality Committee monthly for one quarterly thereafter.	n-serviced by sing, specific care and nent, proper et care y rounding nts with stems for inage bag. In rurse(s) shall sing sure to ent of the ne completion neet esignee shall ne month and fter. The sent any		
	drainage bag was lyi resident without priva	on the floor and the urinary ng on the floor next to the acy cover. NA#3 emptied the while the bed remained on					

PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345311	B. WING			05/	04/2017
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER				90	TREET ADDRESS, CITY, STATE, ZIP CODE 11 RIDGE ROAD OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 328 SS=D	lowered the bed and uncovered or on the function of the function of the sistant Director of the expectation was for the catheter drainage base ADON stated the resibeen at proper position catheter bag should the below the level of the During an interview of Administrator stated to ensure the urinary urinary bladder and of 483.25(b)(2)(f)(g)(5)(f) FOR SPECIAL NEED (b)(2) Foot care. To exproper treatment and and good foot health, (i) Provide foot care as with professional start to prevent complication medical condition(s) as appointments with a carranging for transposit appointments. (f) Colostomy, ureter The facility must ensured.	If he was unaware of who left the drainage bag loor. In 5/3/17 at 2:53 PM, the Nursing (ADON) stated the ne staff to ensure the g was below the bladder. If dent's bed should have on. The ADON stated the ne both off the floor and bladder. In 5/4/17 at 9:15 AM, the he expectation was for staff drainage bag was below the ff the floor. In (i)(j) TREATMENT/CARE In sure that residents receive care to maintain mobility the facility must: Ind treatment, in accordance adards of practice, including ons from the resident's and		315			5/26/17

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	OATE SURVEY OMPLETED		
		345311	B. WING _			05/04/2017		
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP COL 901 RIDGE ROAD ROXBORO, NC 27573)E	, 300002000		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 328	professional standard comprehensive personal standards of practice physician orders, the resident who receives the appropriate ordered care goals and preference (i) Respiratory care, and tracheal suctioning that a resident who receives the appropriate or the person-centered care goals and preference (ii) Respiratory care, and tracheal suctioning that a resident who reincluding tracheostor suctioning, is provided professional standards of practice physician orders. (iii) Prostheses. The resident who has a pand assistance, constandards of practice person-centered care and preferences, to prosthetic device. This REQUIREMENT by:	ch care consistent with ds of practice, the on-centered care plan, and and preferences. It is fed by enteral means iate treatment and services cations of enteral feeding ted to aspiration pneumonia, ehydration, metabolic asal-pharyngeal ulcers. Parenteral fluids must be ent with professional and in accordance with ecomprehensive eplan, and the resident's ess. Including tracheostomy care ng. The facility must ensure needs respiratory care, my care and tracheal ed such care, consistent with ds of practice, the on-centered care plan, the preferences, and 483.65 of facility must ensure that a prosthesis is provided care sistent with professional entered the comprehensive entered the plan, the residents' goals wear and be able to use the	F3					
	Based on observation	ons, record review and staff		F328				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345311	B. WING _	B. WING		05/	04/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			ADDRESS, CITY, STATE, ZIP CODE		-		
DOVEOD	NEALTHCARE & DELL	AD CENTED		901 RIDG	SE ROAD		
KUXBUK	O HEALTHCARE & REH	AB CENTER		ROXBO	RO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	as ordered for 1 of 1 therapy (Resident #2 Findings included: Resident #28 was ac the quarterly Minimu dated 3/24/17, reveal moderately cognitive included chronic obs (COPD) and anemia oxygen therapy. Review of Resident 2 dated 3/18/17 reveal therapy via nasal car continuously, as well oxygen saturation (o shift. Review of Resident 2 3/29/17, revealed an The goal was to keep oxygenation. The ap oxygen as ordered, r distress and vital sign. Review of Resident 2 Administration Recorrevealed that the oxy cannula four liters per provided during first. Review of Resident 2 Administration Recorrevealed that the oxy cannula four liters per provided during first.	failed to administer oxygen resident reviewed for oxygen (28). Imitted on 1/6/17. Review of m Data Set assessment, led that the resident was ly impaired. His diagnoses tructive pulmonary disease. The resident received 28 's physician 's order ed the order for oxygen inula four liters per minute as order to check the exygen blood level) every 28 's plan of care, dated alteration in oxygenation. The resident with adequate proaches were to administer monitor for respiratory ins. 28 's Medication regentation of from 5/1/17 to 5/4/17 regen therapy via nasal er minute continuously was and second shifts.	F 3	STA The defice neces parti prog cons the a Res orde com phys findi bein For be a prace orde oxyg to pl com direct the a to ox phys mon To e the c Oxyg resic and	NDARD DISCLAIMER: Plan of Correction for this alleged cient practice is provided as a ressary requirement for continued icipation in the Medicare and Medigram(s) and does not, in any mannestitute an admission to the validity alleged deficient practice(s). Ident #28 soxygen was reappliedered. A respiratory assessment was pleted by a licensed nurse and the sician notified of the assessmentings. Oxygen currently is currently gradministered per physician order those residents having the potential ffected by the same alleged deficitice(s), all residents with physicial ers for oxygen were assessed for gen administration delivery according to administration delivery according to administration, following sician orders related to oxygen and intoring the resident receiving oxygen and recompliance, during each structured to a compliance, during each structured to a compliance will monitor the pletion of the daily rounding reported to a contract the licensed nurse will monitor the pletion of the daily rounding reported to a contract the licensed nurse will monitor the pletion of the daily rounding reported to a contract the licensed nurse will monitor the pletion of the daily rounding reported to a contract the licensed nurse will monitor the pletion of the daily rounding reported to a contract the licensed nurse will monitor the pletion of the daily rounding reported to a contract the licensed nurse will monitor the pletion of the daily rounding reported to a contract the licensed nurse a	icaid ner, of d as is e ers. al to ent ing id by cific d ien. ift an	
		n 5/1/17 at 3:48 PM and 92% I (normal range is between			Director of Nursing or designee s duct weekly audits for one month a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345311	B. WING			05	/04/2017	
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER			•	90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 RIDGE ROAD OXBORO, NC 27573	,	·	
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 328	dated 5/1/17 at 1:05 revealed that the rest therapy continuously per minute with no number of the period of the pe	sident 28 's nurses' notes, PM and 5/2/17 at 3:10 PM, ident received oxygen via nasal cannula four liters oted respiratory distress. Ons on 5/1/17 at 10:10 AM, AM, Resident #28 was sitting his room: the oxygen tubing ere on the floor, connected in concentrator. The resident ms of respiratory distress. Ons on 5/2/17 at 11:50 AM, :40 PM and 4:30 PM, thing in the wheelchair in his nula was on resident 's face, regen cylinder, attached to the gen flow meter was set up for with the oxygen regulator evel of oxygen. The resident ms of respiratory distress. M, during an interview, hat Resident #28 had and received oxygen therapy ar liters per minute staff was responsible for a therapy equipment and #28 during all three shifts. It is aides checked the status of every round and reported to oxygen cylinder needed to be see had access to the locked	F	328	then quarterly audits thereafter. The Director of Nursing shall present any identified findings/observed discrepancies, to the Quality Assurance Committee monthly for one month and quarterly thereafter.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345311	B. WING		c	5/04/2017	
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER			•	STREET ADDRESS, CITY, STATE, ZIP C 901 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 328	with Resident #28, i received oxygen the liters per minute. She the status of oxyger reported to the nurs needed to be changed observe Resident # nasal cannula lying cylinder. On 5/3/17 at 12:10 Physician indicated	rapy via nasal cannula four the stated the aides checked in therapy with every round and the when the oxygen cylinder the stated. She indicated she did not 28 with the oxygen tubing and on the floor or empty oxygen PM, during an interview, the that if the continuous oxygen d, she expected the resident	F	328			