STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and extended survey was conducted from 09/05/17 through 09/10/17 and 09/12/17. Immediate jeopardy was identified in the following areas at a scope and severity (J): CFR 483.10 at tag F241 CFR 483.12 at tag F224 CFR 483.20 at tag F279 CFR 483.25 at tag F323 CFR 483.35 at tag F353 CFR 483.70 at tag F490 CFR 483.75 at tag F520 CFR 483.80 at tag F441 CFR 483.90 at tag F463 The tags F224, F241 and F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 04/16/17 and it is ongoing. The nursing home was unable to provide an acceptable allegation of removal of the immediate jeopardy before the end of the survey. Due to a CMS software release, the ACO software system was down on 9/16/17 and 9/17/17. This had an impact on report production. CMS allowed this report to go out on 9/19/17.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication.	F 156		10/24/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/16/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1	F 156		

(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a

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F 156	Continued From page 2	F 156		

complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning

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F 156	Continued From page 3 November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 4	F 156		

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 5	F 156		

facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

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F 156	Continued From page 6 (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on Resident Council President interview, observation, record review and staff interview, the facility failed to have an updated list of names, addresses (mailing and email), and telephone numbers for pertinent State agencies and advocacy groups. Findings included: Interview with the President of the Resident Council on 9/7/17 at 8:30 AM revealed, residents could make a complaint to anyone, but she did not know where the complaint number was posted. A framed document entitled, Your Medicare and Medicaid Rights in Long Term Care was observed on 9/07/2017 at 1:16 PM and was hung on the wall down from the nurses' station. The document contained old telephone numbers for the State Survey Agency, the complaint number, the Office of the Long Term Care Ombudsman and protection and advocacy agency. The toll-free complaint number was listed, but indicated it was for the NC Department of Human Resources. There was no information for the Medicaid Fraud Control Unit. The telephone numbers for the state survey agency and complaints were dialed and one said the number was no longer in service and the other just rang	F 156	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The Medicare and Medicaid Rights in LTC poster with expired information was removed on 09/27/17. Contacted Local Ombudsman to request new poster. Resident Council will be educated on where to locate poster to obtain information on contact information to include list of names, mailing and email addresses and telephone numbers for pertinent State agencies and advocacy groups by 10/18/17. All new admissions and/or Responsible party will be informed of Resident Rights and location of poster. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The poster with required information was received and posted on 09/27/17. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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F 156	Continued From page 7 and rang and rang. On 9/07/2017 at 1:16 PM the Administrator was asked for a copy of the posting. She was informed the posting information was outdated. On 9/12/17 at 12:30 PM, the Administrator said it was her responsibility to have accurate information posted.	F 156	requirements; The Social Worker will update information promptly with any changes to ensure compliance with regulatory requirements. The Administrator will audit information on poster monthly; variances will be discussed with Social Worker and reeducation will be completed. Results will be reported to QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Administrator or Designee	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 157		10/24/17

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F 157	Continued From page 8 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, nurse practitioner interview and staff interview, the physician was not notified about a high blood sugar according to the sliding scale insulin order for 1 of 2 residents reviewed for notification of change (Resident #66). Findings included: Resident #66 was admitted to the nursing home on 7/17/17.	F 157	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #66 had noted elevated Blood Sugar of 499 @ 5:23pm on 09/07/17, which required MD notification. Nurse #4 did not review entire order, therefore the MD was not notified of the results. Resident was treated with insulin per MD	

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F 157	Continued From page 9 Her Minimum Data Set (MDS) assessment dated 7/24/17 indicated she had diabetes mellitus (DM) and received daily insulin injections. Humalog Solution 100 units/milliliter (Insulin Lispro) was ordered on 8/14/17. The order read, "Inject as per sliding scale: if 70 - 130 = 0 units; 131 - 180 = 2 units; 181 - 240 = 4 units; 241 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+ = 12 units and call MD (medical doctor), subcutaneously before meals and at bedtime for DM 2." According to the blood sugar (BS) monitoring record and the medication administration record (MAR), the BS was documented as 499 at 5:23 PM on 9/7/17. Twelve units of insulin was administered by Nurse #4. The BS Monitoring record indicated the resident had responded to the insulin administration and returned to a level of 147 at 9:21 PM. There was no progress note entered regarding the high blood sugar. A progress note was made on 9/7/17 at 2:39 PM and the next one was on 9/8/17 at 3:37 PM. Nurse #4 was interviewed on 9/12/17 at 2:08 PM. She confirmed her initials were on the MAR. Initially, she said, "Where does it say to call the MD?" and then she saw it. She said she did not call the MD or make a progress note. This information was shared with the Director of Nurses and the Administrator on 9/12/17 at 3:05 PM. The DON said that was a valid concern. The physician was interviewed on 9/12/2017 at 3:15 PM regarding his expectation for being	F 157	orders and blood sugar improved to 147. MD was notified of results on 09/12/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Nurse #4 was educated on regulation for notification of change on 09/26/17 by Director of Nursing. Review of all current residents□ records with orders as of 09/07/17 that require notification to MD of elevated blood sugar will be completed by 10/6/17 to ensure MD was notified. Licensed nursing staff will be educated on regulation of notification of change by Director of Nursing no later than 10/24/17. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The DON or designee will audit 25% of all residents with orders to notify MD of BS outside of ordered parameters will have blood sugars and MARS reviewed weekly for 30 days, and then 25% monthly for 60 days. If variances are identified the MD will be notified and responsible nurse will be re-educated. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing or designee	

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F 157	Continued From page 10 notified that a resident's blood sugar was 401 or greater. He said those nurses are pretty good at monitoring blood sugars. They should call the provider if the nurse practitioner can't take the call. The nurse practitioner was interviewed on 9/12/2017 at 3:20 PM. He said if the order says notify the provider then that is what should be done.	F 157		
F 224 SS=J	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, interviews with the staff, pharmacist, nurse practitioner, and Medical Director and record review, the facility neglected	F 224	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 11	F 224		

to answer call bells timely, provide assistance in a timely manner and provide functioning call bells in the bathrooms so if a resident needed to summon staff for assistance, they could get help and prevent an accident from occurring, follow up on lab specimens to determine the course of treatment for signs and symptoms of urinary tract infection, feed a resident and provide psychiatric services and behavior monitoring necessary to evaluate the resident's needs and treatment. This affected 5 of 40 sampled residents (#10, #24, #66, #130 and #131).

Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee below the knee amputation, high blood sugar on that day and a continued need for occupational therapy for transferring, toileting and dressing the lower body. On 9/7/17, three hours passed before hand bells were distributed to the bathrooms that had non-functioning call bells.

Examples number 2 - 5 are at no actual harm with potential for more than minimal harm that is not immediate jeopardy and the scope is a pattern (E).

Findings included:
1. Resident #66 was admitted to the nursing home on 7/17/17. Her admission Minimum Data

cited;
Pharmacy recommendations for GDR of Resident #10 reviewed by NP with decision to continue current orders, as followed by psych. Upon further review it was determined Resident #10 had seen LSW but not psycho recently. New order for Psycho consult on 09/08/17 and appointment was made for earliest available for November 6, 2017. Medical Director was provided education on psychotropic medication regulations on 10/04/17.
Resident #24 did not consume any of the lunch meal on 09/07/17 during mealtime observation. Documentation after lunch by Nurse Aide #3 noted Resident #24 consumed 25%-65%; documentation of meal intake was inaccurate. Education on ADL care and documentation was provided to Nurse Aide #3 on 09/27/17. Resident #24 was discharged on 09/09/17.
Resident #66 was re-assessed by therapy on 9/20/2017 and the resident□s care plan was updated on 9/21/2017 to reflect the most current level and type of assistance needed with transfers and toileting. The interventions on the care plan are identified as tasks and linked to the Kardex which is reviewed by CNA staff. Weekly interviews with resident #66 started on 9/20/17. Resident #130 was treated for UTI and later discharged on 09/22/17.

Administrative Staff #1, 2 and 3 were informed Resident #131 concerns of lack of call bell response and were educated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 12 Assessment indicated she had diagnoses including hypertension, peripheral vascular disease, septicemia, diabetes mellitus, non-Alzheimer's dementia, depression, generalized muscle weakness, abdominal pain, kidney failure, acquired abscess of left leg below knee, surgical aftercare for below knee amputation and gastro-esophageal reflux disease. Her Minimum Data Set (MDS) assessment dated 7/24/17 indicated she was moderately impaired in cognition (Brief Interview for Mental Status was 11), required extensive assistance from one person for transfer, dressing and toilet use. She was not steady with moving on and off the toilet and only able to stabilize with staff assistance. She had no fall history and she received both occupational and physical therapy during the assessment period. The Care Area Assessment indicated activity of daily living, urinary incontinence and falls would be addressed in the care plan to minimize risks and avoid complications. A care plan dated 8/1/17 indicated all problems were cancelled and resolved. A new care plan was initiated on 8/7/17. It only contained one problem for being on a therapeutic diet. A Fall Event report indicated Resident #66 had an assisted fall on Sunday, 8/27/17 at 10:00 AM. It said, The Certified Nurse Aide (CNA) was assisting resident with transfer from bed to wheelchair. CNA assisted resident to the floor. There was no harm and the Therapy Director provided education to the CNA on transfers. A corresponding physical therapy note dated 8/30/17 indicated Nurse Aide (NA) #10 was "trained in regards to toilet transfer to support fall prevention during transfers.	F 224	on the no passing zone process by Director of Nursing on 09/15/17. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. Beginning 9/9/2017, 100% of resident rooms and bathrooms were checked for functional call bells by the CEO, CFO, HR, Director of ER, Director of Imaging, and facility staff. If the facility found a bell that was not function, a hand bell was provided to the resident or the resident was temporarily moved into a resident room with a functional bell. An additional 100% audit was completed on 9/18/2017 and there were no calls bells identified as malfunctioning. b. Beginning 9/9/2017, training was conducted on the facility abuse and neglect policy. The DON and Administrator initiated this education for ECU staff. The training was provided by the Quality Director and designees to the ancillary departments on 9/10. These in-services were conducted across multiple shifts and departments. The in-services will continue to be offered as part of the facility orientation program for staff, staff being deployed from the hospital, and for contracted staff. The original training also included discussion on the team□s responsibility for responding to call bells. c. Additional training was initiated 9/20/2017 on No Pass Zones to remind all staff of their responsibility for responding to call bells. No Pass Zone signs have	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 224	Continued From page 13 An attempt to interview NA#10, who worked on the weekends, was made at 11:56 AM on 9/12/17, but it was unsuccessful. Interview with the therapy director on 9/12/17 at 11:30 AM revealed Resident #66 had assisted fall over a weekend. She was in the bathroom and her leg buckled. The therapy director said she was working that day and showed NA#10 how to transfer her using the grip bars. According to the Occupational Therapy (OT) therapy notes dated 9/4/17, Resident #66 required substantial assistance with lower body dressing and had improved in toileting - transfers to being able to safely transfer to the toilet with supervision or touching -minimum assistance for toileting routine. Resident #66 was interviewed on 9/06/2017 at 9:20 AM. She said, sometimes she was treated with dignity and respect and added, "When they don't come and they are short of help, you just have to wait until someone comes and helps you out." On 9/07/2017 at 10:08 AM, Resident #66 said, "At home I used pull ups and used the toilet. Here, I use the ones that fasten on the side. The staff get me to the toilet two to three times a day. When I press the call bell they will come. I used the walker before I came. Therapy gives me exercises in my room sometime. Coming, when I call them, is a problem. Mostly on days sometimes on second shift." A Health Status Note dated 9/7/2017 at 2:39 PM read in part, alert and oriented times three with	F 224	been placed throughout the unit as a reminder to staff. This training is on-going and will be included in orientation for the unit. No Pass Zone is a program that encourages all staff to answer call bells; if the person who answers the call bell is unable to assist the resident then the person answering the bell will seek the assistance that the resident requires. This training has been conducted by multiple and managers within the organization, including the DON, Nurse Executive, Corporate Vice President of Clinical Services, and Department Managers. d. Resident meeting was held on 9/26/17. A resident and family meeting was also held on 9/26/17 to discuss the current situation and reinforce the organization□s commitment to providing quality of life and care for the residents. These meetings were open to all residents and/or their representatives. Residents and family members were encouraged to provide feedback, to discuss concerns, and to provide suggestions for improvement to the leadership team, including the CEO, administrator, DON, Social Worker, and corporate representatives. e. Effective 9/21/2017, the organization created a task in Point of Care for all residents to be used by CNA staff to review the Kardex which is linked to the resident□s care plan to provide person centered care to the resident. The medical record will document CNA review of the	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 224	Continued From page 14 forgetfulness at times. ... Requires extensive assist with activities of daily Living (ADLs), set-up for oral care and meal tray. Blood sugar at 11:30 AM 236, receives insulin per sliding scale insulin order. On 9/07/2017 at 4:25 PM Resident #66 was observed in her private bathroom on her own. She was attempting to transfer back into her wheelchair. She appeared anxious and was tightly gripping the grab bar and struggling to back herself into her wheelchair. At approximately the same time NA #15 was passing by Resident #66's room. She said she had to take vital signs and blood sugars. She said Resident #66 goes to the bathroom on her own if she feels like it. At 4:30 PM Resident #66 came out of the bathroom and said in a loud and angry voice, "I LIKE TO FELL AND NEED MY BRITCHES UP." NA #15 went in the room to assist Resident #66. According to the blood sugar (BS) monitoring record and the medication administration record (MAR), the Resident #66's BS was documented as 499 at 5:23 PM on 9/7/17. Twelve units of insulin was administered by Nurse #4. On 9/08/2017 at 7:54 AM Resident #66 was asked if she had put on the call bell yesterday to let the aide know she needed help. She said the call bell was not working in the bathroom. The surveyor tested the call bell and it did not light outside the door or ring at the nurses' station. On 9/08/2017 at 7:58 AM the surveyor informed the Unit Secretary that the call bell in Resident #66's bathroom was not working. She said it was the first time she had heard about it.	F 224	Kardex each shift. Training for the CNA staff on use of the new link was initiated 9/21/2017. This training is being conducted by the Director of Nursing and/or licensed nurse as designated. f. A hold was placed on new admissions effective 9/9/2017 and will continue until facility is found to be in substantial compliance. The self-imposed hold on new admissions was made on 9/9/2017 by the CEO, administrator, and corporate representative. This hold was communicated to the Admissions Director on 9/11/17 (the next business day) by the Administrator. The Admissions Director has responded to each request stating that currently, the facility was unable to meet the needs of the applicant. g. Internal clinical staff and external clinical consultants have re-evaluated staffing needs and established 3.0 hours per resident day (HRD) as the minimum accepted staffing pattern, which is based on the staff reasonably available to ensure resident safety and quality of care. This 3.0 HRD minimum reflects clinical direct care hours only and does not include support services such as nursing management, restorative nursing, resident ambassadors, or therapy. In developing this staffing pattern, the CMS 5-Star data analysis file for August 2017 was taken into consideration. That data reflects the staffing level for Person Memorial at 2.5 hours per resident day (HRD) for the reported hours and 2.6	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 224	Continued From page 15 On 9/08/2017 at 11:15 AM Nurse #3 was interviewed about call bells. She said, "I am aware of a call bell reported not working. I would get in contact with the Maintenance Director. I would call his pager or leave a message." When Nurse #3 was asked about other means for the resident to use to call for help, she said, "We have bells and would have to find them". Immediately following the interview she was seen distributing hand bells to Resident #66 and to the other residents who did not have functioning call bells. On 9/08/2017 at 11:25 AM, the Director of Plant Operations was interviewed. He said, "If we get a report about a problem, then we get a service call. We would not check other call bells. It is on an as needed basis. He confirmed that the call bell in Resident #66's bathroom room did not work. On 9/09/2017 at 11:01 AM a hand bell was observed in Resident #66's bathroom. On 9/08/2017 at 3:17 PM the Occupational Therapist was interviewed. She said she had worked with Resident #66 on functional transfers to toilet. She said, "Initially she needed two person assistance. Now she needed minimum assist and cues for safety and hand placement. She needed contact guard assistance. We've done safety training with nurse aides in the room. She added, "Typically, someone would be with her. She is good about calling if she needs help. I would not recommend her toileting by herself. She can self-propel in wheelchair. She is compliant. The safety awareness has already been an issue (i.e., hand placement). Safety is a huge thing."	F 224	HRD for the adjusted hours for actual adjustment based on reported case mix. The 3.0 minimum is .4 HRD over the CMS reported adjusted hours. Also, it should be noted the 3.0 HRD is the minimum accepted with 3.27 HRD being the mean and 3.6 HRD being optimal. The facility has contacted multiple staffing agencies to secure additional licensed nurses and certified CNAs. h. The facility has contacted multiple staffing agencies to secure additional licensed nurses and certified CNAs. Contact was initiated 9/10/2017 and was expanded on 9/19/2017 to other agencies. i. Staff will be deployed from the acute hospital staff to assist in covering service gaps. These individuals have been screened through the hospital employment process and have been included in in-service training for ECU including, but not limited to, abuse and neglect, dignity, elopement, employee burnout and no pass zone. j. The facility has offered multiple incentives to fill vacant shifts. On 9/16/2017, the offers included overtime pay for a double shift incentive, retention bonuses, and sign-on bonuses for CNAs. Prior to 9/16/2017, the facility was offering referral bonuses, sign-on bonuses for RNs and LPNs, commitment bonuses, and vacant shift bonuses. k. The organization approved a new	

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F 224	Continued From page 16 Resident #66 was interviewed again on 9/08/2017 at 4:20 PM. She said, "I tried to get someone yesterday and couldn't find anyone. It was dangerous." On 9/09/2017 at 10:15 AM the Director of Nurses was interviewed. She confirmed that Resident #66 required assistance from one person and needed supervision with activities of daily living. She needed a nurse aide (NA) due to her diagnosis of dementia. She can be forgetful at times. Resident #66 had some episodes of confusion. She had tried to get up. She had one assisted fall with staff. She was trying to get out of wheelchair and she did not wait for assist. The Director of Rehab provided education to the CNA. On 9/8/17 at 12:30, the administrator was informed of the immediate jeopardy. 2. Resident #130 was admitted on 8/16/17. Her admitting diagnoses included orthopedic aftercare, pain in left shoulder, pain in right wrist, muscle weakness, gait and mobility abnormalities and hypertension. The resident's admission Minimum Data Set assessment was dated 8/30/17. The resident's cognition was moderately impaired with a Brief Interview for Mental Status score of 12. She required extensive assistance from one person for toileting and she was not steady moving on and off the toilet. She was always continent. Resident #130 had an activity of daily living (ADL) self-care performance deficit related to limited mobility, limited range of motion, musculoskeletal impairment and pain all due to fractures suffered	F 224	position of resident ambassador to assist the clinical team in non-direct care activities such as making unoccupied beds, passing ice or meal trays, answering calls, etc. As of 9/19/2017, four positions have been approved and are scheduled for orientation and assignment. All four positions have reviewed and signed their job descriptions. l. Effective 9/11/2017 the hospital nursing supervisor is to conduct rounds on the long-term care nursing facility unit twice per shift on the 12-hour evening shift. The role of nursing supervisor during this round is to provide additional supervision and oversight to the ECU team as needed. The supervisor will make rounds on the unit and discuss any immediate needs with the licensed nursing staff. The supervisor is also available to the ECU to respond to any emergency that may occur. m. Key members of the facility leadership team will have huddle meetings daily, Monday through Friday, to report progress on the above actions and to identify new opportunities to minimize abuse or neglect. A spreadsheet is maintained and has served to enhance the organization of the meeting and strengthen the structure of the discussion. The leadership team is composed of the Administrator, Director of Nursing, Director of Quality, and Director of Human Resources. Adjunct support will be provided by the CEO, CFO, Social Worker, Corporate Vice President of	

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F 224	Continued From page 17 in a fall at home. A nurse practitioner (NP) progress note dated 8/31/2017 at 12:34 PM stated in part, "Her (family member) also relates patient complaint of painful urination this morning and she noted pink tinge to urine." Her temperature was taken and it was normal. - A thorough assessment was performed. The NP wrote, "Will follow up on lab tests with appropriate orders to follow ..." On 8/31/2017 at 5:23 PM a Health Status Note was written and said, "Resident was noted having white mucus discharge from vagina (NP) was notified". New order was given to obtain UA and complete blood count (CBC). Resident and family were notified. On 9/2/2017 at 2:50 AM a Health Status Note was written and said, " ...her family reports a white discharge from vaginal area, np is aware. Her vital signs are stable and she is afebrile..." On 9/3/2017 at 8:24 PM a Health Status Note was written and said the physician was notified that urinalysis (u/a) was ordered on 8/31 had not yet be obtained. Family wished to speak and see him ...Informed him of her most recent vital signs and again about the u/a. He ordered STAT (immediate) complete blood count (CBC), basal metabolic panel (BMP) and urinalysis and culture and sensitivity (u/a c&s), an antibiotic, Levofloxacin, was started. "The first attempt to obtain u/a was unsuccessful, noted white discharge noted in collection tube. Encouraged her to drink fluids and was able to obtain u/a sample on second attempt. STAT labs results pending. Denies any pain or discomfort." A telephone order was written on 9/3/17 for a Stat	F 224	Clinical Services, Chief Nursing Officer, and Director of Plant Operations. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; A minimum of 10 resident interviews will be completed weekly by the Social worker or designee to solicit resident input on staff response times to call bells, if needs are being met and what the facility could do better. Immediate concerns are being addressed and will be followed by the Administrator or an administrative team member. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. The title of the person responsible for implementing the acceptable plan of correction; Administrator or administrative designee	

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F 224	Continued From page 18	F 224		

CBC, BMP, UA & C&S possible urinary tract infection (UTI) - Levofloxacin 750 milligrams (mg) per oral (PO) daily for 5 days.

On 9/4/2017 at 9:16 AM a Health Status Note read, in part, " ...Lab results faxed in from lab, AM nurse aware. First dose of Levaquin 750 mg given at 9:00 PM for (urinary tract infection) UTI. No (signs or symptoms) s/s of adverse reaction noted. "

On 9/5/17, the C&S result was >100,000 Proteus mirabilis.

On 9/7/2017 a physician's order was written for a different antibiotic.

An NP progress note dated 9/7/2017 at 11:52 AM indicated intramuscular Rocephin had been started and the previous antibiotic was stopped. "Organism was sensitive to both agents, however, clinically she was not improving. With the change she is showing improvement and is able to sit up in bedside chair today and more mentally clear." ... She has improved with Rocephin addition ..."

Interview with the NP on 9/7/17 at 4:22 PM revealed he ordered the UA & C&S. on 8/31/17 "I would have written a hard script for it. The Unit Secretary would take the order off and give it to the nurse. The family asked about results and wanted to see the MD. He ordered another UA C&S. He started her on Levaquin. She had no clinical improvement then put her on Rocephin." The NP was asked what impact not getting the results had on the resident. He said it would have been better if treated. Nurse #9, signed off on the order dated 8/31/17 to obtain a UA and C&S.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 19	F 224		

The physician was interviewed on 9/07/2017 at 4:45 PM. The MD said the family spoke to him on 9/3/17. He ordered new labs and a UA C&S. He said he did not know why the sample was not collected. He said the family said there was pus in urine. No vital signs suggested a problem. He added, "Fortunately the labs CBC & BMP were normal." The vital sign record indicated Resident #130's temperature range from 8/31/17 - 9/3/17 was 96.6 - 98.9 degrees F.

On 9/08/2017at 7:59 AM an attempt was made to interview Resident #130 about her signs and symptoms of UTI. She said she was sleeping a lot and did not remember. She declined observation of care.

Nurse #9 was interviewed on 9/09/2017 at 10:50 AM about her actions on 8/31/17. She said, "I collected the urine and sent it to the lab. It was around lunch time. The NP gave me the order. I asked how to obtain the specimen and was told by in and out catheterization. A family member was in the room. I put a label on the specimen. I put on time and date. I put it in a biohazard bag. I saw the lady in the lab. I put it in the basket. I put label in the computer. I reported off to next shift nurse and sent to lab. I was off the next three days. I came back on 9/4/17 and the resident was on an antibiotic.

On 9/09/2017 at 10:15 AM the Director of Nurses said Nurse #9 claims she collected the urine specimen and took it to the lab. She said, "I am still in the process of trying to validate that the sample was obtained. I am still investigating." She said there should not be a delay. "It goes back to process. I've had conversations with

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 20	F 224		

nurses about how we put lab orders in."

On 9/9/17 at 11:00 AM interview with Resident #130's family member confirmed the specimen was collected on 8/31/17.

3. Resident #24 was admitted on 05/01/17 with the admission of malnutrition, diabetes mellitus and hypertension. The most recent minimum data set dated 08/10/17 revealed Resident #24 was severely impaired cognition, and required limited assistance with dining and had no swallowing problems. Her most current weight on 08/02/17 was 73 pounds.

A review of the most recent care plan dated 05/01/17 revealed Resident #24 had a nutritional problem related to severe malnutrition. The goal was to maintain adequate nutrition status as evidenced by maintaining weight within 10% of 100lbs with no sign or symptoms of malnutrition and consuming greater than 50% of at least 3 meals daily. The interventions were, in part, to provide and serve her diet as ordered.

A review of the August and September 2017 medication administration records (MAR) revealed treatment for a urinary tract infection beginning on 08/28/17.

A review of a nursing note dated 09/01/17 revealed accepted medication with lots of encouragement to close mouth and swallow. A review of the nursing notes from 8/28/17 until 09/07/17 revealed no behaviors during meals. A review of the behavior summary report ending for the week of 09/10/17 revealed no behaviors.

On 09/07/17 at 12:20 PM, a continuous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 21	F 224		

observation was conducted with Aide #3 who was assigned to Resident #24. The trays were delivered to the room at 1:22PM and Resident #24 was lying in bed resting. Aide #3 went into the room at 1:27 PM. The aide woke up and fed Resident #23, the roommate. She completed the feeding at 1:50 PM and left the room and went into the break room across the hall.

During an interview on 09/07/17 at 2:00 pm, Aide #3 indicated that she wasn't going to feed lunch to Resident #24. When asked why, Aide #3 stated Resident #24 wasn't going to eat ground chicken, carrots and mashed potatoes. Aide #3 indicated Resident #24 would just mash it up and play in it and stated that Resident #24 fought and spit during meals and wanted to feed herself and did better with finger foods. Aide #3 indicated that she would leave the tray for the next shift to feed her because she didn't want to upset Resident #24 because she was old and had woke up in a bad mood.

On 09/07/17 at 2:31 PM, Nurse #2 indicated Aide #3 had not reported Resident #24 had not eaten her lunch. Nurse #2 indicated she knew Resident #24 was combative with activities of daily living (ADLs) care and should always be offered her meals.

On 09/08/17 at 8:48 AM, Aide #2 was observed waking up Resident #24 for breakfast. Aide #2 repositioned her and attempted to feed her eggs. Resident #24 pushed the eggs out with her tongue. Aide #2 offered Resident #24 pancakes which she accepted but was very slow to eat.

During the observation, Aide #2 indicated she had heard that Resident #24 would hit during ADL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 22	F 224		

care. Aide #2 stated Resident #24 was a slow eater and required patience and time.

On 09/08/17 at 10:24 AM, the Director of Nursing stated she expected Aides to attempt to feed all residents. If the resident refused, the aides were to re-approach later and feed.

4. Resident #131 was admitted to the facility on 9/4/17 upon discharge from a hospital. The resident's medical history included a fracture of her left hip with surgical repair. A review of the resident's hospital Discharge Summary dated 9/4/17 included special instructions which read, "Patient should be on strict fall precautions she will need physical therapy and occupational therapy."

A review of the facility's medical record for Resident #131 revealed her Admission Minimum Data Set (MDS) assessment and individualized care plan were not yet due for completion.

A review of the facility's Admission Nursing Summary dated 9/4/17 at 3:15 PM revealed the resident was alert. Her short and long term memory were assessed to be intact and decisions were reported to be consistent and reasonable. The resident required extensive assistance for all of her Activities of Daily Living (ADLs), with the exception of requiring limited assistance of one with dressing and being independent with eating. Resident #131 was reported to be continent of bowel and bladder.

A Fall Risk Assessment completed on 9/4/17 revealed Resident #131 was determined to be at a moderate risk for falls. She was noted to have a history of a fall at home with a left hip fracture

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 23	F 224		

and repair. The Fall Risk Assessment indicated the resident required, "hands-on assistance to move from place to place."

A review of Resident #131's Physical Therapy (PT) Plan of Care dated 9/5/17 included an assessment of the resident's current functional abilities. The Plan of Care indicated the resident required supervision or touching assistance for ambulation. This level of assistance was further defined as needing a helper to provide verbal cues or touching/steadying assistance as the resident ambulated, either throughout the activity or intermittently.

A review of Resident #131's Occupational Therapy (OT) Plan of Care dated 9/5/17 also revealed an assessment of the resident ' s current functional abilities was conducted. The Plan of Care indicated the resident required supervision or touching assistance for toileting. The resident was also assessed as requiring supervision for transfer with toileting. She was determined to be at a moderate risk for balance and falls.

A review of the resident's medical record included a Nursing Note dated 9/6/17 at 2:34 PM. The note indicated the resident was able to verbalize her needs. She ambulated with a walker with the assist of one.

Review of a Nursing Note dated 9/7/17 at 8:59 AM also revealed Resident #131 ambulated with the help of a walker, but required assistance and was described as "not very steady."

Further review of Resident #131's medical record included a Nursing Note dated 9/9/17 at 12:58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 24	F 224		

AM. This note also indicated Resident #131 ambulated with a walker and the assistance of one.

An observation was conducted on 9/9/17 at 7:40 AM. Upon entering the resident ' s hallway, Resident #131's call light was observed to be lit above the door to her room and the sound of an activated call bell was heard. The resident's door was closed and she could not be viewed from the hallway. At that time, a continuous observation was made of Resident #131 ' s door and the call light above her doorway. At 7:51 AM a Housekeeping staff member was observed as she passed by Resident #131's room. The Housekeeping staff member did not knock or look into the resident's room. The call light continued to be lit above the door to Resident #131's room. At 8:01 AM, Administrative Staff Member #1 was observed as she walked by the resident's room. The administrative staff member did not knock or look into the resident's room. The call light continued to be lit above the door to Resident #131's room. At 8:07 AM, Administrative Staff Member #2 was observed as she passed by the resident's room. The administrative staff member she did not knock or look into the resident's room. The call light continued to be lit above the door to Resident #131's room. At 8:08 AM, Administrative Staff Member #3 passed by Resident #131's room. The administrative staff member she did not knock or look into the resident's room. The call light continued to be lit above the door to the resident's room. At 8:13 AM, Resident #131's breakfast tray was delivered to her room. Within one minute of the tray delivery, the resident's call light was turned off. On 9/9/17 at 8:15 AM, Nursing Assistant (NA) #2 was observed as she came out of the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 25	F 224		

room and closed the door. An interview was conducted with NA #2 at that time. During the interview, the NA was asked why the resident had her call light on. The NA reported the resident needed assistance to get to the bathroom.

An interview was conducted on 9/9/17 at 3:20 PM with Resident #131. Upon inquiry, the resident recalled putting on her call light in the morning before breakfast and stated she needed to use the bathroom. Resident #131 reported she was not supposed to go to the bathroom by herself and needed assistance to do so. She did not recall what time she put on the call light that morning, but reported, "Sometimes it takes a half hour for them to come." Resident #131 stated she did not have a clock or watch to see exactly how much time had elapsed before staff came to assist her. The resident also described "one night" earlier in the week when she put on the call light to request bathroom assistance. Resident #131 reported she waited for what seemed to be "quite a long time." The resident stated she couldn't wait any longer for staff to come because, "I just knew I would wet myself all over if I waited anymore." Resident #131 reported she used the walker in her room to walk to the bathroom unassisted and then back to bed (also unassisted). Resident #131 stated she met the facility ' s Administrator a couple of days ago and told her, "You need more help."

A follow-up interview was conducted on 9/10/17 at 9:40 AM with Resident #131. During the interview, the resident recalled the night her call light was not answered by staff when she needed assistance to go to the bathroom. The resident stated she had actually used the call light twice that night and ended up getting to the bathroom

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 26	F 224		

and back to bed by herself unassisted because no one came to help her. The resident reported she knew she shouldn't walk unassisted but didn't feel she had a choice. She reported she just didn't feel strong enough to safely walk by herself and had been instructed by therapy and staff that she should not ambulate without assistance.

An interview was conducted on 9/10/17 at 3:36 PM with the facility's Director of Nursing (DON). Upon inquiry as to who was responsible for responding to call lights, the DON responded, "All staff...we have the no-passing zone." The DON reported ' the no-passing zone ' meant all staff from all departments, including housekeeping and dietary, should answer call lights. She reported if the particular staff member answering the call light could not meet the needs of the resident, he/she should let someone know who could take care of the resident's need. When asked what her expected response time would be for staff to answer a call light, the DON stated, "Ideally, less than 5 minutes."

An interview was conducted on 9/12/17 at 11:55 AM with Physical Therapist (PT) #1. PT #1 reported he had been working with Resident #131 since her admission to the facility a little over one week ago. Upon inquiry, the PT reported the resident continued to require assist of one for ambulation and toileting. The resident ' s report of ambulating to/from the bathroom on her own in the night were discussed with the PT. The PT stated he, "would have wanted her to have help."

5. Resident #10 was admitted to the facility on 3/29/16. The resident ' s cumulative diagnoses included schizoaffective disorder (bipolar), major

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 27 depressive disorder (single episode), and anxiety. A review of the resident's November 2016 Physician Orders included the following medications, in part: --2 milligrams (mg) risperidone (an antipsychotic medication) given as 1 tablet by mouth every night at bedtime related to schizoaffective disorder, bipolar type; --0.5 mg risperidone given as 1 tablet by mouth every night at bedtime related to schizoaffective disorder, bipolar type; --20 mg citalopram (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --30 mg duloxetine (an antidepressant) given as 1 capsule by mouth every day related to major depressive disorder, single episode; --40 mg Fetzima (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --20 mg paroxetine (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --5 mg diazepam (an antianxiety medication) given as one tablet by mouth twice daily for bipolar and anxiety. A review of the resident ' s medical record included a notation made by Resident #10's former physician (dated 11/15/16) written in response to a Consultation Report (dated 9/27/16) from the facility ' s consultant pharmacist. The Consultation Report reported Resident #10 received 4 antidepressants in addition to an antipsychotic and antianxiety medication. The pharmacist indicated the need for four antidepressant agents with the same (or similar) action represented a duplication of	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 28	F 224		

therapy and recommended the need for four antidepressant agents be re-evaluated. She suggested consideration be given to tapering and discontinuing use of one or more (perhaps citalopram or paroxetine) to avoid the risk of side effects. The physician declined the pharmacist's recommendation on 11/15/16 with a notation that read: "Recently - psych (psychotropic) meds reviewed by [Name of Medical Center] - no changes were made."

A review of Resident #10's March 2017 Physician Orders revealed the resident continued to receive the same psychotropic medications in the same dosages as those ordered in November 2016. The psychotropic medications included risperidone, citalopram, duloxetine, Fetzima, paroxetine, and diazepam.

Further review of the resident's medical record included a Consultation Report from the consultant pharmacist dated 3/14/17. The Consultation Report indicated Resident #10 received 4 antidepressants in addition to an antipsychotic and antianxiety medication. The pharmacist recommendation indicated the need for four antidepressant agents with the same (or similar) action represented a duplication of therapy and suggested the regimen be re-evaluated with consideration given to tapering the citalopram dose at this time. The NP declined the recommendation on 4/15/17, noting "Long standing h/o (history of) mental illness-meds eval (evaluated) by psych with no changes--no med change at this time."

A review of Resident #10's medical record revealed the frequency of her diazepam dosing was increased on 5/11/17 from 5 mg given twice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 29	F 224		

daily to 5 mg diazepam given three times a day. There was no documentation in the resident's paper or electronic medical record to indicate the resident's target behaviors/mood were being monitored and to support the rationale for the dose increase.

A review of the resident's medical record included a Consultation Report from the consultant pharmacist dated 5/17/17. The Consultation Report indicated diazepam was a long-acting medication and considered a high risk medication due to the increased risk of sedation, depression, confusion, addiction and falls in the elderly. The report acknowledged the recent dose increase of diazepam and recommended consideration be given to tapering down the dose. The NP declined the pharmacist's recommendation on 7/17/17 with a notation that read: "Recently assessed by psych-no changes were made to her long term psych meds including Valium (diazepam)."

Further review of the resident's medical record included a Consultation Report from the consultant pharmacist dated 6/9/17. The Consultation Report indicated the resident received paroxetine, which increased her risk for dry mouth, constipation, urinary retention, blurred vision, and increased confusion/sedation. The pharmacist also noted the resident received 3 additional antidepressants, an antipsychotic and an antianxiety medication. The report recommended consideration be given to re-assessing the use of paroxetine due to the risk for side effects. The NP declined the pharmacist's recommendation on 7/17/17 with a notation that read: "Recently assessed by psych-no changes were made to her long term

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 30	F 224		

psych meds including Paxil (paroxetine)."

A review of the resident ' s medical record included a 7/17/17 Consultation Report (noted as a repeat recommendation from 5/17/17) from the consultant pharmacist. This report reiterated the recommendations made in the 5/17/17 Consultation Report. The NP declined the pharmacist's recommendation on 8/22/17 with a notation that read: "Psych eval completed with med rec (medication reconciliation) done and no changes made - will continue current regimen."

A review of Resident #10's August 2017 Physician Orders revealed the resident continued to receive the same psychotropic medications in the same dosages as her November 2016 orders, with the exception of the dose increase for diazepam on 5/11/17. The psychotropic medications included risperidone, citalopram, duloxetine, Fetzima, paroxetine, and diazepam.

A review of Resident #10's most recent quarterly Minimum Data Set (MDS) assessment dated 8/9/17 indicated the resident had intact cognitive skills for daily decision making. Section D of the MDS reported the resident had a mood severity score of zero (0); Section E indicated the resident exhibited no behaviors nor rejection of care. Section N of Resident #10's assessment revealed she received an antipsychotic, antidepressant, and antianxiety medication on 7 out of 7 days during the look back period.

A review of the resident's care plan (not dated) included the following area of focus: The resident uses psychotropic medications related to depression, anxiety, and insomnia (Initiated and Revised on 6/28/16). The planned interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 31	F 224		

for this area of focus included:
--"Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q-shift (every shift).
--Monitor/document/report PRN (as needed) any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person."

A review of the resident's paper and electronic medical record revealed the resident's target behaviors/mood were not routinely monitored or documented by the nurses or the nursing assistants.

An observation and interview was conducted of the resident on 9/6/17 at 9:30 AM. The resident did not exhibit any behaviors at that time.

An interview was conducted on 9/8/17 at 11:30 AM with the NP caring for Resident #10. During the interview, the NP reported he was aware Resident #10 received multiple psychotropic medications, including 4 antidepressants. He stated the resident had a longstanding history of psychiatric disorders and had been on the medications a long time. The NP reported Resident #10 was assessed and evaluated by a psychiatric service and they opted not to make any changes to her medications at that time. The NP stated he did not agree with the pharmacist recommendations to reassess Resident #10 ' s medications and consider gradual dose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 32	F 224		

reductions because he felt such meds were best adjusted by a psychiatric service. When asked if a psychiatric service was following the resident, he stated "No, she was seen as a one-time only evaluation." He was not certain of the date the resident was seen by the psychiatric service.

An observation and interview was conducted of the resident on 9/9/17 at 9:45 AM. The resident did not exhibit any behaviors at that time.

A review of the resident's paper and electronic medical record revealed there was no documentation to indicate the Resident #10 had been seen for a psychiatric evaluation.

A telephone interview was conducted on 9/9/17 at 9:53 AM with the facility's consultant pharmacist. The pharmacist reported she was aware Resident #10 was on multiple antidepressants and thought perhaps these could be consolidated. However, the pharmacist reported each time the issue was addressed, her recommendation was declined. The pharmacist reported she thought the resident was being seen by psych in the past.

An interview was conducted on 9/9/17 at 11:44 AM with the facility's Director of Nursing. Upon review of Resident #10's medical record, the DON reported that since her admission to the facility, Resident #10 was seen by a counseling program one time only on 5/18/16. The DON confirmed the report of this visit was recently received by the facility (on 9/8/17). This report indicated Resident #10 needed to be seen for a psychiatric evaluation. The DON stated, "It most definitely was not a psychiatric evaluation." The DON confirmed Resident #10 had not been seen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 33	F 224		

by a psychiatric service at any time over the past year and one-half (since her admission to the facility).

A telephone interview was conducted with the facility's Medical Director on 9/9/17 at 4:15 PM. A brief overview of Resident #10's medical history and concerns regarding her medication regimen was reviewed with the Medical Director. At that time, the Medical Director identified the credentials of the provider who saw Resident #10 on 5/18/16 as a Clinical Social Worker. Since Resident #10 was a long-term care resident, the Medical Director indicated he would have expected her to have had a psychiatric evaluation along with psychiatric follow up. He stated, "We're going to need on-going assistance for managing medications from psych."

An interview was conducted on 9/10/17 at 10:15 AM with the facility ' s MDS Nurse. During the interview, the MDS nurse reviewed Resident #10's care plan and the interventions put into place related to the psychotropic medications she received. Upon review, the MDS nurse stated, "There are a lot of interventions that could have been added specific to this resident." The MDS Nurse also reviewed the nursing staff's documentation in Resident #10 ' s electronic medical record regarding behaviors and mood. The MDS Nurse reported she identified a "few" Nurses ' Notes in the resident's medical record which were primarily focused on isolated episodes of confusion, but not related to behavior or mood issues. The MDS nurse indicated she would have expected to see more documentation of behaviors/mood due to Resident #10 ' s use of antipsychotic medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 34 A follow-up interview was conducted on 9/12/17 at 11:35 AM with the NP. During the interview, the NP indicated it was now his understanding the resident was only seen by a Clinical Social Worker since her admission to the facility. The NP acknowledged the report written by the Clinical Social Worker recommended a psychiatric evaluation be completed. The NP also confirmed he had been working under the assumption a psychiatric evaluation had been completed for this resident. The NP stated he wrote another order on 9/8/17 and requested Resident #10 be seen by a psychologist for a psychiatric evaluation and medication review.	F 224		
F 241 SS=J	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record, review and staff and resident interviews, the facility failed to provide: Resident #66 a functioning call bell in her bathroom so she could call for assistance when needed; Resident #56 incontinence care when requested; Resident #10 a bath and incontinence care in a manner to maintain the dignity; Resident #131 timely call bell response for toileting assistance. This affected 4 of 40 sample residents reviewed for dignity (Resident #10, #56, #66 and #131). Immediate jeopardy began on 9/7/17 and is	F 241	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #66, was re-assessed by therapy on 9/20/2017 and the resident□s care plan was updated on 9/21/2017 to reflect the most current level and type of assistance needed with transfers and toileting. The interventions on the care plan are identified as tasks and linked to the Kardex which is reviewed by CNA	10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 35	F 241		

ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous.

Examples number 2 - 4 are at no actual harm with potential for more than minimal harm that is not immediate jeopardy and the scope is isolated (D).

Findings included:

1. Resident #66 was admitted to the nursing home on 7/17/17. Her admission Minimum Data Assessment indicated she had diagnoses including hypertension, peripheral vascular disease, septicemia, diabetes mellitus, non-Alzheimer's dementia, depression, generalized muscle weakness, abdominal pain, kidney failure, acquired abscess of left leg below knee, surgical aftercare for below knee amputation and gastro-esophageal reflux disease.

Her Minimum Data Set (MDS) assessment dated 7/24/17 indicated she was moderately impaired in cognition, required extensive assistance from one person for transfer, dressing and toilet use. She was not steady with moving on and off the toilet and only able to stabilize with staff assistance. She had no fall history and she received both occupational and physical therapy during the assessment period. The Care Area Assessment indicated activity of daily living, urinary incontinence and falls would be addressed in the

staff.

Resident #66 (who resided in room 262) was initially provided a hand bell to use in the bathroom. The Resident was then moved to room 263 with a functioning call bell. Parts were ordered and the call bell in room 262 was repaired on 9/15/17. The resident is content in room 263 and has remained there.

Weekly interviews with resident #66 started on 9/20/17. Weekly interviews will be conducted with Resident #66 by the social worker and/or designee for four weeks to ensure that her call bell is functional and that staff are responding to requests for assistance with toileting in an appropriate and timely manner. Any variances will be communicated to the facility leadership team during the huddles which are being held daily, Monday through Friday.

Resident # 10 was provided appropriate incontinence care on 09/09/17, after the deficient practice was observed. Nurse Aide #7 was educated on Incontinence care and infection control by Director of Nursing on 09/10/17.

Administrative Staff #1 is no longer employed. Administrative staff # 2 and 3 will be informed Resident #131 concerns of lack of call bell response and were re=educated on the no passing zone process by Director of Nursing by 10/06/17.
Resident #56 was informed of resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 36 care plan to minimize risks and avoid complications. Resident #66 was interviewed on 9/06/2017 at 9:20 AM. She said, sometimes she was treated with dignity and respect and added, "When they don't come and they are short of help, you just have to wait until someone comes and helps you out." On 9/07/2017 at 10:08 AM, Resident #66 said, "At home I used pull ups and used the toilet. Here, I use the ones that fasten on the side. The staff get me to the toilet two to three times a day. When I press the call bell they will come. I used the walker before I came. Therapy gives me exercises in my room sometime. Coming, when I call them, is a problem. Mostly on days sometimes on second shift." Nurse Aide (NA) #6 was interviewed on 9/07/2017 at 10:22 AM about how she knows what care to provide residents. She said, "After a day or two, I get to know the routine. ... Sometimes, she (Resident #66) will pee in a diaper. Now, she likes to use the commode. She wears a diaper just in case. She will press call bell for help ..." The nurse aide's Documentation Survey Report for September 7, 2017 had no activity of daily life entry for that day. It also did not include any individualized instruction for dressing, transferring or toileting. On 9/07/2017 at 4:25 PM Resident #66 was observed in her private bathroom on her own. She was attempting to transfer back into her wheelchair. She appeared anxious and was tightly gripping the grab bar and struggling to back herself into her wheelchair. At	F 241	right and expectation to have call bell answered timely. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. Staff training on dignity was conducted on 9/21/2017 and will continue across multiple shifts and departments. This training will be conducted by the social worker, a licensed nurse, or the Administrator. b. The Ombudsman participated in a meeting with residents on 9/26/2017, focusing on reinforcing their rights as residents. The Ombudsman has agreed to provide additional visits for resident and staff education on a date to be determined. c. A resident meeting was held on Tuesday, 9/26/17. A resident and family meeting was also held on 9/26/2017 to discuss the current situation and reinforce the organization□s commitment to providing quality of life and care for the residents. These meetings were open to all residents and their representatives. Residents and family members were encouraged to provide feedback, to discuss concerns, and to provide suggestions for improvement to the leadership team, including the CEO, administrator, DON, Social Worker, and corporate representatives. d. Departmental Managers will be reminded on how to identify signs and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 37 approximately the same time NA #15 was passing by Resident #66's room. She said she had to take vital signs and blood sugars. She said Resident #66 goes to the bathroom on her own if she feels like it. At 4:30 PM Resident #66 came out of the bathroom and said in a loud and angry voice, "I LIKE TO FELL AND NEED MY BRITCHES UP." NA #15 went in the room to assist Resident #66. On 9/08/2017 at 7:54 AM Resident #66 was asked if she had put on the call bell yesterday to let the aide know she needed help. She said the call bell was not working in the bathroom. The surveyor tested the call bell and it did not light outside the door or ring at the nurses' station. On 9/08/2017 at 7:58 AM the surveyor informed the Unit Secretary that the call bell in Resident #66's bathroom was not working. She said it was the first time she had heard about it. On 9/08/2017 at 11:15 AM Nurse #3 was interviewed about call bells. She said, "I am aware of a call bell reported not working. I would get in contact with the Maintenance Director. I would call his pager or leave a message. When Nurse #3 was asked about other means for the resident to use to call for help, she said, "We have bells and would have to find them". Immediately following the interview she was seen distributing hand bells to Resident #66 and to the other residents who did not have functioning call bells. On 9/09/2017 at 11:01 AM a hand bell was observed in Resident #66's bathroom. On 9/08/2017 at 3:17 PM the Occupational	F 241	symptoms of stress and burnout. The organization has a strong employee assistance program and departmental managers will be encouraged to offer these programs to staff who demonstrate signs and symptoms of stress and burnout. The discussion was initiated on 9/25/2017 during the Departmental Stand-Up Meeting and was facilitated by the CEO and Director of Human Resources. Departmental Directors will provide additional education to their respective departments. e. Key members of the facility leadership team will have huddle meetings daily, Monday through, Friday to report progress on the above actions and to identify new opportunities to minimize abuse or neglect. A spreadsheet is maintained and has enhanced the organization of the meeting and strengthened the structure of the discussion. The leadership team is composed of the Administrator, Director of Nursing, Director of Quality, and Director of Human Resources. Adjunct support is provided by the CEO, CFO, Social Worker, Corporate Vice President of Clinical Services, Chief Nursing Officer, and Director of Plant Operations. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; A minimum of 10 resident interviews will be completed weekly by the Social worker or designee to solicit resident input on staff response times to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 38 Therapist was interviewed. She said she had worked with Resident #66 on functional transfers to toilet. She said, "Initially she needed two person assistance. Now she needed minimum assist and cues for safety and hand placement. She needed contact guard assistance. We've done safety training with nurse aides in the room. She added, "Typically, someone would be with her. She is good about calling if she needs help. I would not recommend her toileting by herself. She can self-propel in wheelchair. She is compliant. The safety awareness has already been an issue (i.e., hand placement). Safety is a huge thing." Resident #66 was interviewed again on 9/08/2017 at 4:20 PM. She said, "I tried to get someone yesterday and couldn't find anyone. It was dangerous." On 9/8/17 at 12:30 PM, the administrator was informed of the immediate jeopardy. 2. Resident #131 was admitted to the facility on 9/4/17 upon discharge from a hospital. The resident's medical history included a fracture of her left hip with surgical repair. A review of the resident ' s hospital Discharge Summary dated 9/4/17 included special instructions which read, "Patient should be on strict fall precautions she will need physical therapy and occupational therapy." A review of the facility's medical record for Resident #131 revealed her Admission Minimum Data Set (MDS) assessment and individualized care plan were not yet due for completion. A review of the facility's Admission Nursing Summary dated 9/4/17 at 3:15 PM revealed the	F 241	call bells, if needs are being met and what the facility could do better. Immediate concerns are being addressed and will be followed by the Administrator or an administrative team member. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. The title of the person responsible for implementing the acceptable plan of correction; Administrator or administrative designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 39	F 241		

resident was alert. Her short and long term memory were assessed to be intact and decisions were reported to be consistent and reasonable. The resident required extensive assistance for all of her Activities of Daily Living (ADLs), with the exception of requiring limited assistance of one with dressing and being independent with eating. Resident #131 was reported to be continent of bowel and bladder.

A Fall Risk Assessment completed on 9/4/17 revealed Resident #131 was determined to be at a moderate risk for falls. She was noted to have a history of a fall at home with a left hip fracture and repair. The Fall Risk Assessment indicated the resident required, "hands-on assistance to move from place to place."

A review of Resident #131's Physical Therapy (PT) Plan of Care dated 9/5/17 included an assessment of the resident's current functional abilities. The Plan of Care indicated the resident required supervision or touching assistance for ambulation. This level of assistance was further defined as needing a helper to provide verbal cues or touching/steadying assistance as the resident ambulated, either throughout the activity or intermittently.

A review of Resident #131's Occupational Therapy (OT) Plan of Care dated 9/5/17 also revealed an assessment of the resident's current functional abilities was conducted. The Plan of Care indicated the resident required supervision or touching assistance for toileting. The resident was also assessed as requiring supervision for transfer with toileting. She was determined to be at a moderate risk for balance and falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 40	F 241		

A review of the resident's medical record included a Nursing Note dated 9/6/17 at 2:34 PM. The note indicated the resident was able to verbalize her needs. She ambulated with a walker with assistance of one staff member.

Review of a Nursing Note dated 9/7/17 at 8:59 AM also revealed Resident #131 ambulated with the help of a walker, but required assistance and was described as "not very steady."

Further review of Resident #131's medical record included a Nursing Note dated 9/9/17 at 12:58 AM. This note also indicated Resident #131 ambulated with a walker and the assistance of one.

An observation was conducted on 9/9/17 at 7:40 AM. Upon entering the resident ' s hallway, Resident #131's call light was observed to be lit above the door to her room and the sound of an activated call bell was heard. The resident ' s door was closed and she could not be viewed from the hallway. At that time, a continuous observation was made of Resident #131's door and the call light above her doorway. At 7:51 AM a Housekeeping staff member was observed as she passed by Resident #131's room. The Housekeeping staff member did not knock or look into the resident's room. The call light continued to be lit above the door to Resident #131's room. At 8:01 AM, Administrative Staff Member #1 was observed as she walked by the resident's room. The administrative staff member did not knock or look into the resident's room. The call light continued to be lit above the door to Resident #131's room. At 8:07 AM, Administrative Staff Member #2 was observed as she passed by the resident's room. The administrative staff member

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 41	F 241		

she did not knock or look into the resident's room. The call light continued to be lit above the door to Resident #131's room. At 8:08 AM, Administrative Staff Member #3 passed by Resident #131's room. The administrative staff member she did not knock or look into the resident's room. The call light continued to be lit above the door to the resident ' s room. At 8:13 AM, Resident #131's breakfast tray was delivered to her room. Within one minute of the tray delivery, the resident's call light was turned off. On 9/9/17 at 8:15 AM, Nursing Assistant (NA) #2 was observed as she came out of the resident's room and closed the door. An interview was conducted with NA #2 at that time. During the interview, the NA was asked why the resident had her call light on. The NA reported the resident needed assistance to get to the bathroom.

An interview was conducted on 9/9/17 at 3:20 PM with Resident #131. Upon inquiry, the resident recalled putting on her call light in the morning before breakfast and stated she needed to use the bathroom. Resident #131 reported she was not supposed to go to the bathroom by herself and needed assistance to do so. She did not recall what time she put on the call light that morning, but reported, "Sometimes it takes a half hour for them to come." Resident #131 stated she did not have a clock or watch to see exactly how much time had elapsed before staff came to assist her. The resident also described "one night" earlier in the week when she put on the call light to request bathroom assistance. Resident #131 reported she waited for what seemed to be "quite a long time." The resident stated she couldn't wait any longer for staff to come because, "I just knew I would wet myself all over if I waited anymore." Resident #131 reported she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 42	F 241		

used the walker in her room to walk to the bathroom unassisted and then back to bed (also unassisted).

A follow-up interview was conducted on 9/10/17 at 9:40 AM with Resident #131. During the interview, the resident recalled the night her call light was not answered by staff when she needed assistance to go to the bathroom. The resident stated she had actually used the call light twice that night and ended up getting to the bathroom and back to bed by herself unassisted because no one came to help her. The resident reported she knew she shouldn't walk unassisted but didn't feel she had a choice. When asked how this made her feel, the resident stated, "I felt bad." She reported she just didn't feel strong enough to safely walk by herself and had been instructed by therapy and staff that she should not ambulate without assistance.

An interview was conducted on 9/10/17 at 3:36 PM with the facility's Director of Nursing (DON). Upon inquiry as to who was responsible for responding to call lights, the DON responded, "All staff...we have the no-passing zone." The DON reported 'the no-passing zone' meant all staff from all departments, including housekeeping and dietary, should answer call lights. She reported if the particular staff member answering the call light could not meet the needs of the resident, he/she should let someone know who could take care of the resident's need. When asked what her expected response time would be for staff to answer a call light, the DON stated, "Ideally, less than 5 minutes."

An interview was conducted on 9/12/17 at 11:55 AM with Physical Therapist (PT) #1. PT #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 43	F 241		

reported he had been working with Resident #131 since her admission to the facility a little over one week ago. Upon inquiry, the PT reported the resident continued to require assist of one for ambulation and toileting. The resident's report of ambulating to/from the bathroom on her own in the night were discussed with the PT. The PT stated he, "would have wanted her to have help."

3. Resident #10 was admitted to the facility on 03/29/16 with diagnoses which included heart failure, hypertension, and hyperlipidemia.

A review of the most recent quarterly minimum data set (MDS) assessment dated 08/09/17 revealed Resident #10 was cognitively intact, was incontinent of her bladder and bowel, and that she was totally dependent upon staff for toilet use and bathing. The resident required extensive assistance of one staff member for personal hygiene.

An observation of a bath and incontinence care provided for Resident #10 was made on 09/09/17 at 11:19 AM. Nursing assistant (NA) # 7 and NA # 13 provided the bath using a washcloth, soap, and warm water. While Resident #10 lay on her back, NA #7 provided perineal care using a washcloth with soap and warm water, wiping front to back 3 times, folding the washcloth with each wipe. Some light brown color was noted on the washcloth at that time. The resident was turned to her side, and then NA #7 noted there was a large bowel movement on the buttocks. NA #7 used disposable wipes to clean most of the bowel movement, and then she continued cleaning the buttocks with the washcloth with soap and water. NA #7 dried the buttocks, drew a fresh basin of water, then continued bathing Resident #10's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 44	F 241		

upper and lower back and the back of her thighs using the same washcloth and wearing the same gloves she wore while cleaning the bowel movement. When the bath was completed, NA #7 applied a zinc paste to the buttocks, and then to the front perineal area as she still wore the same pair of gloves used to clean the bowel movement. NA #7 applied a clean pillowcase to Resident #10's pillow, placed it under her head, and then picked up her clean shirt and assisted the resident with pulling the shirt over her head. A clean top sheet was placed over the resident. All this care was provided while NA #7 was wearing the same pair of gloves. NA #7 did not wash her hands or change gloves throughout the entire procedure.

In an interview with NA #7 on 09/09/17 at 11:46 AM, she stated she had not been educated to wash hands or change gloves after cleaning a bowel movement and before continuing the remainder of the bath or applying a zinc paste to the perineal area. She added she had not been instructed to wash hands or change gloves after providing bowel incontinence care and before applying clean sheets to the bed. NA #7 also stated she had not thought about this being a dignity issue for the resident.

During an interview with the Director of Nursing (DON) on 09/09/17 at 4:09 PM, she stated she would expect for the nursing assistant to wash hands and change gloves after providing bowel incontinence care and before continuing the bath and applying perineal paste. The DON continued that hand hygiene she be performed after bowel incontinence care and before clothing, sheets or pillowcase should be applied. She confirmed this was a dignity issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 45	F 241		

Resident #10 was interviewed on 09/12/17 at 11:45 AM. She stated that after she received the remainder of her bath with the same washcloth used to clean her bowel movement on 09/09/17, she did not feel clean and she would not want other people to see her or smell odors from her. She stated she felt as though staff didn't really care about her basic cleanliness.

4. Resident #56 was admitted to the facility from the hospital as a short-term resident with diagnoses including heart failure, diabetes mellitus, and aftercare from surgery.

The admission Minimum Data Set (MDS) assessment dated 08/16/17 revealed Resident #56 was cognitively intact, required extensive assistance with toileting and personal hygiene, and was totally dependent upon staff for bathing. Resident #56 was always incontinent of bowel.

During an interview with Resident #56 on 09/09/17 at 10:34 AM, he stated he had used his call light during the week (09/03/17 through 09/09/17) to summon help after he had soiled himself with a bowel movement, and no one responded until 2 hours later. He stated he could not remember exactly what time he called for help, but it was at least 2 hours he waited before staff arrived. He added he even called his wife at home to see if she could get to the facility to help him after no one responded for so long. He explained he felt that the staff did not care about him and did not respect his need for help. He added that he did not like sitting in his own "mess."

Upon request, there was no nursing assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 46	F 241		

(NA) documentation provided to indicate whether toileting or incontinence care was provided for Resident #56 during the month of September 2017.
In an interview with NA #2 on 09/09/17 at 4:25 PM, she stated she worked with Resident #56 during the week of 09/03/17 but did not recall providing incontinence care for him on any specific date.

During an interview with the Director of Nursing on 9/10/17 at 4:09 PM, she agreed that lack of bowel incontinence care was a dignity issue and that nursing assistants were expected to provide incontinent care as soon as possible to their assigned residents.

On 09/12/17 at 2:16 PM an interview was conducted with Nurse #4 on 9/12/17. She stated that she always worked on the rehabilitation hall. She stated it would be her expectation that anyone who needed incontinence care should receive the care within 5 to 15 minutes, depending on how busy the staff were at that time. She added that no one should have to sit in soiled clothing and sheets for any long period.

During an interview with NA #6 on 09/12/17 at 2:40 PM, she stated she worked with Resident #56 on during the week of 09/03/17, and she did not specifically remember providing bowel incontinence care on any specific date, but was aware of his incontinence issue. NA #6 stated that a resident might have to wait for incontinence care when she had 15 to 20 residents assigned to her as she often did. She explained she would have to prioritize who needed care the most and finish up with one resident before she could move to the next. She further explained that she tried

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 47 to get to each one as soon as possible and she agreed that a resident would not want to wait a few hours to receive bowel incontinence care. In an interview with the on-call physician on 9/12/17 at 3:18 PM he stated that bowel incontinence care should be provided as soon as possible and that he would not want his family member to lie in feces waiting for care for 2 hours or even 20 minutes.	F 241		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to repair the door to a resident's room so it would close for 1 of 40 sample residents reviewed (Resident #10). The findings included: Resident #10 was admitted to the facility on 3/29/16 from a hospital. The resident's most recent quarterly Minimum Data Set (MDS) assessment dated 8/9/17 reported the resident was cognitively intact. The resident required supervision for eating, extensive assistance for bed mobility and personal hygiene, and was totally dependent on staff for transfers, toileting, and bathing. On 9/6/17 at 10:02 AM, an observation was made of the door to Resident #10's room. A metal bar (approximately 12 inches long) appeared to be	F 253	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #10s door was observed to be broken on 090717. On 09/10/17, a work order to fix the door was created and the repair was completed on 09/15/17. All other resident doors were checked to ensure they were in good repair by 10/13/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Staff were educated on how to create work orders for maintenance repairs on 09/27/17. All repairs identified during walkthrough by 10/13/17 will have work orders created. Repairs will be completed	10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 253	Continued From page 48 partially attached to the top of the door frame on the hinged side of the door. The opposite end of the metal bar was observed to hang down in front of the door, preventing the door from closing. Upon attempting to close the door, the door to the room could only partially close and would remain approximately 3 inches open. Accompanied by the Director of Plant Operations, an observation of Resident #10's door was conducted on 9/7/17 at 4:10 PM. The broken metal bar on top of the door could be viewed from the hallway as the room was approached. An interview was conducted with the Director of Plant Operations at that time. The Director reported the broken bar (hinge) could be taken care of with a work order. He stated he saw all work orders and was almost certain none had been completed to repair this door. The Director of Plant Operations stated he was concerned about the inability to close the resident's room door. An interview was conducted on 9/10/17 at 3:36 PM with the facility's Director of Nursing (DON). During the interview, the observation of Resident #10's room door and inability to close the door completely was discussed. The DON reported she would have expected a work order to be completed so maintenance would be notified of the broken door. Upon inquiry, the DON stated the inability to close a resident's room door would be a concern. An interview was conducted on 9/12/17 at 3:00 PM with Resident #10. The resident did not provide additional information as to how long her room door had been broken. However, upon exiting the room, the resident was asked how she liked the door (open versus closed). The resident	F 253	by 10/24/17. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Environmental rounds will occur weekly to identify need for repairs by Maintenance or Environmental Services Director. Work orders will be created upon identification of repair need. Results of rounding audits and work order completion will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Maintenance or Environmental Service Director	

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F 253	Continued From page 49 stated she preferred the door to be closed all the way.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must	F 272		10/24/17

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F 272	Continued From page 50 include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to complete a comprehensive assessment of a resident ' s problem/condition of the use of psychotropic medications (any medications capable of affecting the mind, emotions, and behavior) for 1 of 6 sampled residents reviewed for unnecessary medications (Resident #10). The findings included: Resident #10 was admitted to the facility on 3/29/16. The resident's cumulative diagnoses included schizoaffective disorder (bipolar), major depressive disorder (single episode), and anxiety. A review of the resident's November 2016 Physician Orders included the following medications, in part: --2 milligrams (mg) risperidone (an antipsychotic medication) given as 1 tablet by mouth every night at bedtime related to schizoaffective disorder, bipolar type; --0.5 mg risperidone given as 1 tablet by mouth every night at bedtime related to schizoaffective	F 272	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #10□s CAA summary for psychotropic drug use was reviewed and care plan revised to include an analysis for continued use of medication and pharmacy communication on 09/30/17. Annual MDS with ARD 09/28/17 for Resident #10 will be completed by 10/06/17 with comprehensive assessment with each triggered CAA. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; New MDS Coordinator is in place and was educated of CAA completion process by the Administrator on 10/05/1The MDS Coordinator will review all current resident□s most recent comprehensive assessment with CAA summaries to ensure analysis for each triggered CAA by 10/24/17.	

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F 272	Continued From page 51 disorder, bipolar type; --20 mg citalopram (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --30 mg duloxetine (an antidepressant) given as 1 capsule by mouth every day related to major depressive disorder, single episode; --40 mg Fetzima (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --20 mg paroxetine (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --5 mg diazepam (an antianxiety medication) given as one tablet by mouth twice daily for bipolar and anxiety. A review of the resident's medical record included a notation made by Resident #10's former physician (dated 11/15/16) written in response to a Consultation Report (dated 9/27/16) from the facility's consultant pharmacist. The Consultation Report reported Resident #10 received 4 antidepressants in addition to an antipsychotic and antianxiety medication. The pharmacist indicated the need for four antidepressant agents with the same (or similar) action represented a duplication of therapy and recommended the need for four antidepressant agents be re-evaluated. She suggested consideration be given to tapering and discontinuing use of one or more (perhaps citalopram or paroxetine) to avoid the risk of side effects. The physician declined the pharmacist's recommendation on 11/15/16 with a notation that read: "Recently - psych (psychotropic) meds (medications) reviewed by [Name of Medical Center] - no changes were made."	F 272	" The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Administrator or designee will audit 25% of all comprehensive assessments, prior to submission, weekly for 30 days and then monthly for 60 days to ensure accurate CAA summary completion. Variances will be reviewed with MDS Coordinator. Results to determine need for corrections. Audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Administrator or Designee	

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F 272	Continued From page 52	F 272		

A review of Resident #10's March 2017 Physician Orders revealed the resident continued to receive the same psychotropic medications in the same dosages as her admission orders. These medications included risperidone, citalopram, duloxetine, Fetzima, paroxetine, and diazepam.

Further review of the resident's medical record included a Consultation Report from the consultant pharmacist dated 3/14/17. The Consultation Report indicated Resident #10 received 4 antidepressants in addition to an antipsychotic and antianxiety medication. The pharmacist recommendation indicated the need for four antidepressant agents with the same (or similar) action represented a duplication of therapy and suggested the regimen be re-evaluated with consideration given to tapering the citalopram dose at this time. The NP declined the recommendation on 4/15/17, noting "Long standing h/o (history of) mental illness-meds eval (evaluated) by psych with no changes--no med change at this time."

Resident #10's last annual, comprehensive Minimum Data Set (MDS) assessment was completed on 3/15/17. Section C of the annual MDS revealed the resident had intact cognitive skills for daily decision making. Section D reported the resident had a mood severity score of zero (0) and Section E of the assessment indicated the resident exhibited no behaviors nor rejection of care. Section N of Resident #10's MDS assessment revealed she received an antipsychotic, antidepressant, and antianxiety medication on 7 out of 7 days during the look back period. The Care Area Assessment (CAA) Summary in Section V of the MDS revealed the care area related to Psychotropic Drug Use did

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F 272	Continued From page 53	F 272		

trigger for review and indicated the resident would be care planned for this area of focus.

A review of Resident #10's Care Area Assessment (CAA) Summary dated 3/29/17 addressed the use of psychotropic medications for this resident. Identical narrative information in the CAA Worksheet was written under each of the following headings: Nature of the problem/condition; Classes of medication this resident is taking; Treatable/reversible reasons for use of psychotropic drug; Adverse consequences of antipsychotics exhibited by this resident; Adverse consequences of anxiolytics exhibited by this resident; and Adverse consequences of sedatives/hypnotics exhibited by this resident. The narrative information from each of these sections read as follows:
"Resident is triggering for Psychotropic Drug Use CAA related to resident requires extensive to total assist (assistance) with all ADLs (Activities of Daily Living), total assist (assistance) with toileting and is always incontinent requiring incontinence care. Resident is also taking an antianxiety, antidepressant and an antipsychotic medication. She also has poor balance issues with transfers and has decreased mobility with generalized weakness. Resident is also edentulous. Placing her at risk for falls, adverse reactions, oral pain/infection and skin breakdown. Current diagnoses include CHF (congestive heart failure), HTN (hypertension), chronic pain, overactive bladder, schizophrenia, GERD (gastroesophageal reflux disease), depression, obesity, and HLD (hyperlipidemia). POC (plan of care) documentation 3/15/17, nursing documentation 3/15/17, bowel and bladder documentation 3/15/17, current diagnoses 3/15/17, MDS interview 3/15/17, MAR

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F 272	Continued From page 54	F 272		

(Medication Administration Record) 3/15/17, Pain interview 3/15/17, Weekly skin assessments." The CAA Summary did not provide a comprehensive assessment of Resident #10's use of psychotropic medications. It did not include an analysis of the problem/condition the psychotropic medications were intended to treat nor did it address any mood/behavior patterns (or lack of) the resident was exhibiting. The CAA Summary did not indicate whether or not the resident experienced adverse consequences of the psychotropic medications used in her treatment. Additionally, the CAA Summary did not include communication from the consultant pharmacist (nor responses from the NP or physician) with concerns about the potential duplication of antidepressant therapy, recommendations for gradual dose reductions, and potential side effects from the psychotropic medications she received.

A review of the resident's care plan (not dated) included the following area of focus: The resident uses psychotropic medications related to depression, anxiety, and insomnia (Initiated and Revised on 6/28/16). The planned interventions for this area of focus included:
--"Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q-shift (every shift).
--Monitor/document/report PRN (as needed) any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the

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F 272	Continued From page 55 person." An interview was conducted on 9/10/17 at 10:15 AM with the facility's MDS Nurse. Upon request, the MDS nurse reviewed the Resident #10's CAA Worksheet dated 3/29/17 for the use of psychotropic medications. After reviewing the CAA Worksheet, the MDS Nurse stated, "It's a general assessment. This doesn't address the psychotropic medications for this particular resident." When asked if she would consider this information to be a comprehensive assessment of the resident's problem/condition and reason for use of the psychotropic medications, the MDS Nurse responded, "No." An interview was conducted on 9/10/17 at 3:36 PM with the facility's Director of Nursing (DON). During the interview, a review of concerns identified for Resident #10's comprehensive assessment and CAA Worksheet related to psychotropic medications were discussed. The DON reported she had recognized some discrepancies in the facility's MDS and care planning process, overall. The DON stated her expectation was for the MDS assessments and CAA Worksheet information to capture everything and to be comprehensive.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve	F 274		10/24/17

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F 274	Continued From page 56 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview and physician interview, the facility failed to complete a significant change assessment for 1 of 1 sampled resident (Resident #66) who experienced a significant change after returning from a stay in the hospital. Findings included: Resident #66 was originally admitted to the facility on 7/3/17 with diagnoses including depression and dementia without behaviors. The admission Minimum Data Set (MDS) dated 7/24/17, specified Resident #66 had depression, dementia and was coded as having no behaviors. The resident was also assessed to be moderately cognitively impaired. Resident #66 was discharged to the hospital on 7/31/17. On 8/2/17, the resident was readmitted to the facility and physician orders included Zyprexa 1.25/milligrams (mg) daily as needed for agitation/anxiety. Zyprexa is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder. Review of a Nurse's Note dated 8/4/17 included, "Resident yelling out, restless in bed." Review of a Nurse's Note dated 8/6/17 indicated the resident was confused and included, "Pt (Patient) yells out, for staff does not use call bell	F 274	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #66 was noted to have a significant change upon readmission from hospital on 08/02/17. A comprehensive significant change MDS will be completed by 10/13/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All resident□s readmitting from the hospital or residents that have a change in condition have the potential to require a significant change assessment completed. Resident□s identified with a possible need for a significant change will have significant change assessment completed no later day 14 of observed change. Residents with change in condition will be reported during clinical meeting and the IDT will determine if significant change is warranted. Any resident with a change in condition that resolves within 14 days or resident returns to baseline will have a summary documented related to the decision on why not to proceed with a significant change.	

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F 274	Continued From page 57 which is in reach." During an interview on 9/10/17 at 11:06 AM, the attending physician revealed Resident #66 had been started on the Zyprexa due to "severe sundowning." Sundowning is a symptom of dementia characterized by confusion and agitation that is more prevalent late in the afternoon and evening. The MDS Coordinator who completed Resident #66's admission MDS, and evaluated the resident at readmission on 8/2/17, no longer worked in the extended care unit and was not available for interview. During an interview on 9/12/17 at 3:40 PM, the Director of Nursing indicated residents were to be assessed for changes and stated a Significant Change in Condition assessment should have been done for this resident upon return from the hospital.	F 274	" The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or Designee will audit 25% of all residents, readmitting from the hospital or having a change in condition, to determine if a significant change assessment or documentation to justify significant change was not indicated was completed, weekly for 30 days and then monthly for 60 days. Variances of audits will be reviewed with MDS coordinator to determine need for corrections. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing or Designee	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum	F 276	" The plan of correcting the specific deficiency. The plan should address the	10/24/17

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F 276	Continued From page 58 Data Set (MDS) within 92 days of the most recent assessment for 1 of 19 sampled residents reviewed for MDS assessments (Resident #111). The findings included: Resident #111 was admitted to the facility on 5/16/17 from a hospital with a cumulative diagnoses which included osteoarthritis, muscle weakness, and malnutrition. A review of Resident #111's Minimum Data Set (MDS) records revealed her Admission MDS assessment was completed with an Assessment Reference Date (ARD) of 5/23/17. The resident ' s next clinical assessment was scheduled as a quarterly MDS assessment with an ARD date of 8/23/17. As of 9/8/17 (108 days after the last MDS ARD date), Resident #111's quarterly MDS assessment had not been completed. An interview was conducted on 9/8/17 at 4:43 PM with the facility's MDS nurse. Upon inquiry, the MDS nurse reported she was "a little bit behind" on completion of the MDS assessment for Resident #111. An interview was conducted on 9/9/17 at 12:13 PM with the facility's Director of Nursing (DON). Upon inquiry, the DON stated she expected MDS assessments to be completed on a timely basis. The DON stated if the MDS Nurse was behind on completing the assessments, she would have expected the MDS nurse to make her aware of the situation.	F 276	processes that lead to the deficiency cited; Resident #111 Quarterly MDS with ARD of 8/23/17 was completed 09/13/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All residents requiring a MDS has the potential for this deficient practice. 100% audit was completed on 09/09/17 and again on 09/26/17 to determine missing or late assessments by Director of Clinical Operations, LTC; information was communicated to MDS coordinator. MDS assessment schedules will be in compliance by 10/06/17. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Administrator or designee will review the MDS schedule for all scheduled assessments at least weekly to ensure timely compliance of MDS completion by interdisciplinary team. Any assessments noted to be missed or late will be completed by the MDS coordinator within 24hours. Audits will continue weekly for 4 weeks and then monthly for 60 days. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 276	Continued From page 59	F 276	correction; Administrator or Designee	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.	F 278		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 278	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set assessment accurately for 5 of 20 sampled residents (Resident #6, #10, #62, #66 and #92). Findings included: 1. Resident #92 was admitted to the nursing home on 5/10/17. The admission weight for this resident was 254 pounds (lbs) according to the weight record. A Nutrition Assessment note was entered on 5/10/2017at 5:29 PM. Excerpts of the note included his admitting diagnoses including central pontine myelinolysis (a neurological disorder), hypertension, hypothyroidism and type II diabetes mellitus. The assessment acknowledged his medications included a diuretic. The note indicated the resident was trying to cut back, lose weight and eat healthier since his stroke. The current diet order was a cardiac, diabetic, low sodium diet. The most recent weight was 254.3 lb. on 5/10/2017. The assessment acknowledged the resident had lost weight since a previous admission and was trying to lose more weight. A plan was established to weigh the resident weekly and encourage weight loss. The weekly weights were 254.3 lbs. on 5/10/17, 253.0 on 5/18/2017 and 239.8 on 5/23/2017. The difference between the admission weight and the weight of 5/23/17 was greater than 5%. The Minimum Data Set (MDS) with an assessment reference date of 5/24/17 indicated there was no weight loss. The MDS Coordinator was interviewed on	F 278	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; MDS were modified with corrections for Residents #6 and # 62 on 10/01/1. MDS were modified with corrections for Resident #10 on 10/03/17 and Residents #66 and #92 on 10/05/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All residents requiring MDS completion have the potential to be affected by this deficient practice. Current MDS coordinator and Dietician were educated on using RAI for MDS completion guidance on 10/05/17 by Administrator K0300, N410, G0110J1 and I2300. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Administrator or designee will audit 25% of all MDS completed for accuracy of sections K0300, N410, G0110J1 and I2300 weekly for 30 days, then monthly for 60 days. The MDS coordinator will notified of errors and MDS will be corrected and submitted timely. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter.	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 278	Continued From page 61 9/08/2017 at 8:06 AM. She said the dietitian gives a list of residents who had weight loss along with percentages and timeframes on Wednesdays and Thursdays. She said I don't know what they were doing in May. She added, "We would identify weight loss". The Registered Dietitian was interviewed on 9/08/2017 at 10:10 AM. She said she didn't sign Resident #92's assessment. It would have been the previous MDS Coordinator. She said it appears to be an inaccurate coding. 2. Resident #66 was re-admitted to the nursing home on 7/17/17 with diagnoses including depression and dementia without behaviors. Record review revealed a physician's order 7/17/17 for Zyprexa 1.25 mg daily as needed (PRN) for agitation or anxiety. Zyprexa is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder. Review of the Medication Administration Record (MAR) revealed Resident #66 received the PRN Zyprexa on 7/20/17 at 8:41 PM. A nurse's note dated 7/20/17 at 8:41 PM, indicated Resident #66 was restless and yelling. The MAR revealed Resident #66 received the PRN Zyprexa again on 7/24/17 at 10:44 PM. There was no associated nursing note about the reason for giving the Zyprexa. The admission Minimum Data Set (MDS) dated 7/24/17, specified Resident #66 had moderately impaired cognition, had depression and dementia. The section of the MDS that identified specific medications administered during the assessment period of 7/18/17 through 7/24/17,	F 278	" The title of the person responsible for implementing the acceptable plan of correction; Administrator or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 278	Continued From page 62	F 278		

did not indicate the resident had received an antipsychotic medication.

The MDS Coordinator was interviewed on 9/12/17 at 2:25 PM. She specified she had only worked at the facility for a month and the person who had completed Resident #66's MDS dated 7/24/17, was no longer working at the facility. The MDS Coordinator referenced Resident #66's MAR from 7/18 through 7/24/17 and stated the resident had received the antipsychotic twice and it should have been coded on the MDS.

During an interview on 9/12/17 at 3:40 PM, the Director of Nursing stated a comprehensive care plan was expected to capture the resident's status accurately.

3. Resident #6 was admitted on 09/08/15 with diagnoses of hemiplegia/ hemiparesis osteoarthritis and depression.

Review of the annual Minimum Data Set dated 07/13/17 revealed Resident #6 had moderately impaired cognition and required extensive assistance with bed mobility and was totally dependent on staff for transfer, dressing, toileting and bathing. The coding indicated Resident #6 was supervised for personal hygiene.

Review of the Care Area Assessment dated 07/13/17 triggered area cognitive loss/dementia and activity of daily living (ADL). It revealed generalized weakness poor balance issues with transfers and required extensive to total assist with all ADLs.

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 278	Continued From page 63	F 278		

On 09/06/17 at 11:00 AM Resident #6 was observed in bed. She revealed she required the assistance of staff for personal hygiene.
On 09/12/17 at 2:15 PM Aide #8 indicated resident #6 required assistance with all activities of daily living. On 09/12/17 at 2:21 PM Administrative Staff Member #3 indicated the coding was incorrect for personal hygiene of resident #6, the correct coding was extensive assistance with personal hygiene. She revealed she compared previous assessments for coding irregularities. She interviewed the staff when there was a difference in the assessment.

4. Resident #62 was admitted to the facility on 3/21/16 from a hospital. Her cumulative diagnoses included Alzheimer's disease and recurrent major depressive disorder. The resident received Hospice services related to her diagnosis of Alzheimer's disease.

A review of Resident #62's July 2017 Medication Administration Record (MAR) revealed the resident's medications included, in part: 25 milligrams (mg) trazodone (an antidepressant medication) given as one tablet by mouth every night at bedtime; 25 mg quetiapine (an antipsychotic which may be indicated as an add-on medication to treat major depressive disorder) given as one tablet by mouth twice daily; and, 1 mg clonazepam (an antianxiety medication) given as one tablet by mouth three times daily.

A review of Resident #62's last quarterly Minimum Data Set (MDS) assessment dated 7/14/17 was completed. Section N of the MDS assessment indicated the resident received both an antipsychotic and an antidepressant medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 64	F 278		

on 7 out of 7 days. There was no report of the resident receiving an antianxiety medication during the 7 day look back period.

An interview was conducted on 9/8/17 at 4:46 PM with the facility's MDS Nurse. During the interview, the omission of an antianxiety medication on Resident #62's MDS assessment dated 7/14/17 was discussed. At that time, the MDS Nurse reported the 7-day look back period for this assessment was from 7/8/17 to 7/14/17. Upon review of Resident #62's July 2017 MAR, the MDS nurse reported the resident received an antianxiety medication each day during this 7-day look back period. The MDS nurse stated she would expect Section N of the MDS to indicate the resident received an antianxiety medication on 7 out of 7 days during the look back period.

An interview was conducted with the facility's Director of Nursing (DON) on 9/9/17 at 12:13 PM. During the interview, the omission of an antianxiety medication in Section N of Resident #62's MDS assessment was discussed. Upon inquiry, the DON stated her expectation would be for the MDS assessments to be coded appropriately for the medications.

5. Resident #10 was admitted to the facility on 03/29/16 with diagnoses which included heart failure, hypertension, and hyperlipidemia.

A review of the documented diagnoses in the medical record indicated she had a history of urinary tract infections (UTIs), and a lab report dated 07/26/2017 revealed Resident #10 had a UTI due to the bacteria found in stool, E. Coli, of greater than 100,000 colony forming units.

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 65 The July 2017 Medication Administration Records revealed Resident #10 had received Rocephin (antibiotic) one gram, once daily beginning 07/27/10 through 07/31/2017 to treat a UTI. In a review of the most recent quarterly minimum data set (MDS) assessment dated 08/09/17 the diagnosis section revealed Urinary Tract Infection (UTI) (Last 30 days) was not checked. On 09/10/17 at 9:37 AM, an interview was conducted with the MDS Coordinator. She explained that had worked in the facility for about a month to fill the temporary position as the MDS nurse, and the former MDS Nurse had completed the diagnosis section of the quarterly MDS assessment dated 08/09/17. She acknowledged that the diagnosis of the UTI (Last 30 days) should have been captured as a diagnosis. During an interview with the Director of Nursing (DON) on 09/10/17 at 4:09 PM, she stated that it was her expectation that the MDS assessments be completed accurately.	F 278		
F 279 SS=J	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans	F 279		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 66	F 279		

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the resident’s representative (s)-

(A) The resident’s goals for admission and desired outcomes.

(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 279	Continued From page 67 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop comprehensive care plans to address the current needs of the residents and to form the basis for the delivery of care for 4 of 18 sampled residents (Resident #8, #56, #66 and #128). Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee amputation, high blood sugar on that day and a continued need for occupational therapy for transferring, toileting and dressing the lower body. Three hours passed before hand bells were distributed to the bathrooms that had non-functioning call bells. Examples number 2 - 4 are at no actual harm with potential for more than minimal harm that is not immediate jeopardy and the scope is isolated (D).	F 279	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #8s had diagnosis of ESRD with dialysis care; care plan was updated with ESRD/dialysis care on 09/08/17 by MDS coordinator. Resident #56 did not have a comprehensive care plan completed; resident discharged 09/09/17 and unable to correct deficiency. Resident #66, was re-assessed by therapy on 9/20/2017 and the resident□s care plan was updated on 9/21/2017 to reflect the most current level and type of assistance needed with transfers and toileting. The interventions on the care plan are identified as tasks and linked to the Kardex which is reviewed by CNA staff. Resident #128 did not have a comprehensive care plan completed; resident discharged 09/06/17 and unable to correct deficiency. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. Training on developing	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 68 Findings included: 1. Resident #66 was admitted to the nursing home on 7/17/17. Her admission Minimum Data Assessment indicated she had diagnoses including hypertension, peripheral vascular disease, septicemia, diabetes mellitus, non-Alzheimer's dementia, depression, generalized muscle weakness, abdominal pain, kidney failure, acquired abscess of left leg below knee, surgical aftercare for below knee amputation and gastro-esophageal reflux disease. Her Minimum Data Set (MDS) admission assessment dated 7/24/17 indicated she was moderately impaired in cognition, required extensive assistance from one person for transfer, dressing and toilet use. She was not steady with moving on and off the toilet and only able to stabilize with staff assistance. She had no fall history and she received both occupational and physical therapy during the assessment period. The Care Area Assessment indicated activity of daily living, urinary incontinence and falls would be addressed in the care plan to minimize risks and avoid complications. The Care Area Assessment dated 7/28/17 associated with MDS above indicated a care plan would be initiated to address cognitive loss/dementia, activity of daily living rehabilitation potential, urinary incontinence, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, psychotropic drug use and pain. The MDS section of the electronic medical record indicated Resident #66 was discharged with a return anticipated on 7/31/17. A care plan dated 8/1/17 indicated all problems were cancelled and resolved.	F 279	person-centered care plans will be conducted for the interdisciplinary team no later than 9/28/2017. The training to the interdisciplinary team on person-centered care plans will be facilitated by a long-term care consultant certified in MDS and QAPI. b. Effective 9/21/2017, the organization has created a task in Point of Care for all residents to be used by CNA staff to review the Kardex which is linked to the resident□s care plan to provide person centered care to the resident. The medical record will document CNA review of the Kardex each shift. Training for the CNA staff on the use of the new link was initiated 9/21/2017 by the DON and will continue to be administered by the DON or a designated licensed nurse. c. The organization has contracted with a second nurse to provide support to the MDS coordinator with a focus on developing person centered care plans, updating the care plans with changes in resident conditions, identifying tasks within the care plan that will be linked to the Kardex, and participating in care plan meetings with the residents and/or their representative. This person was employed 9/26/2017 after orientation to the facility. This position will remain in place until all care plans are current and up to date. d. Key members of the facility leadership team will have huddle meetings daily, Monday through, Friday to report progress	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 279	Continued From page 69 The MDS section of the electronic medical record (EMR) indicated Resident #66 was readmitted to the nursing home on 8/2/17 A new care plan was initiated on 8/7/17. It only contained one problem for being on a therapeutic diet. A Kardex located under the care plan tab within the EMR included one instruction for transfer. * Use lifting device, draw sheet, etc. etcetera) to reduce friction. Monitor Vitals All (BP [Blood Pressure], P [Pulse], R [Respirations], T [Temperature]). A Current Care Record located under the care plan tab within the EMR contained a form for nurse aides to document care. In a hard copy format this form is called the Documentation Survey Report v2. In the left column it indicated an intervention/task. The next column included the shift and the subsequent columns included the days of the month. A key that explained the coding was located below each intervention/task section. The Documentation Survey Report v2 for the month of September was reviewed for Resident #66. The Intervention/Tasks included in part, "Transferring," "Toilet Use" and "Dressing." There were no individualized instructions. Documentation was reviewed for transfer from September 1 - 7, 2017. On 9/1 transfer occurred one time on second shift with total dependence from two staff. There was no entry made on Saturday, 9/2, Monday, 9/4 or Thursday 9/7. On Sunday, 9/3, night shift documented "NA." This was the same for Tuesday, 9/5 and Wednesday 9/6. Documentation was reviewed for toilet use from September 1 - 7, 2017. On 9/1 toilet use	F 279	on the above actions and to identify new opportunities to minimize abuse or neglect. A spreadsheet is maintained and has enhanced the organization of the meeting and strengthened the structure of the discussion. The leadership team is composed of the Administrator, Director of Nursing, Director of Quality, and Director of Human Resources. Adjunct support is provided by the CEO, CFO, Social Worker, Corporate Vice President of Clinical Services, Chief Nursing Officer, and Director of Plant Operations. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or Designee will audit the completion of 100% of care plans for triggered CAAs and other person centered care needs on a weekly basis. Variances will be reported to the MDS Coordinator for completion. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 70	F 279		

occurred one time on second shift with total dependence from one staff. There was no entry made on Saturday, 9/2, Monday, 9/4 or Thursday 9/7. On Sunday, 9/3, night shift documented "total dependence from one person." This was the same for Tuesday, 9/5 and Wednesday 9/6. Documentation was reviewed for dressing from September 1 - 7, 2017. On 9/1 dressing occurred one time on second shift with total dependence from one staff. There was no entry made on Saturday, 9/2, Monday, 9/4 or Thursday 9/7. On Sunday, 9/3, night shift documented "NA." This was the same for Tuesday, 9/5 and Wednesday 9/6.

On 9/07/2017 at 10:08 AM, Resident #66 said, "At home I used pull ups and used the toilet. Here, I use the ones that fasten on the side. The staff get me to the toilet two to three times a day. When I press the call bell they will come.
Nurse Aide (NA) #6 was interviewed on 9/07/2017 at 10:22 AM about how she knows what care to provide residents. She said, "After a day or two, I get to know the routine. ... Sometimes, she (Resident #66) will pee in a diaper. Now, she likes to use the commode. She wears a diaper just in case. She will press call bell for help ..."

Nurse #4 interview was interviewed on 9/07/2017 at 10:33 AM. She had been employed for a couple of weeks. She said for care needs she looks at the chart and gets report. She said nurse aides are given a verbal report. She said nurse aides document in the electronic medical record. She pulled up the care plan and said there was only one problem for a therapeutic diet. She said Resident #66 can tell you what she needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 71	F 279		

A Health Status Note dated 9/7/2017 at 2:39 PM read in part, alert and oriented times three with forgetfulness at times. ... Requires extensive assist with activities of daily Living (ADLs), set-up for oral care and meal tray.

On 9/07/2017 at 4:25 PM Resident #66 was observed in her private bathroom on her own. She was attempting to transfer back into her wheelchair. She appeared anxious and was tightly gripping the grab bar and struggling to back herself into her wheelchair. At approximately the same time NA #15 was passing by Resident #66's room. She said she had to take vital signs and blood sugars. She said Resident #66 goes to the bathroom on her own if she feels like it. At 4:30 PM Resident #66 came out of the bathroom and said in a loud and angry voice, "I LIKE TO FELL AND NEED MY BRITCHES UP." NA #15 went in the room to assist Resident #66.

The MDS Nurse was interviewed on 9/08/2017at 3:34 PM. She said she had worked there a little less than a month and didn't know the residents. She confirmed that Resident #66 discharged on 8/1/17 and returned on 8/2/17. She said all care plan problems were discontinued on 8/1/17 and the previous care plan problems were not viewable to staff. She said the therapeutic diet problem was restarted. She said Resident #66 should have a whole lot of care plans.

Interview with Nurse #3 on 9/08/2017 at 11:15 am revealed Resident #66 was alert and oriented. She needed assistance with transfer and she was still working with therapy.

On 9/08/2017 at 3:17 PM the Occupational

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 72	F 279		

Therapist was interviewed. She said she had worked with Resident #66 on functional transfers to toilet. She said, "Initially she needed two person assistance. Now she needed minimum assist and cues for safety and hand placement. She needed contact guard assistance. We've done safety training with nurse aides in the room. She added, "Typically, someone would be with her. She is good about calling if she needs help. I would not recommend her toileting by herself. She can self-propel in wheelchair. She is compliant. The safety awareness has already been an issue (i.e., hand placement). Safety is a huge thing."

Resident #66 was interviewed again on 9/08/2017 at 4:20 PM. She said, "I tried to get someone yesterday and couldn't find anyone. It was dangerous."

On 9/09/2017 at 10:15 AM the Director of Nurses was interviewed. She confirmed that Resident #66 required assistance from one person and needed supervision with activities of daily living. She needed a nurse aide (NA) due to her diagnosis of dementia. She can be forgetful at times. Resident #66 had some episodes of confusion. She had tried to get up. She had one assisted fall with staff. She was trying to get out of wheelchair and she did not wait for assist. The Director of Rehab provided education to the CNA.

On 09/09/2017 at 3:03 PM NA #2 was interviewed. She was a new employee. She said she found out how to provide care for a resident by shift report from another nurse aide and sometimes from the nurse. She said she had never used any written document to provide care. She added, "I've tried the Kardex, but it kicks me

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 73	F 279		

out.

On 9/9/17 at 4:30 PM, the Chief Executive Officer was informed of the immediate jeopardy for this problem.

The Physical Therapy director was interviewed on 9/12/2017 at 11:41 AM. She described an assisted fall the resident have over a weekend and how she provided training to NA #11. She said one thing I thought was important was when a resident comes in new, they should have a care guide in the closet so the aides would know what to do. She said this was brought up to the Administrator. She added that in the EMR, there is a care guide, but does not know who is entering the information onto it. She said we are working on getting the individualization onto the care record.

On 9/12/2017 at 12:50 PM, the Administrator was interviewed regarding the Kardex system. She said we knew it was not in place and were working with corporate to figure out whether we have all of the components to the EMR.

2. Resident #128 was admitted on 8/16/2017. Her admitting diagnoses included orthopedic aftercare, hypertension, chronic diastolic congestive heart failure, chronic obstructive pulmonary disease, pain in left shoulder, muscle weakness, abnormalities of gait and mobility, dysphagia, hypothyroidism, and gastro-esophageal reflux disease.
A physician order dated 8/19/17 was for Occupational Therapy to evaluate and treat with interventions including activities of daily living retraining to address functional deficits as a result of her status post reverse total shoulder

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 74	F 279		

replacement.
The admission Minimum Data Set with an assessment reference date of 8/23/17. She was assessed as cognitively intact. For dressing, toilet use and personal hygiene she required supervision by one person. Her balance was not steady. She had functional limitation on one side for range of motion. She was totally dependent on staff for bathing from one person. She was always continent and received both occupational and physical therapy.

Her Care Area Assessment dated 9/5/17 indicated a care plan would be initiated to address activity of daily living rehabilitation potential, psychosocial well-being, falls, nutritional status, dental, pressure ulcer, and pain.

The care plan dated 8/17/17 had two problems. One was for falls and the other for being on a therapeutic Diet.

The only instruction on the Kardex was ensure that the resident was wearing appropriate footwear when ambulating or mobilizing in wheelchair and follow facility fall protocol.

The Documentation Survey Report v2 did not include any individualized instructions for how to bathe the resident. The intervention/task was "bathing." On Sunday, August"20th, it indicated a bath was given that required total assistance from one person. A Look Back Report was provided for September. On Sunday, August 27, 2017 the bathing entry was blank and on Sunday, September 3, 2017, an entry at 2:39 AM indicated not applicable.

The resident was interviewed on 9/06/2017at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 75	F 279		

10:59 AM about her care. She said she cleaned her own teeth. She said it would be after 3:00 PM before she got dressed unless the therapist did it. She said she could bathe from her waist down, but not waist up. She said, "It was like pulling teeth. Three times I did not get a bath. Every Sunday it was after 3:00 PM." She added that she had a bad skin disease and it has an odor. She said she was conscious of the odor when church friends would see her. The resident was packed up and ready to be discharged following the interview, therefore an observation of care had not been made.

NA #6 was interviewed on 9/08/2017 at 11:23 AM. She said she needed help with bathing and that she always gave her a bed bath.

The MDS Nurse was interviewed on 9/10/2017 at 10:37 AM about the care plan and how to bathe the resident. She acknowledged the lack of a care plan for activities of daily living said I am behind on my care plans and confirmed the resident had been in the nursing home for twenty-two days.

Nurse #3 was interviewed about the flow of care need on 9/10/2017at 11:02 AM. She said OT and PT would communicate needs with nursing and nurses would communicate with the nurse aides.

3. Resident #8 was admitted to the facility on 05/17/17 and had diagnoses including end stage renal disease.

A review of the care plan dated 05/03/17 for Resident #8 revealed there was no plan of care for her end stage renal disease or her dialysis treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 76	F 279		

A review of the quarterly Minimum Data Set (MDS) dated 06/08/17 for Resident #8 revealed she had a diagnosis of chronic renal disease, received dialysis treatment and was on a therapeutic diet.

Record review of a discharge summary dated 08/16/17 revealed a left thigh fistula on 08/13/17 and a right femoral catheter and dialysis three times per week.

On 09/07/2017 at 5:19 PM Aide #1 indicated Resident #8 was a dialysis patient.

On 09/10/2017 at 3:51 PM, Nurse #9 indicated that she referred to the medication administration record (MAR) when she cared for residents with dialysis.

On 09/07/2017 at 5:21 PM Administrative Staff Member #3 indicated a care plan for dialysis should have been initiated on 5/9/17 and updated on 6/8/17.

4. Resident #56 was originally admitted to the facility on 11/30/15 and was discharged on 12/02/15. Resident #56 was admitted to the facility again on 08/09/17 with diagnoses which included specified aftercare, diabetes mellitus, and abnormalities of gait and mobility.

Resident #56's current nursing care plan dated 08/09/2017 revealed there were 2 problems present as follows: "constipation related to decreased mobility, use/side effects of medication usage" and "resident is on a therapeutic diet of diabetic, cardiac due to past medical history." The problem of constipation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 77	F 279		

indicated it was initiated and last revised on 11/30/15, and the problem regarding the therapeutic diet was initiated on 12/01/15 and last revised on 08/16/17. There were no other problems addressed on the resident's current care plan.

Review of the admission Minimum Data Set (MDS) assessment dated 08/16/17 revealed Resident #56 had diagnoses which included, in part, heart failure, diabetes mellitus, encounter for other specified aftercare, non-pressure chronic ulcer, muscle weakness, and abnormality of gait. The same MDS indicated Resident #56 was cognitively intact, required extensive assistance with bed mobility, toileting and personal hygiene, and was totally dependent upon staff for bathing. Resident #56 was always incontinent of bowel. In addition, the same MDS indicated that Resident #56 had frequent pain which made it hard for him to sleep at night and limited his day-to-day activities. The pain intensity level assessed for the resident was "8" on a scale of 1 through 10, with 10 representing the most severe pain.

The Care Area Assessment Summary signed on 08/23/17 revealed the following care areas triggered for care planning, and that each area would be care planned: ADL function, falls, nutritional status, pressure ulcers, pain, and return to the community.

Further review of Resident #56's current care plan of 08/09/2017 revealed it did not address the areas of ADL function, falls, pressure ulcers, pain, and return to the community.

In an interview with Resident #56 on 09/09/17 at 10:34 AM, he stated he received physical and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 78	F 279		

occupational therapy to help him with is core strength and to help with his ability to perform his activities of daily living. He also explained he had frequent pain due to his arthritis and his recent surgery to amputate his foot, and at times he had to wait a long time to receive repositioning or pain medication to relieve his pain. He added he did not recall participating in a care plan meeting with the staff after his admission to the facility on 08/09/17. Resident #56 further stated he had not been a resident in the facility since December of 2015 and he was going to be discharged from his current stay in the facility on 09/09/17.

On 09/10/17 at 9:37 AM, an interview was conducted with the MDS Coordinator. She explained that she recently started working at the facility to fill the temporary position as the MDS nurse, and that she was working on a backlog of MDS assessments and care plans for the facility's residents. She explained that she was aware that the care plan for Resident #56 needed to be comprehensive and based upon his admission MDS assessment dated 08/16/17. The MDS nurse reviewed Resident #56's care plan and stated it was inadequate. She added that the resident had a previous admission to the facility in 2015, and that the intervention for constipation last updated 11/30/15 may not be pertinent to his current needs. She stated she had not had time to develop his care plan, and that at the very least, the care plan should have included problems and interventions based upon the current triggered care areas, the physician orders, and Resident #56's diagnoses. She also stated that interventions to address his needs for surgical aftercare, activities of daily living, incontinence, pain, and his skin conditions should have been included in a comprehensive care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 79 plan. During an interview with the Director of Nursing (DON) on 09/10/17 at 4:09 PM, she stated that the facility was trying to provide MDS assessments and care plans based upon the comprehensive assessments. She indicated that a temporary MDS nurse was hired to help with completing all comprehensive MDS assessments so that care plans could be individualized to meet the residents' needs.	F 279		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 80 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff, resident, and physician interviews, the facility failed to provide pain relief for one of 1 resident reviewed for pain management (Resident #56.) Findings included: Resident #56 was admitted to the facility on 08/09/17 from the hospital as a short-term resident with multiple diagnoses including aftercare from surgical amputation of the left foot. A review of Resident #56's current nursing care plan dated 08/09/2017 revealed there were no problems, goals, or interventions for pain management or aftercare from surgery. There were two physician's orders in place to provide pain relief for Residents #56 as follows: 08/09/17 - Dilaudid Tablet 2 MG give 1 milligram (mg) by mouth every 4 hours as needed for pain. 08/10/17 - Lidoderm Patch 5 %. apply to painful area topicallyone time a day for pain. Apply patch to most painful area up to 12	F 309	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #56 was discharged 09/09/17 and was unable to update care plan or complete pain assessment. Nurse #4 and Nurse Aides #2 and 6 were educated on pain management policy by 10/13/17 by Director of Nursing or Designee. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All residents with complaint of pain or discomfort has the potential to be affected by this deficient practice. Nursing staff will be educated on pain management policy by 10/13/17. All new hires nursing staff will be educated on pain management during orientation. 100% residents with ordered pain medication will have a care plan audit to ensure a care plan is in place for pain management by 10/24/17. Incorporation of the pain scale will be added for residents to evaluate pain level twice daily.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 81 hours and remove per schedule. Review of the admission Minimum Data Set (MDS) assessment dated 08/16/17 revealed Resident #56 had diagnoses which included, in part, heart failure and diabetes mellitus. The same MDS indicated Resident #56 was cognitively intact and had frequent pain which made it hard for him to sleep at night and limited his day-to-day activities. The pain intensity level recorded on the assessment was "8" on a scale of "1 through 10", with 10 representing the most severe pain. In an interview with Resident #56 on 09/09/17 at 10:34 AM, he stated he had used his call light the previous Friday (09/01/2017) and that it took at least an hour for someone to respond to provide him with pain medication. He was unable to remember exactly what time he called for pain medication, but he knew it was a little over an hour. Resident #56 explained that he had pain from his recent foot surgery as well as pain in his back due to arthritis. He added that sometimes repositioning helped his back pain, but both his back pain and surgical pain sometimes were strong enough that he needed the Lidocaine patch or his oral pain medication, Dilaudid. He further stated that his pain in his back was at pain level 7 on a scale of 1 through 10 that Friday, but by the time he was given pain medication, his pain level was at 8. Resident #56 stated this was not the only time he had to wait a long time to receive pain medication. He explained it took a very long time for anyone to answer his call light for any of his pain issues or other needs, so staff never knew he needed pain medication until they finally answered the call light.	F 309	" The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; 25% of residents with ordered pain medication will have care plan and pain medication management plan audited weekly for 30 days and then monthly for 60 days. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 82	F 309		

Review of the August 2017 Medication Administration Record (MAR) revealed Resident #56 received Dilaudid 1 mg by mouth at 3:43 AM on 08/30/17 and on 08/31/17 at 8:57 PM.

A review of the September 2017 MAR revealed Resident #56 had received Dilaudid 1 mg by mouth at 8:20 PM on 09/01/2017.

An interview was conducted on 09/09/17 at 4:15 PM with the Nurse #9 who was on duty on 09/01/17 when Resident #56 reported having pain at level 7. She stated if a resident had pain issues, then she would typically refer to the care plan for pain management interventions and would check to see if pain medications were ordered. Nurse #9 explained Resident #56 had a scheduled Lidocaine patch to be given once daily, and Dilaudid ordered as needed every 4 hours to address his pain. She did not specifically recall Resident #56 complaining of pain on 09/01/17 or how long it took to respond to his call, but added that she would want to have pain medication provided in a timely way, especially if the pain level was at 7 or 8.

Nurse #4, who had worked with Resident #56 regularly, was interviewed on 9/12/17 at 2:16 pm. She stated that the resident did not ask for pain medication very often, but when he did, she would expect for pain medication to be given within 5 to 10 minutes.

In an interview with nursing assistant (NA) #6 on 09/12/17 at 2:50 PM, she stated she did recall the Resident #56 had asked for pain medication at times, but did not specifically remember answering his call light on 09/01/17 for his pain medication request. She stated that anytime a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 309	Continued From page 83 resident reported to her he had pain, she reported it to the nurse. During an interview with NA #2 on 09/12/17 at 4:25 PM, she stated if a resident reported to her that he/she needed pain medication she would report it to the nurse as soon as she could. She explained she had been working in the facility a very short time and that she was not very familiar with the residents and which ones had pain problems. She did not remember answering Resident #56's call light when he requested pain medication on 09/01/2017. During an interview with the on-call physician on 09/12/17 at 3:18 PM, he stated his expectation was to provide pain medication as soon as possible after the resident called for pain relief and that there is no reason for a resident to be in pain.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to provide a bed bath in a manner to promote cleanliness (Resident #10) and failed to provide showers (Resident #22) for 2 of 3 residents who required total and extensive assistance with activities of daily living care. Findings included:	F 312	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident # 10 was provided appropriate incontinence care 09/09/17 after the deficient practice was observed. Resident #22 received a shower/full bed bath on 09/09/17. Nurse aides # 2, 3, 5, 7 and 12	10/24/17

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 84 1. Resident #10 was admitted to the facility on 03/29/16 with diagnoses which included heart failure, hypertension, and hyperlipidemia. A review of the most recent quarterly minimum data set (MDS) assessment dated 08/09/17 revealed Resident #10 was cognitively intact, was incontinent of her bladder and bowel, and that she was totally dependent upon staff for toilet use and bathing. The resident required extensive assistance of one staff member for personal hygiene and for dressing. An observation of a bath and incontinence care provided for Resident #10 was made on 09/09/17 at 11:19 AM. Nursing assistant (NA) # 7 and NA # 12 provided the bath using a washcloth, soap, and warm water. While Resident #10 lay on her back, NA #7 provided perineal care using a washcloth with soap and warm water, wiping front to back 3 times, folding the washcloth with each wipe. A brown color was noted on the washcloth after the second wipe. The resident was turned to her side, and then NA #7 noted there was a large bowel movement on the buttocks. NA #7 used disposable wipes to clean most of the bowel movement, and then she continued cleaning the buttocks with the washcloth with soap and water. NA #7 dried the buttocks, drew a fresh basin of water, then continued bathing Resident #10's upper and lower back and the back of her thighs using the same washcloth and wearing the same gloves she wore while cleaning the bowel movement. NA #7 and NA #12 turned Resident #10 and then NA #7 re-bathed the perineal area to ensure all the bowel movement had been removed. She was wearing the same gloves and using the same washcloth that had been soiled	F 312	will be educated on appropriate ADL care and the ADL care policy by 10/13/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All residents that require assistance with incontinence care and/or showers have the potential to be affected by this deficient practice. Nurse aides will be re-educated on ADL care and incontinence care policies to prevent UTI by Director of Nursing or Designee by 10/24/17. Care will provided as required and documented in POC as completed. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or designee will make observations during incontinence care on 2 nurse aides weekly to ensure appropriate practice. The Director of Nursing or designee will make observations of residents scheduled to be showered/shaved on 5 residents weekly to ensure showers/shaves were provided as assigned and documented. Weekly audits will continue for 30 days and then monthly for 60 days. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 312	Continued From page 85 with bowel movement. When the bath was completed, NA #7 applied a clean pillowcase to Resident #10's pillow, placed it under her head, and then picked up her clean shirt and assisted the resident with pulling the shirt over her head. A clean top sheet was placed over the resident. All this care was provided while NA #7 was wearing the same pair of gloves she used to clean the bowel movement. In an interview with NA #7 on 09/09/17 at 11:46 AM, she stated she had not been educated to wash hands or change gloves after cleaning a bowel movement and before continuing the remainder of the bath. She added she had not been instructed to use a clean washcloth after cleaning the rectal area, before cleansing the perineum. During an interview with the Director of Nursing (DON) on 09/09/17 at 4:09 PM, she stated she would expect for the nursing assistant to perform hand hygiene and use a clean washcloth after providing bowel incontinence care and before continuing the bath or providing perineal care. 2. Resident # 22 was admitted on 05/31/15 with diagnoses in part, of Alzheimer's disease and diabetes mellitus. Review of the Care Area Assessment (CAA) dated 11/16/16 revealed the areas of cognition, and activity of daily living (ADL) were triggered The most recent Minimum Data Set (MDS) quarterly assessment dated 8/16/17 revealed the Resident #22 was moderately cognitively impaired and required limited assist with personal hygiene and total dependence with bathing. Resident # 22 was frequently incontinent of bowel	F 312	correction; Director of Nursing or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 312	Continued From page 86	F 312		

and bladder.

A review of the care plan dated 8/16/17 revealed a plan of care for ADLs self-care performance deficit related to dementia. He required extensive assistance by staff with bathing and shower.

Review of the Kardex dated 09/08/17 revealed no documentation with regards to bathing or showering.

Record review of the shower schedule for Resident # 22 revealed a scheduled shower on Monday and Thursdays.

Review of the shower assignment for 09/04/17 revealed Resident #22 was scheduled for a shower between 7:00 AM -7:00 PM. Review of the shower sign off sheet revealed no shower was given.

Review of the point of care documentation revealed no bathing or hygiene of any sort documented for this day. Review of the schedule for 09/04/17 revealed Aide #2 cared for Resident #22 7 AM-11 AM and Aide # 4 care for him from 11:00 AM- 3:00 PM.

On 09/05/2017 at 1:08 PM, Resident #22 was observed with an unshaven face and disheveled.

On 09/07 /2017 at 10:04 AM, Nurse #3 indicated there was one person to do showers on the shower team. The shower team does all the showers.

On 09/07/2017 10:07:39 AM, Aide #5 indicated she was the shower team. There was a list of which residents get showers each day, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 312	Continued From page 87 initialed next to their named after a shower was completed. Shaving was done in the shower. The aids also shaved when there was a lot of facial hair. Showers were scheduled on weekdays and Saturdays. She indicated she had not worked on 09/04/17 and had not showered Resident #22. On 09/07/2017 12:57 PM, Aide #3 revealed that showers were not done because the staffing was so short. On 09/08/17 at 2:45 AM, Aide #2 indicated that she cared for Resident #22 on 09/04/17 from 7:00 AM until 11:00 AM. She had washed his face and hands that day. She had not shaved him. She indicated the shower team provided the showers, shaved and provided residents nail care. She indicated she had worked for the facility for a week and wasn't sure how the showers were handled when there was no shower team. On 09/08/17 at 2:50 PM, Aide # 4 indicated that there wasn't a shower team on 09/04/17. She had intended to shave Resident #22 but was unable to get to the task. She revealed when there wasn't a shower team there wasn't enough time to give showers and provide care to all the residents. On 09/09/17 at 11:26 AM the Director of Nursing indicated the expectation was for the shower team to do the assigned showers and the staff to do the showers when there wasn't a shower team.	F 312		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 88 (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, nurse	F 315	" The plan of correcting the specific	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 89 practitioner interview, physician (MD) interview, staff interview, resident and family interview, the facility failed to follow up on a urinalysis and culture and sensitivity (UA C&S) that was ordered when Resident #130 had experienced signs and symptoms of a urinary tract infection. The facility also failed to provide perineal care in a manner to prevent the risk of a urinary tract infection (UTI) for Resident #10 who had a history of UTIs. This affected 2 of 2 sampled residents reviewed for providing care to prevent and identify urinary tract infections (#130 and #10). Findings included: 1. Resident #130 was admitted on 8/16/17. Her admitting diagnoses included orthopedic aftercare, pain in left shoulder, pain in right wrist, muscle weakness, gait and mobility abnormalities and hypertension. The Minimum Data Set assessment was dated 8/30/17. The resident's cognition was moderately impaired with a Brief Interview for Mental Status score of 12. She required extensive assistance from one person for toileting and she was not steady moving on and off the toilet. She was always continent. Resident #130 had an activity of daily living (ADL) self-care performance deficit related to limited mobility, limited range of motion, musculoskeletal impairment and pain all due to fractures suffered in a fall at home. A nurse practitioner (NP) progress note dated 8/31/2017 at 12:34 PM stated in part, "Her (family member) also relates patient complaint of painful urination this morning and she noted pink tinge to urine." Her temperature was taken and it was normal. - A thorough assessment was performed. The NP wrote, "Will follow up on lab tests with appropriate orders to follow ..."	F 315	deficiency. The plan should address the processes that lead to the deficiency cited; Resident #130 was treated for UTI and later discharged on 09/22/17. Resident #10 was treated for UTI and is asymptomatic as of 10/1/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All residents have the potential to be affected by this deficient practice. Lab results are reported directly in EHR and are to be reviewed timely by the charge nurse. Nurses were educated on lab results tab on 09/25/17. New nurses will be educated on lab results process during orientation. Nurse aides #7 and 13 were educated on appropriate ADL care by 10/13/17 by the Director of Nursing. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Lab results will be recorded on MAR and results will be reviewed via lab/results tab in EHR. Lab tracking form will be utilized to track ordered labs to ensure completion and review of results. The Director of Nursing or Designee will audit 100% labs weekly for 30 days and then 50% monthly for 60 days. The Director of Nursing or designee will make observations of 2 nurse aides during incontinence care weekly for 30 days then monthly for 60 days to ensure	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 315	Continued From page 90 On 8/31/2017 at 5:23 PM a Health Status Note was written and said, "Resident was noted having white mucus discharge from vagina (NP) was notified". New order was given to obtain UA and complete blood count (CBC). Resident and family was notified. On 9/2/2017 at 2:50 AM a Health Status Note was written and said, " ...her family reports a white discharge from vaginal area, np is aware. Her vital signs are stable and she is afebrile...". On 9/3/2017 at 8:24 PM a Health Status Note was written and said the physician was notified that urinalysis (u/a) was ordered on 8/31 had not yet be obtained. Family wished to speak and see him ...Informed him of her most recent vital signs and again about the u/a. He ordered STAT CBC, basal metabolic panel (BMP) and U/A c&s, an antibiotic, Levofloxacin, was started. "The first attempt to obtain u/a was unsuccessful, noted white discharge noted in collection tube. Encouraged her to drink fluids and was able to obtain u/a sample on second attempt. STAT labs results pending. Denies any pain or discomfort." A telephone order was written on 9/3/17 for a Stat CBC, BMP, UA & C&S possible urinary tract infection (UTI) - Levofloxacin 750 milligrams (mg) per oral (PO) daily for 5 days. On 9/4/2017 at 9:16 AM a Health Status Note read, in part, "...Lab results faxed in from lab, AM nurse aware. First dose of Levaquin 750 mg given at 9:00 PM for (urinary tract infection) UTI. No (signs or symptoms) s/s of adverse reaction noted." On 9/5/17, the C&S result was >100,000 Proteus	F 315	appropriate practice. Variances will be shared with the Nurse Aide immediately for remediation. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 91	F 315		

mirabilis.

On 9/7/2017 a physician's order was written for a different antibiotic.

An NP progress note dated 9/7/2017 at 11:52 AM indicated intramuscular Rocephin had been started and the previous antibiotic was stopped. "Organism was sensitive to both agents, however, clinically she was not improving. With the change she is showing improvement and is able to sit up in bedside chair today and more mentally clear." ... She has improved with Rocephin addition ..."

Interview with the NP on 9/7/17 at 4:22 PM revealed he ordered the UA & C&S. on 8/31/17 "I would have written a hard script for it. The Unit Secretary would take the order off and give it to the nurse. The family asked about results and wanted to see the MD. He ordered another UA C&S. He started her on Levaquin. She had no clinical improvement then put her on Rocephin." The NP was asked what impact not getting the results had on the resident. He said it would have been better if treated. Nurse #9, signed off on the order dated 8/31/17 to obtain a UA and C&S.

The physician was interviewed on 9/07/2017 at 4:45 PM. The MD said the family spoke to him on 9/3/17. He ordered new labs and a UA C&S. He said he did not know why the sample was not collected. He said the family said there was pus in urine. No vital signs suggested a problem. He added, "Fortunately the labs CBC & BMP were normal." The vital sign record indicated Resident #130's temperature range from 8/31/17 - 9/3/17 was 96.6 - 98.9 degrees F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 92	F 315		

On 9/08/2017at 7:59 AM an attempt was made to interview Resident #130 about her signs and symptoms of UTI. She said she was sleeping a lot and did not remember. She declined observation of care.

Nurse #9 was interviewed on 9/09/2017 at 10:50 AM about her actions on 8/31/17. She said, "I collected the urine and sent it to the lab. It was around lunch time. The NP gave me the order. I asked how to obtain the specimen and was told by in and out catheterization. A family member was in the room. I put a label on the specimen. I put on time and date. I put it in a biohazard bag. I saw the lady in the lab. I put it in the basket. I put label in the computer. I reported off to next shift nurse and sent to lab. I was off the next three days. I came back on 9/4/17 and the resident was on an antibiotic.

On 9/09/2017 at 10:15 AM the Director of Nurses said Nurse #9 claims she collected the urine specimen and took it to the lab. She said, "I am still in the process of trying to validate that the sample was obtained. I am still investigating." She said there should not be a delay. "It goes back to process. I've had conversations with nurses about how we put lab orders in."

On 9/9/17 at 11:00 AM Resident #130's family member confirmed the specimen was collected on 8/31/17. On 9/9/17 at 11:00 AM Resident #130's family member confirmed the specimen was collected on 8/31/17.

2. Resident #10 was admitted to the facility on 03/29/16 with diagnoses which included heart failure, hypertension, and hyperlipidemia. A review of the documented diagnoses in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 93	F 315		

medical record indicated she had a history of urinary tract infections, and a lab report dated 07/26/2017 revealed Resident #10 had a UTI due to the bacteria found in stool, E. Coli.

The July and August 2017 Medication Administration Records for revealed Resident #10 had received Rocephin (antibiotic) one gram, once daily beginning 07/21/10 through 08/02/2017 to treat a UTI.

A review of the most recent quarterly minimum data set (MDS) assessment dated 08/09/17 revealed Resident #10 was cognitively intact, was incontinent of her bladder and bowel, and that she was totally dependent upon staff for toilet use and bathing. The resident required extensive assistance of one staff member for personal hygiene.

An observation of a bath and incontinence care provided for Resident #10 was made on 09/09/17 at 11:19 AM. Nursing assistant (NA) # 7 and NA # 13 provided the bath using a washcloth, soap, and warm water. While Resident #10 lay on her back, NA #7 provided perineal care using a washcloth with soap and warm water, wiping front to back 3 times, folding the washcloth with each wipe. Some light brown color was noted on the washcloth after the second wipe. NA #7 rinsed the washcloth in the basin of water. The resident was turned to her side, and then NA #7 noted there was a large bowel movement on the buttocks. NA #7 used disposable wipes to clean most of the bowel movement, and then she continued cleaning the buttocks with the same washcloth with soap and water. NA #7 dried the buttocks, drew a fresh basin of water, then continued the bath with the same washcloth that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 94	F 315		

had the brown residue present and wearing the same gloves. NA #7 applied a zinc paste to the buttocks. When the resident was turned to her back, perineal care was provided again to ensure all the bowel movement had been removed. NA #7 continued to wear the same gloves and use the same washcloth to provide the perineal care. NA #7 then applied zinc paste to the front perineal area as she continued to wear the same pair of gloves worn to clean the bowel movement. NA #7 did not wash her hands or change gloves throughout the entire bathing and incontinence care procedure, or perineal care procedure.

In an interview with NA #7 on 09/09/17 at 11:46 AM, she stated she had not been educated to wash hands or change gloves after cleaning a bowel movement and before continuing the remainder of the bath, cleansing the perineum, or applying a zinc paste to the perineal area. She added she had not been instructed to use a clean washcloth after cleaning the rectal area, before cleansing the perineum, and she did not know that using bowel contaminated washcloths or gloves during perineal care could put the resident at risk for UTIs.

During an interview with the Director of Nursing (DON) on 09/09/17 at 4:09 PM, she stated she would expect for the nursing assistant to wash hands and change gloves after providing bowel incontinence care and before continuing the bath or providing perineal care. She also stated she would expect the NAs to follow the perineal care procedure. The DON added that zinc paste should not have been applied to the perineum using the same gloves used to clean the bowel movement and acknowledged the procedure used could lead to a UTI.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319 SS=E	483.40(b)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES 483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- (b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interviews with the staff, pharmacist, nurse practitioner, and Medical Director, and record reviews, the facility failed to provide a psychiatric service to assess and evaluate the resident ' s needs and the appropriate use of psychotropic medications (any medications capable of affecting the mind, emotions, and behavior) in the treatment for 1 of 6 sample residents reviewed for unnecessary medications (Resident #10). The findings included: Resident #10 was admitted to the facility on 3/29/16. The resident's cumulative diagnoses included schizoaffective disorder (bipolar), major depressive disorder (single episode), and anxiety. A review of the resident's November 2016 Physician Orders included the following medications, in part: --2 milligrams (mg) risperidone (an antipsychotic medication) given as 1 tablet by mouth every night at bedtime related to schizoaffective	F 319	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #10 has orders for psychotropic medications. Pharmacy recommendations for GDR reviewed by NP with decision to continue current orders, as followed by psych. Upon further review it was determined Resident #10 had seen LSW but not psycho recently. Attending practitioner will review Resident #10s psychotropic medications by 10/10/17. New order for Psycho consult on 09/08/17 and appt scheduled for October 23, 2017. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All residents with orders for psychotropic medications and recent denial for GDR will have a psych consult. Pharmacy recommendations will be reviewed and signed by DON and Attending Physician,	10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 96 disorder, bipolar type; --0.5 mg risperidone given as 1 tablet by mouth every night at bedtime related to schizoaffective disorder, bipolar type; --20 mg citalopram (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --30 mg duloxetine (an antidepressant) given as 1 capsule by mouth every day related to major depressive disorder, single episode; --40 mg Fetzima (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --20 mg paroxetine (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --5 mg diazepam (an antianxiety medication) given as one tablet by mouth twice daily for bipolar and anxiety. A review of the resident's medical record included a notation made by Resident #10's former physician (dated 11/15/16) written in response to a Consultation Report (dated 9/27/16) from the facility' s consultant pharmacist. The Consultation Report reported Resident #10 received 4 antidepressants in addition to an antipsychotic and antianxiety medication. The pharmacist indicated the need for four antidepressant agents with the same (or similar) action represented a duplication of therapy and recommended the need for four antidepressant agents be re-evaluated. She suggested consideration be given to tapering and discontinuing use of one or more (perhaps citalopram or paroxetine) to avoid the risk of side effects. The physician declined the pharmacist's recommendation on 11/15/16 with a notation that read: "Recently - psych (psychotropic) meds	F 319	within 30 days of pharmacy review. Pharmacy will communicate outstanding items to DON during monthly consultation visits. Medical Director was provided education on psychotropic medication regulations by the Director on Nursing on 10/04/17; other attending practitioners were provided education by Quality Director on 10/4/17. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing will audit Monthly pharmacy recommendation for GDR for accuracy of reason of declination by attending practitioner for the next 90 days. Discrepancies will be addressed for clarification. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 97	F 319		

reviewed by [Name of Medical Center] - no changes were made."

A review of Resident #10's March 2017 Physician Orders revealed the resident continued to receive the same psychotropic medications in the same dosages as those ordered in November 2016. The psychotropic medications included risperidone, citalopram, duloxetine, Fetzima, paroxetine, and diazepam.

Further review of the resident's medical record included a Consultation Report from the consultant pharmacist dated 3/14/17. The Consultation Report indicated Resident #10 received 4 antidepressants in addition to an antipsychotic and antianxiety medication. The pharmacist recommendation indicated the need for four antidepressant agents with the same (or similar) action represented a duplication of therapy and suggested the regimen be re-evaluated with consideration given to tapering the citalopram dose at this time. The NP declined the recommendation on 4/15/17, noting "Long standing h/o (history of) mental illness-meds eval (evaluated) by psych with no changes--no med change at this time."

A review of Resident #10's medical record revealed the frequency of her diazepam dosing was increased on 5/11/17 from 5 mg given twice daily to 5 mg diazepam given three times a day. There was no documentation in the resident's paper or electronic medical record to indicate the resident ' s target behaviors/mood were being monitored and to support the rationale for the dose increase.

A review of the resident's medical record included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 98	F 319		

a Consultation Report from the consultant pharmacist dated 5/17/17. The Consultation Report indicated diazepam was a long-acting medication and considered a high risk medication due to the increased risk of sedation, depression, confusion, addiction and falls in the elderly. The report acknowledged the recent dose increase of diazepam and recommended consideration be given to tapering down the dose. The NP declined the pharmacist's recommendation on 7/17/17 with a notation that read: "Recently assessed by psych-no changes were made to her long term psych meds including Valium (diazepam)."

Further review of the resident's medical record included a Consultation Report from the consultant pharmacist dated 6/9/17. The Consultation Report indicated the resident received paroxetine, which increased her risk for dry mouth, constipation, urinary retention, blurred vision, and increased confusion/sedation. The pharmacist also noted the resident received 3 additional antidepressants, an antipsychotic and an antianxiety medication. The report recommended consideration be given to re-assessing the use of paroxetine due to the risk for side effects. The NP declined the pharmacist ' s recommendation on 7/17/17 with a notation that read: "Recently assessed by psych-no changes were made to her long term psych meds including Paxil (paroxetine)."

A review of the resident's medical record included a 7/17/17 Consultation Report (noted as a repeat recommendation from 5/17/17) from the consultant pharmacist. This report reiterated the recommendations made in the 5/17/17 Consultation Report. The NP declined the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 99	F 319		

pharmacist's recommendation on 8/22/17 with a notation that read: "Psych eval completed with med rec (medication reconciliation) done and no changes made - will continue current regimen."

A review of Resident #10's August 2017 Physician Orders revealed the resident continued to receive the same psychotropic medications in the same dosages as her November 2016 orders, with the exception of the dose increase for diazepam on 5/11/17. The psychotropic medications included risperidone, citalopram, duloxetine, Fetzima, paroxetine, and diazepam.

A review of Resident #10's most recent quarterly Minimum Data Set (MDS) assessment dated 8/9/17 indicated the resident had intact cognitive skills for daily decision making. Section D of the MDS reported the resident had a mood severity score of zero (0); Section E indicated the resident exhibited no behaviors nor rejection of care. Section N of Resident #10's assessment revealed she received an antipsychotic, antidepressant, and antianxiety medication on 7 out of 7 days during the look back period.

A review of the resident's current care plan (not dated) included the following area of focus: The resident uses psychotropic medications related to depression, anxiety, and insomnia (Initiated and Revised on 6/28/16).

An interview was conducted on 9/8/17 at 11:30 AM with the NP caring for Resident #10. During the interview, the NP reported he was aware Resident #10 received multiple psychotropic medications, including 4 antidepressants. He stated the resident had a longstanding history of psychiatric disorders and had been on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 100	F 319		

medications a long time. The NP reported Resident #10 was assessed and evaluated by a psychiatric service and they opted not to make any changes to her medications at that time. The NP stated he did not agree with pharmacist recommendations to reassess Resident #10's medications and consider gradual dose reductions because he felt such meds were best adjusted by a psychiatric service. When asked if a psychiatric service was following the resident, he stated "No, she was seen as a one-time only evaluation." He was not certain of the date the resident was seen by the psychiatric service.

A review of the resident's paper and electronic medical record revealed there was no documentation to indicate the Resident #10 had been seen for a psychiatric evaluation.

A telephone interview was conducted on 9/9/17 at 9:53 AM with the facility's consultant pharmacist. The pharmacist reported she was aware Resident #10 was on multiple antidepressants and thought perhaps these could be consolidated. However, the pharmacist reported each time the issue was addressed, her recommendation was declined. The pharmacist reported she thought the resident was being seen by psych in the past.

An interview was conducted on 9/9/17 at 11:44 AM with the facility's Director of Nursing. Upon review of Resident #10's medical record, the DON reported that since her admission to the facility, Resident #10 was seen by a counseling program one time only on 5/18/16. The DON confirmed the report of this visit was recently received by the facility (on 9/8/17). This report indicated Resident #10 needed to be seen for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 101 psychiatric evaluation. The DON stated, "It most definitely was not a psychiatric evaluation." The DON confirmed Resident #10 had not been seen by a psychiatric service at any time over the past year and one-half (since her admission to the facility). A telephone interview was conducted with the facility's Medical Director on 9/9/17 at 4:15 PM. A brief overview of Resident #10's medical history and concerns regarding her medication regimen was reviewed with the Medical Director. At that time, the Medical Director identified the credentials of the provider who saw Resident #10 on 5/18/16 as a Clinical Social Worker. Since Resident #10 was a long-term care resident, the Medical Director indicated he would have expected her to have had a psychiatric evaluation along with psychiatric follow up. He stated, "We're going to need on-going assistance for managing medications from psych." A follow-up interview was conducted on 9/12/17 at 11:35 AM with the NP. During the interview, the NP indicated it was now his understanding the resident was only seen by a Clinical Social Worker since her admission to the facility. The NP acknowledged the report written by the Clinical Social Worker recommended a psychiatric evaluation be completed. The NP also confirmed he had been working under the assumption a psychiatric evaluation had been completed for this resident. The NP stated he wrote another order on 9/8/17 and requested Resident #10 be seen by a psychologist for a psychiatric evaluation and medication review.	F 319		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 102 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review, the facility failed to provide functioning call bells in resident bathrooms so that if a resident needed to summon staff for assistance, they could get help and prevent an accident from occurring. The call bell was not working in the bathroom for 2 of 2 sampled residents who used the private bath in their rooms (Resident #66 & Resident #38). The facility also failed to supervise and prevent the elopement of a cognitively impaired resident	F 323	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; a. Resident #103 was discharged home on 4/22/2017 with family. There was no further documentation of or attempt to elope from time of the 4/16/2017 incident until discharge. Following the incident of 4/16/2017, the Director of Plant Operations performed an assessment of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 103	F 323		

(Resident #103), known to have wandering behavior. This affected 1 of 3 sampled residents reviewed for supervision to prevent accidents.

Immediate jeopardy began on 4/16/17 for Resident #103, unsupervised by staff, took the elevator to the first floor, exited the building and was found in the facility parking lot. Resident #103 was located by staff after an undetermined amount of time outside of the facility and had no injuries.

Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee amputation, high blood sugar on that day and a continued need for occupational therapy for transferring, toileting and dressing the lower body. Three hours passed before hand bells were distributed to the bathrooms that had non-functioning call bells.

Immediate jeopardy began on 9/8/17 and is ongoing for Resident #38 who toilets independently and had a call bell that did not work.

Findings included:

1. Resident #66 was admitted to the nursing home on 7/17/17. Her admission Minimum Data Assessment indicated she had diagnoses

the elopement system by testing the alarm sensors and found them to be working properly. The elevator sensor was re-positioned to provide greater sensitivity to the resident bracelets. The elevator RoamAlert system was also enhanced to provide automated shut-off when a sensor is in the sensitivity zone.

b. Resident #38 resided in room 201, on 9/8/2017, the resident was provided with a hand bell to use in the bathroom. Her call bell was repaired on 9/8/2017.

c. Resident #66
i. Resident #66, was re-assessed by therapy on 9/20/2017 and the resident□s care plan was updated on 9/21/2017 to reflect the most current level and type of assistance needed with transfers and toileting. The interventions on the care plan are identified as tasks and linked to the Kardex which is reviewed by CNA staff.
ii. Resident #66 (who resided in room 262) was initially provided a hand bell to use in the bathroom. The Resident was then moved to room 263 with a functioning call bell. Parts were ordered and the call bell in room 262 was repaired on 9/15/17. The resident is content in room 263 and has remained there.

iii. Weekly interviews with resident #66 started on 9/20/17. Weekly interviews will be conducted with Resident #66 by the social worker and/or designee for four weeks to ensure that her call bell is functional and that staff are responding to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 104	F 323		

including hypertension, peripheral vascular disease, septicemia, diabetes mellitus, non-Alzheimer's dementia, depression, generalized muscle weakness, abdominal pain, kidney failure, acquired abscess of left leg below knee, surgical aftercare for below knee amputation and gastro-esophageal reflux disease.

Her Minimum Data Set (MDS) assessment dated 7/24/17 indicated she was moderately impaired in cognition, required extensive assistance from one person for transfer, dressing and toilet use. She was not steady with moving on and off the toilet and only able to stabilize with staff assistance. She had no fall history and she received both occupational and physical therapy during the assessment period. The Care Area Assessment indicated activity of daily living, urinary incontinence and falls would be addressed in the care plan to minimize risks and avoid complications.

A care plan dated 8/1/17 indicated all problems were cancelled and resolved. A new care plan was initiated on 8/7/17. It only contained one problem for being on a therapeutic diet.

According to occupational therapy (OT) notes, Resident #66 began working with occupational therapy on 8/3/17. Goals were set for lower body dressing, toileting hygiene and toileting transfer. She was assessed as needing substantial/maximal assistance in lower body dressing and toileting hygiene.

On 8/16/17 another MDS indicated her brief interview for mental status score improved from 11 to 12.

requests for assistance with toileting in an appropriate and timely manner. Any variances will be communicated to the facility leadership team during the huddles which are being held daily, Monday through Friday.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
a. The facility has reviewed 100% of current residents to ensure that each resident has a completed elopement risk assessment. If the risk assessment determines that the resident is at risk of elopement, the resident□s plan of care will be updated to include interventions to minimize elopement. Elopement risk assessments are complete and care plans for residents who are at risk for elopement will be completed by 9/28/2017. Elopement risk assessments will be completed on admission / re-admission, quarterly, and whenever the resident experiences a significant change in condition that would impact their risk for elopement. Elopement risk assessments are completed by a licensed nurse.

b. The facility has reviewed, revised, and approved on 9/22/2017, the protocol for responding when a resident is missing from the facility. Education will be provided by a representative of the emergency management department to the staff of ECU, no later than 9/28/2017. The Plant Operation Director also ordered additional bracelets for residents, an additional testing device, and provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 105 A Fall Event report indicated Resident #66 had an assisted fall on Sunday, 8/27/17 at 10:00 AM. It said, The Certified Nurse Aide (CNA) was assisting resident with transfer from bed to wheelchair. CNA assisted resident to the floor. There was no harm and the Therapy Director provided education to the CNA on transfers. A corresponding physical therapy note dated 8/30/17 indicated Nurse Aide #10 was "trained in regards to toilet transfer to support fall prevention during transfers. An attempt to interview NA #10, who worked on the weekends, was made at 11:56 AM on 9/12/17. Interview with the therapy director on 9/12/17 at 11:30 AM revealed Resident #66 had assisted fall over a weekend. She was in the bathroom and her leg buckled. The therapy director said she was working that day and showed NA#10 how to transfer her using the grip bars. On 8/27/17 a Fall Risk Assessment was done. She was determined to need assistance with elimination and was unable to come to a standing position and a recent fall. An aide's care record for September had entries for toilet use every shift on 9/1, 9/3, 9/5 & 9/6. According to the Occupational Therapy (OT) therapy notes dated 9/4/17, Resident #66 required substantial assistance with lower body dressing and had improved in toileting - transfers to being able to safely transfer to the toilet with supervision or touching -minimum assistance for toileting routine. Resident #66 was interviewed on 9/06/2017 at 9:20 AM. She said, sometimes she was treated	F 323	additional training materials to the unit. The training materials include two videos on proper application of the bracelets and storage of the transponders. c. The facility protocol for checking the resident safety bracelets and functionality of doors that have alarms was reviewed on 9/21/17 by the DON and discussed in multiple huddle meetings. Alert bracelets worn by residents will be checked for placement during each shift. Alert bracelets will be checked for functionality each week. These placement and functionality checks and will be documented in the resident□s medical record (Point of Care) by the CNAs, which began on 9/25/17. Non-functional bracelets or bracelets that have been removed will be replaced immediately upon discovery. The DON or a designee will monitor the electronic dashboard at least 3 times per week in the electronic medical record to identify variances. d. An additional supply of bracelets and transponders for the Roam Alert System are maintained at the nurses□ station for accessibility when a resident is determined to be at risk. e. The organization utilizes the Roam Alert Intelligent system that constantly monitors the functionality of door and elevator alarms. In the event of a malfunction in the door or elevator alarm, an alert shows on a designated computer located at the nursing station. If there is an alert, staff will immediately notify Plant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 106 with dignity and respect and added, "When they don't come and they are short of help, you just have to wait until someone comes and helps you out." On 9/07/2017 at 10:08 AM, Resident #66 said, "At home I used pull ups and used the toilet. Here, I use the ones that fasten on the side. The staff get me to the toilet two to three times a day. When I press the call bell they will come. I used the walker before I came. Therapy gives me exercises in my room sometime. Coming, when I call them, is a problem. Mostly on days sometimes on second shift." Nurse Aide (NA) #6 was interviewed on 9/07/2017 at 10:22 AM about how she knows what care to provide residents. She said, "After a day or two, I get to know the routine. ... Sometimes, she (Resident #66) will pee in a diaper. Now, she likes to use the commode. She wears a diaper just in case. She will press call bell for help ..." The nurse aide's Documentation Survey Report for September 7, 2017 had no activity of daily life entry for that day. It also did not include any individualized instruction for dressing, transferring or toileting. A Health Status Note dated 9/7/2017 at 2:39 PM read in part, alert and oriented times three with forgetfulness at times. ... Requires extensive assist with activities of daily Living (ADLs), set-up for oral care and meal tray. Blood sugar at 11:30 AM 236, receives insulin per sliding scale insulin order. On 9/07/2017 at 4:25 PM Resident #66 was observed in her private bathroom on her own. She was attempting to transfer back into her	F 323	Operations for repair and safety will be maintained for the residents during repair. On 9/21/2017, the Director of Plant Operations contacted the service company of the alarm system and diagnostic evaluation indicated that all systems were functional. Weekly review of the alarm function tracking system will be completed beginning the week of 9/25/2017. f. Key members of the facility leadership team have huddle meetings daily, Monday through Friday to report progress on the above actions and to identify new opportunities to minimize abuse or neglect. A spreadsheet is maintained and has enhanced the organization of the meeting and strengthened the structure of the discussion. The leadership team is composed of the Administrator, Director of Nursing, Director of Quality, and Director of Human Resources. Adjunct support will be provided by the CEO, CFO, Social Worker, Corporate Vice President of Clinical Services, Chief Nursing Officer, and Director of Plant Operations. g. Staff awareness has been heightened through education, drills, interviews, and daily huddles as outlined above. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Quality or designee will	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 107	F 323		

wheelchair. She appeared anxious and was tightly gripping the grab bar and struggling to back herself into her wheelchair. At approximately the same time NA #15 was passing by Resident #66's room. She said she had to take vital signs and blood sugars. She said Resident #66 goes to the bathroom on her own if she feels like it. At 4:30 PM Resident #66 came out of the bathroom and said in a loud and angry voice, "I LIKE TO FELL AND NEED MY BRITCHES UP." NA #15 went in the room to assist Resident #66.

According to the blood sugar (BS) monitoring record and the medication administration record (MAR), the Resident #66's BS was documented as 499 at 5:23 PM on 9/7/17. Twelve units of insulin was administered by Nurse #4.
Interview with Nurse #3 on 9/08/2017 at 11:15 am revealed Resident #66 was alert and oriented. She needed assistance with transfer and she was still working with therapy.

On 9/08/2017 at 7:54 AM Resident #66 was asked if she had put on the call bell yesterday to let the aide know she needed help. She said the call bell was not working in the bathroom. The surveyor tested the call bell and it did not light outside the door or ring at the nurses' station.

On 9/08/2017 at 7:58 AM the surveyor informed the Unit Secretary that the call bell in Resident #66's bathroom was not working. She said it was the first time she had heard about it.

On 9/08/2017 at 8:13 AM Contract Maintenance Person #1 and #2 arrived. One said, "It's hooked up, but not working." There were two call bells in the bathroom - one about waist height on one

conduct unannounced missing person drills at least weekly for 4 weeks, beginning the week of 9/25/2017, on both day and evening shift, and then monthly thereafter. Staff responses to the drills will be documented to identify areas for improvement and additional education or other correction will be made as needed. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter.

The title of the person responsible for implementing the acceptable plan of correction;

The Director of Quality or Designee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 323	Continued From page 108	F 323		

side of the commode and another about knee height on the other side of the commode and neither worked. The Contract Maintenance Person #1 said, "I've tried both and neither works."

Surveyors initiated call bell checks on 9/08/2017 at 10:00 AM. Four more calls in bathrooms were not working. These were in rooms 201, 265, 270 and shared bathroom 240 and 241.

On 9/08/2017 at 10:58 AM, the Administrator said she calls maintenance when there is a call bell in the bathroom that doesn't work.

On 9/08/2017 at 11:15 AM Nurse #3 was interviewed about call bells. She said, "I am aware of a call bell reported not working. I would get in contact with the Maintenance Director. I would call his pager or leave a message. When Nurse #3 was asked about other means for the resident to use to call for help, she said, "We have bells and would have to find them". Immediately following the interview she was seen distributing hand bells to Resident #66 and to the other residents who did not have functioning call bells.

On 9/08/2017 at 11:25 AM, the Director of Plant Operations was interviewed. He said, "If we get a report about a problem, then we get a service call. We would not check other call bells. It is on an as needed basis. He confirmed that the call bell in Resident #66's bathroom room did not work.

On 9/09/2017 at 11:01 AM a hand bell was observed in Resident #66's bathroom.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 109	F 323		

On 9/08/2017 at 3:17 PM the Occupational Therapist was interviewed. She said she had worked with Resident #66 on functional transfers to toilet. She said, "Initially she needed two person assistance. Now she needed minimum assist and cues for safety and hand placement. She needed contact guard assistance. We've done safety training with nurse aides in the room. She added, "Typically, someone would be with her. She is good about calling if she needs help. I would not recommend her toileting by herself. She can self-propel in wheelchair. She is compliant. The safety awareness has already been an issue (i.e., hand placement). Safety is a huge thing."

Resident #66 was interviewed again on 9/08/2017 at 4:20 PM. She said, "I tried to get someone yesterday and couldn't find anyone. It was dangerous."

On 9/09/2017 at 10:15 AM the Director of Nurses was interviewed. She confirmed that Resident #66 required assistance from one person and needed supervision with activities of daily living. She needed a nurse aide (NA) due to her diagnosis of dementia. She can be forgetful at times. Resident #66 had some episodes of confusion. She had tried to get up. She had one assisted fall with staff. She was trying to get out of wheelchair and she did not wait for assist. The Director of Rehab provided education to the CNA.

On 9/8/17 at 12:30, the administrator was informed of the immediate jeopardy.

2. Resident #38's bathroom call bell was tested on 9/08/2017 during rounds at 10:00 AM. The resident said she used the bathroom.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 110	F 323		

Her quarterly Minimum Data Set had an assessment reference date of 7/11/17 indicated her cognition was severely impaired. Her dressing, transfer and toileting ability was independent. A care plan with a review start date of 10//17 included approaches for problems with ADLs and for falls indicated, "Encourage the resident to use bell to call for assistance" and "The resident needs a safe environment with floors free from spills and/or clutter; adequate light; a working and reachable call light and personal items within reach."

Her care plan dated 7/20/2017 indicated she was able to toilet independently.

Surveyors initiated call bell checks on 9/08/2017 at 10:00 AM. The call bell in Resident #38's bathroom did not work when tested.

On 9/08/2017 at 10:58 AM, the Administrator said she calls maintenance when there is a call bell in the bathroom that doesn't work.

On 9/08/2017 at 11:15 AM Nurse #3 was interviewed about call bells. She said she would contact the Maintenance Director if a call bell problem was noted. "I would call his pager or leave a message." When Nurse #3 was asked about other means for the resident to use to call for help, she said, "We have bells and would have to find them". Immediately following the interview she was seen distributing hand bells to Resident #38 and to the other residents who did not have functioning call bells.

On 9/08/2017 at 11:25 AM, the Director of Plant Operations was interviewed. He said, "If we get a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 111	F 323		

report about a problem, then we get a service call. We would not check other call bells. It is on an as needed basis. He confirmed that the call bell in Resident #38's bathroom room did not work.

On 9/09/2017 at 11:05 AM a hand bell was observed in Resident #38's bathroom.

On 9/08/2017 at 11:25 AM, the Director of Plant Operations was interviewed. He said, "If we get a report about a problem, then we get a service call. We would not check other call bells. It is on an as needed basis.

Interview with NA#8 on 9/12/17 at 11:52 AM revealed Resident #38 was very independent with activities of daily living and used the bathroom on her own.

3. Resident #103 was admitted to the facility on 4/10/17 with multiple diagnoses including dementia.
The resident was discharged to the community on 4/22/17.

The attending physician's admission note dated 4/10/17, had early onset, advanced dementia.

There was no written, initial plan of care in Resident #103's clinical record.

A Nurse's Note, written by Nurse #10, dated 4/14/17 at 7:52 AM stated, "redirected several times on PM (evening) shift ambulation in hallway attempting to go in other patients room without knocking. Combative with incontinent care on pm shift. Hitting and kicking staff as care was being provided. Refused pain med (medication). Night shift redirected X2[twice] ambulating in hallway.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 112	F 323		

Observed sleeping in bed A several times."

A Nurse's Note, written by Nurse #10, dated 4/15/17 at 8:31 AM, revealed the resident had become combative and a one-time intramuscular dose of Haldol 5 milligrams (mg) was administered at 6:16 AM for agitation. Haldol is an antipsychotic drug used to treat acute psychosis.

The facility was unable to provide a Wander Risk Assessment for Resident #103 or documentation about when a wander guard was placed on Resident #103.

The admission comprehensive Minimum Data Set (MDS) was in progress but had not yet been completed.

The Nurse's Notes written by Nurse #2 dated 4/16/17 at 3:30 PM read, "Pt (Patient) eloped from facility. Pt located sitting on curbing in front of ER (Emergency Room which was in the same building as the nursing facility). Pt ambulated back to floor. Skin intact. Denies pain." The note also stated the Director of Nursing (DON), physician, House Supervisor and the Resident Representative had been notified and that the resident was wearing a wander guard alarm bracelet on her right ankle at the time of the elopement.

A Safety/Security Event form dated 4/16/17, specified the resident had wandered outside of the facility and was found sitting on a curb in front of the ER. It also stated a wander guard was on her right ankle and that it did not trigger the door alarm to lock. On the form, the Section for Witnesses/Parties Involved stated "Not Specified"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 113	F 323		

The Follow-up Actions on the Safety/Security Event form was dated 4/27/17 by the DON and indicated that Maintenance and the wander guard company had been contacted.

The facility provided email correspondence dated 4/17/17, in which the DON asked the Plant Operations Director to review the camera in an effort to establish a timeline for the elopement. The response was, "The resident came off the elevator on the first floor at 2:38. She was found outside the ER by CNA's (Nursing Assistants) at 3:03."

When asked for an investigation of the incident, the facility provided a note, handwritten by Nurse #2 that was dated 4/20/17 (no time). It simply stated which staff persons had tried to locate Resident #103 and where each person had searched. It also stated the resident had been found sitting on the curb in front of the ER. The paragraph was signed by the nurse.

Nurse #1, who had participated in the search was interviewed on 9/12/17 at 2:28 PM. Nurse #1 said, "I think [Nurse #2] is the one who had her. [Resident #103] was a wanderer and went into other people's rooms and she could ambulate pretty well. The wander guard helped by alarming when she passed certain zones." Nurse #1 did not know if the wander guard had malfunctioned or if it had been tested.
The Admissions Coordinator, who had assisted in the search for Resident #103 was interviewed on 9/12/17 at 2:38 PM. The Admissions Coordinator stated, Resident #103 was known to wander in other resident rooms and in the halls. She stated the resident was wearing a wander guard ankle bracelet, but when the resident left via the second

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 114	F 323		

floor elevator, it had not locked in place. The Admissions Coordinator did not know which NA was assigned to Resident #103 but said, "We looked for 5 or 10 minutes. By the time we were looking, if I remember, it was the ER [staff who] brought her back up." The Admissions Coordinator specified the ER staff had been made aware of the missing resident due to a "Code Pink" that was paged overhead in the building that described the resident and what she was wearing.

NA #9, who had participated in the search was interviewed on 9/12/17 at 2:46 PM. NA #9 said, "They are in and it's hard to keep up on resident names." NA #9 was unable to remember Resident #103 or the incident.

Nurse #2, who was assigned to the Resident #103 on day of elopement, could not be reached by phone for an interview.

The facility was unable to identify which nursing assistant was assigned to the resident on the day of the elopement.

The Plant Operations Director was interviewed on 9/12/17 at 4:54 PM. The Plant Operations Director stated he had only worked at the facility for a few weeks at the time of the elopement. He said that prior to the elopement, there was an alarm that was near the elevator that would sound if the resident was near the elevator. The Plant Operations Director was not aware at the time of the elopement, that the wander guard system did not include locking the elevator door when a resident wearing a wander guarded entered the elevator. The Plant Operations Director indicated after Resident #103 was found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 115 outside in the parking lot, he was asked by administration to check the cameras to see how the resident got out of the building. He said, "She took the elevator to first floor and then went out the door by the ER." He also said, "I immediately brought folks in who knew the system, both the elevator and the company for the wander guard system. We found that it had an outdated transponder. To make a long story short, we purchased an updated transponder and brought in the state elevator folks to approve it. We did our due diligence and now it locks and will not move if a person with a wander guard enters the elevator." He did not know if the ankle bracelet itself was tested to see if it was working at the time of the elopement. The Administrator and DON were interviewed on 9/12/17 at 4:16 PM. The Administrator stated Resident #103 was wearing a wander guard ankle bracelet at the time of the elopement which was effective in sounding an alarm and locking all exit doors, but that the resident had left the second floor of the facility by using the elevator. The Administrator stated that prior to the elopement in April, she had made a request for something that would prevent the elevator from working with a resident with a wander guard who attempted to get on. She also stated that since the elopement, the elevator had been fixed and residents could no longer get out of the facility that way.	F 323		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 116 drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observations, interviews of the staff, pharmacist, nurse practitioner, and Medical Director, and record reviews, the facility failed to	F 329	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 117 monitor resident behaviors and evaluate the possibility of gradual dose reductions (GDRs) of a resident's antipsychotic, antidepressant, and antianxiety medications (Resident #10). The facility also failed to document evidence to support a clinical rationale for an antipsychotic medication, failed to monitor target behaviors and failed respond to pharmacy recommendations (Resident #66). This affected 2 of 6 sample residents reviewed for unnecessary medications (Resident #10 and Resident #66). The findings included: 1. Resident #10 was admitted to the facility on 3/29/16. The resident's cumulative diagnoses included schizoaffective disorder (bipolar), major depressive disorder (single episode), and anxiety. A review of the resident's November 2016 Physician Orders included the following medications, in part: --2 milligrams (mg) risperidone (an antipsychotic medication) given as 1 tablet by mouth every night at bedtime related to schizoaffective disorder, bipolar type; --0.5 mg risperidone given as 1 tablet by mouth every night at bedtime related to schizoaffective disorder, bipolar type; --20 mg citalopram (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --30 mg duloxetine (an antidepressant) given as 1 capsule by mouth every day related to major depressive disorder, single episode; --40 mg Fetzima (an antidepressant) given as 1 tablet by mouth every day related to major depressive disorder, single episode; --20 mg paroxetine (an antidepressant) given as	F 329	cited; Resident #10 has orders for psychotropic medications. Pharmacy recommendations for GDR reviewed by NP with decision to continue current orders, as followed by psych. Upon further review it was determined Resident #10 had seen LSW but not psycho recently. New order for Psycho consult on 09/08/17 and appointment was made for earliest available for November 6, 2017. Resident #66 had pharmacy recommendation on 08/22/17 for GDR of Zyprexa with goal to discontinue the PRN dose. The pharmacy recommendation was not reviewed by attending practitioner and the record did not indicate supporting diagnosis or documented behaviors. Order to discontinue Zyprexa was received and noted on 09/30/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All residents with orders for psychotropic medications and recent denial for GDR will have a psych consult. Pharmacy recommendations will be reviewed and signed by DON and Attending Physician within 30 days of pharmacy review. Pharmacy will communicate outstanding items to DON during monthly consultation visits. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Monthly pharmacy recommendation for GDR will be audited	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 118 1 tablet by mouth every day related to major depressive disorder, single episode; --5 mg diazepam (an antianxiety medication) given as one tablet by mouth twice daily for bipolar and anxiety. A review of the resident's medical record included a notation made by Resident #10's former physician (dated 11/15/16) written in response to a Consultation Report (dated 9/27/16) from the facility ' s consultant pharmacist. The Consultation Report reported Resident #10 received 4 antidepressants in addition to an antipsychotic and antianxiety medication. The pharmacist indicated the need for four antidepressant agents with the same (or similar) action represented a duplication of therapy and recommended the need for four antidepressant agents be re-evaluated. She suggested consideration be given to tapering and discontinuing use of one or more (perhaps citalopram or paroxetine) to avoid the risk of side effects. The physician declined the pharmacist's recommendation on 11/15/16 with a notation that read: "Recently - psych (psychotropic) meds reviewed by [Name of Medical Center] - no changes were made." A review of Resident #10's March 2017 Physician Orders revealed the resident continued to receive the same psychotropic medications in the same dosages as those ordered in November 2016. The psychotropic medications included risperidone, citalopram, duloxetine, Fetzima, paroxetine, and diazepam. A review of the resident's medical record included a Consultation Report from the consultant pharmacist dated	F 329	for accuracy of reason of declination for the next 90 days by the Administrator or Designee. Discrepancies will be addressed for clarification. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter " The title of the person responsible for implementing the acceptable plan of correction; Administrator or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 329	Continued From page 119	F 329		

3/14/17. The Consultation Report indicated Resident #10 received 4 antidepressants in addition to an antipsychotic and antianxiety medication. The pharmacist indicated the need for four antidepressant agents with the same (or similar) action represented a duplication of therapy and suggested the regimen be re-evaluated with consideration given to tapering the citalopram dose at this time. The NP declined the recommendation on 4/15/17, noting "Long standing h/o (history of) mental illness-meds (medications) eval (evaluated) by psych (psychiatry) with no changes--no med change at this time."

A review of Resident #10's medical record revealed the frequency of her diazepam dosing was increased on 5/11/17 from 5 mg given twice daily to 5 mg diazepam given three times a day. There was no documentation in the resident's paper or electronic medical record to indicate the resident's target behaviors/mood were being monitored and support the rationale for the dose increase.

A review of the resident's medical record included a Consultation Report from the consultant pharmacist dated 5/17/17. The Consultation Report indicated diazepam was a long-acting medication and considered a high risk medication due to the increased risk of sedation, depression, confusion, addiction and falls in the elderly. The report acknowledged the recent dose increase of diazepam and recommended consideration be given to tapering down the dose. The NP declined the pharmacist's recommendation on 7/17/17 with a notation that read: "Recently assessed by psych-no changes were made to her long term psych meds including Valium

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 120	F 329		

(diazepam)."

Further review of the resident's medical record included a Consultation Report from the consultant pharmacist dated 6/9/17. The Consultation Report indicated the resident received paroxetine, which increased her risk for dry mouth, constipation, urinary retention, blurred vision, and increased confusion/sedation. The pharmacist also noted the resident received 3 additional antidepressants, an antipsychotic and an antianxiety medication. The report recommended consideration be given to re-assessing the use of paroxetine due to the risk for side effects. The NP declined the pharmacist's recommendation on 7/17/17 with a notation that read: "Recently assessed by psych-no changes were made to her long term psych meds including Paxil (paroxetine)."

A review of the resident's medical record included a Consultation Report (noted as a repeat recommendation from 5/17/17) from the consultant pharmacist. The report dated 7/17/17 reiterated the recommendations made in the 5/17/17 Consultation Report. The NP declined the pharmacist's recommendation on 8/22/17 with a notation that read: "Psych eval completed with med rec (medication reconciliation) done and no changes made - will continue current regimen."

A review of Resident #10's August 2017 Physician Orders revealed the resident continued to receive the same psychotropic medications in the same dosages as her November 2016 orders, with the exception of the dose increase for diazepam on 5/11/17. The psychotropic medications included risperidone, citalopram, duloxetine, Fetzima, paroxetine, and diazepam.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 329	Continued From page 121	F 329		

A review of Resident #10's most recent quarterly Minimum Data Set (MDS) assessment dated 8/9/17 indicated the resident had intact cognitive skills for daily decision making. The resident required supervision for eating, extensive assistance for bed mobility and personal hygiene, and was totally dependent on staff for transfers, toileting, and bathing. Section D of the MDS reported the resident had a mood severity score of 0; Section E indicated the resident exhibited no behaviors nor rejection of care. Section N of Resident #10's assessment revealed she received an antipsychotic, antidepressant, and antianxiety medication on 7 out of 7 days during the look back period.

A review of the resident's current care plan (not dated) included the following area of focus: The resident uses psychotropic medications related to depression, anxiety, and insomnia (Initiated and Revised on 6/28/16). The planned interventions included monitoring for side effects and effectiveness every shift.

A review of the resident's paper and electronic medical record revealed the resident's target behaviors/mood were not routinely monitored or documented by the nurses or the nursing assistants.

An observation and interview was conducted of the resident on 9/6/17 at 9:30 AM. The resident did not exhibit any behaviors at that time.

An interview was conducted on 9/7/17 at 2:00 PM with NA #7. NA #7 worked 1st shift and was frequently assigned to care for Resident #10. Upon inquiry, the NA stated she would tell the hall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 329	Continued From page 122	F 329		

nurse if she noticed any changes in behaviors for a resident. NA #7 indicated the resident did not typically exhibit any behaviors.

An interview was conducted on 9/8/17 at 11:30 AM with the NP caring for Resident #10. During the interview, the NP reported he was aware Resident #10 received multiple psychotropic medications, including 4 antidepressants. He stated the resident had a longstanding history of psychiatric disorders and had been on the medications a long time. The NP reported Resident #10 was assessed and evaluated by a psychiatric service and they opted not to make any changes to her medications at that time. The NP stated he did not agree with the pharmacist recommendations to reassess Resident #10's medications and consider gradual dose reductions because he felt such meds were best adjusted by a psychiatric service. When asked if a psychiatric service was following the resident, he stated "No, she was seen as a one-time only evaluation." He was not certain of the date the resident was seen by the psychiatric service.

A review of the resident's paper and electronic medical record revealed there was no documentation to indicate the Resident #10 had been seen for a psychiatric evaluation.

An observation and interview was conducted of the resident on 9/9/17 at 9:45 AM. The resident did not exhibit any behaviors at that time.

A telephone interview was conducted on 9/9/17 at 9:53 AM with the facility's consultant pharmacist. The pharmacist reported she was aware Resident #10 was on multiple antidepressants and thought perhaps these could be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 123	F 329		

consolidated. However, the pharmacist reported each time the issue was addressed, her recommendation was declined. The pharmacist reported she thought in the past the resident was being seen by psych. With the responses received from the provider regarding the resident having received a recent psych evaluation, the pharmacist reported she would have expected the evaluation to have been more recent than May of 2016.

An interview was conducted on 9/9/17 at 11:44 AM with the facility's Director of Nursing. Upon review of Resident #10's medical record, the DON reported that since her admission to the facility, Resident #10 was seen by a counseling program one time only on 5/18/16. The DON confirmed the report of this visit was recently received by the facility (on 9/8/17). This report indicated Resident #10 needed to be seen for a psychiatric evaluation. The DON stated, "It most definitely was not a psychiatric evaluation." The DON confirmed Resident #10 had not been seen by a psychiatric service at any time over the past year and one-half (since her admission to the facility). The DON stated she would be talking with the Medical Director regarding the need for education of providers on the use of psychotropic medications, the monitoring of these medications and making adjustments to them. Upon inquiry as to how resident behaviors were monitored, the DON reported her expectation was for the nurse to document a resident's target behavior when she administered a psychotropic medication. The DON indicated the nurse's documentation should be located in the resident ' s electronic medical record.

A telephone interview was conducted with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 329	Continued From page 124	F 329		

facility's Medical Director on 9/9/17 at 4:15 PM. A brief overview of Resident #10's medical history and concerns regarding her medication regimen was reviewed with the Medical Director. At that time, the Medical Director identified the credentials of the provider seen by Resident #10 on 5/18/16 as a Clinical Social Worker. As a long-term care resident, the Medical Director indicated he would have expected Resident #10 to have had a psychiatric evaluation along with psychiatric follow up. He stated, "We're going to need on-going assistance for managing medications from psych."

An interview was conducted on 9/10/17 at 10:15 AM with the facility's MDS Nurse. During the interview, the MDS Nurse reviewed the nursing staff's documentation in Resident #10's electronic medical record regarding behaviors and mood. The MDS Nurse reported she identified a "few" Nurses' Notes in the resident ' s medical record which were primarily focused on isolated episodes of confusion, but not related to behavior or mood issues. The MDS nurse indicated she would have expected to see more documentation of behaviors/mood due to Resident #10's use of antipsychotic medications.

A follow-up interview was conducted on 9/12/17 at 11:35 AM with the NP. During the interview, the NP indicated it was now his understanding the resident was only seen by a Clinical Social Worker since her admission to the facility. The NP acknowledged the report written by the Clinical Social Worker recommended a psychiatric evaluation be completed. The NP also confirmed he had been working under the assumption a psychiatric evaluation had been completed for this resident. The NP stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 125	F 329		

wrote another order on 9/8/17 and requested Resident #10 be seen by a psychologist for a psychiatric evaluation and medication review.
2. Resident #66 was originally admitted to the facility on 7/3/17, with diagnoses including depression and dementia without behaviors.

The admission Minimum Data Set (MDS) dated 7/24/17, specified Resident #66 had moderately impaired cognition, had depression and dementia. The MDS also indicated the resident did not have any behaviors during the assessment period.

Resident #66 was discharged to the hospital on 7/31/17.

The resident was re-admitted to the nursing home on 8/2/17 with diagnoses including depression and dementia without behaviors.

Record review revealed a physician's order dated 8/2/17, for Zyprexa 1.25 mg daily as needed (PRN) for agitation or anxiety. Zyprexa is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder.

A new MDS assessment was not completed with the re-admission, but a new care plan was initiated on 8/7/17 for Resident #66. It only contained one problem, which was for being on a therapeutic diet.

Review of the August Medication Administration Record (MAR) revealed Resident #66 received the PRN Zyprexa on thirteen times during the month of August. A review of the resident's paper and electronic medical record revealed the target behaviors/mood were not routinely monitored or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 126	F 329		

documented.

A review of the resident's medical record included a Consultation Report from the consultant pharmacist dated 8/22/17. The Consultation Report indicated Resident #66 was receiving the antipsychotic medication Zyprexa, and recommended it be discontinued. The pharmacist recommendation stated that the use of an antipsychotic medication required a qualifying diagnosis. The recommendation also stated that "as needed" antipsychotic orders in an emergency situation were limited to seven days and required documentation for the continued need of the antipsychotic medication.

During an observation of Resident #66 on 9/9/17 at 1:45 PM, the resident did not exhibit any behaviors.

On 9/9/17 at 4:21 PM, the Medical Director was interviewed about the use of the antipsychotic medication and lack of response to the pharmacy recommendations. The Medical Director stated the resident returned from the hospital with medication orders that included the Zyprexa and to taper the use of the antipsychotic medication. He stated his plan was to introduce a different medication and discontinue the Zyprexa. The Medical Director reviewed the pharmacy Consultant Report and stated his expectation was that the Nurse Practitioner should have reviewed and responded to the pharmacy recommendation within 3-5 days. He also stated he expected whenever a PRN was administered, there had to be documentation for the reason it was used.

An interview was conducted on 9/12/17 at 12:16 PM with the Nurse Practitioner (NP) regarding the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 127 pharmacy recommendation on 8/22/17. The NP stated that usually he reviews the pharmacy recommendations within a week but that he had been busy with some hospital admissions recently and had not addressed pharmacy recommendations at the facility.	F 329		
F 353 SS=J	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 353		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 128 (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and review of the staffing records, the facility failed to provide staffing in sufficient numbers to meet the needs of residents for 4 of 40 sampled residents (#66, #103, #131, and #56). Examples 1 and 2 were at the immediate jeopardy level. Examples 3 - 5 were at no actual harm with potential for more than minimal harm that is not immediate jeopardy and the scope is a pattern (E). Findings included: 1. Resident #66 was admitted to the nursing home on 7/17/17. Her admission Minimum Data Assessment indicated she had diagnoses including hypertension, peripheral vascular disease, septicemia, diabetes mellitus, non-Alzheimer's dementia, depression, generalized muscle weakness, abdominal pain, kidney failure, acquired abscess of left leg below knee, surgical aftercare for below knee amputation and gastro-esophageal reflux	F 353	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #66, was re-assessed by therapy on 9/20/2017 and the resident□s care plan was updated on 9/21/2017 to reflect the most current level and type of assistance needed with transfers and toileting. The interventions on the care plan are identified as tasks and linked to the Kardex which is reviewed by CNA staff. Resident #66 was initially provided a hand bell to use in the bathroom while in room 262. The Resident was then moved to room 263 with a functioning call bell. Parts were ordered and the call bell in room 262 was repaired on 9/15/17. The resident is content in room 263 and has remained there. Weekly interviews with resident #66 started on 9/20/17. Weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 129 disease. Her Minimum Data Set (MDS) assessment dated 7/24/17 indicated she was moderately impaired in cognition (Brief Interview for Mental Status was 11), required extensive assistance from one person for transfer, dressing and toilet use. She was not steady with moving on and off the toilet and only able to stabilize with staff assistance. She had no fall history and she received both occupational and physical therapy during the assessment period. The Care Area Assessment indicated activity of daily living, urinary incontinence and falls would be addressed in the care plan to minimize risks and avoid complications. According to the Occupational Therapy (OT) therapy notes dated 9/4/17, Resident #66 required substantial assistance with lower body dressing and had improved in toileting - transfers to being able to safely transfer to the toilet with supervision or touching -minimum assistance for toileting routine. Resident #66 was interviewed on 9/06/2017 at 9:20 AM. She said, sometimes she was treated with dignity and respect and added, "When they don't come and they are short of help, you just have to wait until someone comes and helps you out." On 9/07/2017 at 10:08 AM, Resident #66 said, "At home I used pull ups and used the toilet. Here, I use the ones that fasten on the side. The staff get me to the toilet two to three times a day. When I press the call bell they will come. I used the walker before I came. Therapy gives me exercises in my room sometime. Coming, when I	F 353	interviews will be conducted with Resident #66 by the social worker and/or designee for four weeks to ensure that her call bell is functional and that staff are responding to requests for assistance with toileting in an appropriate and timely manner. Any variances will be communicated to the facility leadership team during the huddles which are being held daily, Monday through Friday. e. The facility has offered multiple incentives to fill vacant shifts. On 9/16/2017, the offers included: overtime pay, double shift incentives, retention bonuses, and sign-on bonuses for LPNs, RNs, and CNAs. Prior to 9/16/2017, the facility was offering referral bonuses, sign-on bonuses, and commitment bonuses. f. The organization approved a new position of resident ambassador to assist the clinical team in non-direct care activities such as making unoccupied beds, passing ice or meal trays, answering calls, etc. As of 9/19/2017, four positions have been approved and are scheduled for orientation and assignment. All four have signed their job descriptions. These individuals have been screened through the hospital employment process and have been included for in-service training in the ECU including, but not limited to, abuse and neglect, dignity, elopement, employee burnout and No Pass Zone.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 353	Continued From page 130	F 353		

call them, is a problem. Mostly on days sometimes on second shift."

A Health Status Note dated 9/7/2017 at 2:39 PM read in part, alert and oriented times three with forgetfulness at times. ... Requires extensive assist with activities of daily Living (ADLs), set-up for oral care and meal tray. Blood sugar at 11:30 AM 236, receives insulin per sliding scale insulin order.

On 9/07/2017 at 4:25 PM Resident #66 was observed in her private bathroom on her own. She was attempting to transfer back into her wheelchair. She appeared anxious and was tightly gripping the grab bar and struggling to back herself into her wheelchair. At approximately the same time NA #15 was passing by Resident #66's room. She said she had to take vital signs and blood sugars. She said Resident #66 goes to the bathroom on her own if she feels like it. At 4:30 PM Resident #66 came out of the bathroom and said in a loud and angry voice, "I LIKE TO FELL AND NEED MY BRITCHES UP." NA #15 went in the room to assist Resident #66.

On 9/08/2017 at 7:54 AM Resident #66 was asked if she had put on the call bell yesterday to let the aide know she needed help. She said the call bell was not working in the bathroom.

On 9/08/2017 at 3:17 PM the Occupational Therapist was interviewed. She said she had worked with Resident #66 on functional transfers to toilet. She said, "Initially she needed two person assistance. Now she needed minimum assist and cues for safety and hand placement. She needed contact guard assistance. We've

Resident #103 was discharged home on 4/22/2017 with family. There was no further documentation of or attempt to elope from time of the 4/16/2017 incident until discharge.

Resident #56 was informed of expectation to have call bell answered timely. Resident #56 was discharged on 09/09/17.

Resident #131 was informed of expectation to have call bell answered timely. Resident #131 was discharged on 09/22/17.
Resident Council meeting was held on 09/26/17; concerns related to staffing voiced and addressed by Director of Nursing.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
a. A hold was placed on new admissions effective 9/9/2017 and will continue until facility is found to be in substantial compliance. The self-imposed hold on new admissions was made on 9/9/2017 by the CEO, administrator and corporate representative. This hold was communicated to the Admissions Director on 9/11 (the next business day) by the Administrator. The Admissions Director has responded to each request stating that currently, the facility was unable to meet the needs of the applicant.

b. Staff will be deployed from the acute hospital staff to assist in covering service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 131	F 353		

done safety training with nurse aides in the room. She added, "Typically, someone would be with her. She is good about calling if she needs help. I would not recommend her toileting by herself. She can self-propel in wheelchair. She is compliant. The safety awareness has already been an issue (i.e., hand placement). Safety is a huge thing."

Resident #66 was interviewed again on 9/08/2017 at 4:20 PM. She said, "I tried to get someone yesterday and couldn't find anyone. It was dangerous."

On 9/09/2017 at 10:15 AM the Director of Nurses was interviewed. She confirmed that Resident #66 required assistance from one person and needed supervision with activities of daily living. She needed a nurse aide (NA) due to her diagnosis of dementia. She can be forgetful at times. Resident #66 had some episodes of confusion. She had tried to get up. She had one assisted fall with staff. She was trying to get out of wheelchair and she did not wait for assist. The Director of Rehab provided education to the CNA.

Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee below the knee amputation, high blood sugar on that day and a continued need for occupational therapy for transferring,

gaps. These individuals have been screened through the hospital employment process and have been included in in-service training for ECU including, but not limited to, abuse and neglect, dignity, elopement, employee burnout, and No Pass Zone.

c. Starting 9/11/2017, the hospital nursing supervisor has been conducting rounds on the long-term care nursing facility unit, twice per shift, on the 12-hour evening shift. The role of nursing supervisor during this round is to provide additional supervision and oversight to the ECU team as needed. The supervisor will make rounds on the unit and discuss any immediate needs with the licensed nursing staff. The supervisor is also available to the ECU to respond to any emergency that may occur.

d. Responsibility for completing a master staff schedule has been re-assigned temporarily to the Chief Financial Officer for Person Memorial Hospital. The clinical department will manage and update the daily schedule. Call-outs will be made directly to the DON or Administrator. Staffing needs are reviewed daily, Monday through Friday, during the leadership team huddle meetings.

g. The CEO is holding small group staff meetings beginning 9/27/2017 to inform the employees of the survey findings and the organization□s efforts and commitment to improve staff recruitment and engagement. During these meetings,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 132	F 353		

toileting and dressing the lower body. On 9/7/17, three hours passed before hand bells were distributed to the bathrooms that had non-functioning call bells. On 9/8/17 at 12:30, the administrator was informed of the immediate jeopardy.

2. Resident #103 was admitted to the facility on 4/10/17 with multiple diagnoses including dementia.
The resident was discharged to the community on 4/22/17.

The attending physician's admission note dated 4/10/17, had early onset, advanced dementia.

There was no written, initial plan of care in Resident #103's clinical record.

A Nurse's Note, written by Nurse #10, dated 4/14/17 at 7:52 AM stated, "redirected several times on PM (evening) shift ambulation in hallway attempting to go in other patient's room without knocking. Combative with incontinent care on pm shift. Hitting and kicking staff as care was being provided. Refused pain med (medication). Night shift redirected X2[twice] ambulating in hallway. Observed sleeping in bed A several times."

A Nurse's Note, written by Nurse #10, dated 4/15/17 at 8:31 AM, revealed the resident had become combative and a one-time intramuscular dose of Haldol 5 milligrams (mg) was administered at 6:16 AM for agitation. Haldol is an antipsychotic drug used to treat acute psychosis.

The facility was unable to provide a Wander Risk Assessment for Resident #103 or documentation

the staff are being reminded of the expectations regarding performance and accountability to the improvement of the quality of life for the residents.

h. Key members of the facility leadership team will have huddle meetings daily, Monday through Friday, to report progress on the above actions and any new opportunities related to resident safety. A spreadsheet is maintained and has enhanced the organization of the meeting and strengthened the structure of the discussion. The leadership team is composed of the Administrator, Director of Nursing, Director of Quality, and Director of Human Resources. Adjunct support will be provided by the CEO, CFO, social worker, and Director of Plant Operations.

Prior to the survey, Person Memorial Hospital ECU was actively recruiting for full-time, part-time, and travel licensed nurses and CNAs. Two jobs fairs have been
conducted in the community one on 6/29/2017 and on 8/29/2017 for both licensed nurses and CNAs. Since the survey, the search has been broadened.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
The Director of Nursing will communicate position vacancies to CFO and/or Human Resources upon change in staffing needs. Position control will be monitored daily by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 353	Continued From page 133 about when a wander guard was placed on Resident #103. The admission comprehensive Minimum Data Set (MDS) was in progress but had not yet been completed. The Nurse's Notes written by Nurse #2 dated 4/16/17 at 3:30 PM read, "Pt (Patient) eloped from facility. Pt located sitting on curbing in front of ER (Emergency Room which was in the same building as the nursing facility). Pt ambulated back to floor. Skin intact. Denies pain." The note also stated the Director of Nursing (DON), physician, House Supervisor and the Resident Representative had been notified and that the resident was wearing a wander guard alarm bracelet on her right ankle at the time of the elopement. A Safety/Security Event form dated 4/16/17, specified the resident had wandered outside of the facility and was found sitting on a curb in front of the ER. It also stated a wander guard was on her right ankle and that it did not trigger the door alarm to lock. On the form, the Section for Witnesses/Parties Involved stated "Not Specified" The Follow-up Actions on the Safety/Security Event form was dated 4/27/17 by the DON and indicated that Maintenance and the wander guard company had been contacted. The facility provided email correspondence dated 4/17/17, in which the DON asked the Plant Operations Director to review the camera in an effort to establish a timeline for the elopement. The response was, "The resident came off the elevator on the first floor at 2:38. She was found outside the ER by CNA's (Nursing Assistants) at 3:03."	F 353	Director of Nursing and variances will be reported no less than weekly to the Administrator. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. The title of the person responsible for implementing the acceptable plan of correction; Administrator or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 134	F 353		

When asked for an investigation of the incident, the facility provided a note, handwritten by Nurse #2 that was dated 4/20/17 (no time). It simply stated which staff persons had tried to locate Resident #103 and where each person had searched. It also stated the resident had been found sitting on the curb in front of the ER. The paragraph was signed by the nurse.

Nurse #1, who had participated in the search was interviewed on 9/12/17 at 2:28 PM. Nurse #1 said, "I think [Nurse #2] is the one who had her. [Resident #103] was a wanderer and went into other people's rooms and she could ambulate pretty well. The wander guard helped by alarming when she passed certain zones." Nurse #1 did not know if the wander guard had malfunctioned or if it had been tested.

The Admissions Coordinator, who had assisted in the search for Resident #103 was interviewed on 9/12/17 at 2:38 PM. The Admissions Coordinator stated, Resident #103 was known to wander in other resident rooms and in the halls. She stated the resident was wearing a wander guard ankle bracelet, but when the resident left via the second floor elevator, it had not locked in place. The Admissions Coordinator did not know which NA was assigned to Resident #103 but said, "We looked for 5 or 10 minutes. By the time we were looking, if I remember, it was the ER [staff who] brought her back up." The Admissions Coordinator specified the ER staff had been made aware of the missing resident due to a "Code Pink" that was paged overhead in the building that described the resident and what she was wearing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 135	F 353		

NA #9, who had participated in the search was interviewed on 9/12/17 at 2:46 PM. NA #9 said, "They are in and it's hard to keep up on resident names." NA #9 was unable to remember Resident #103 or the incident.

Nurse #2, who was assigned to the Resident #103 on day of elopement, could not be reached by phone for an interview.

The facility was unable to identify which nursing assistant was assigned to the resident on the day of the elopement.

The Plant Operations Director was interviewed on 9/12/17 at 4:54 PM. The Plant Operations Director stated he had only worked at the facility for a few weeks at the time of the elopement. He said that prior to the elopement, there was an alarm that was near the elevator that would sound if the resident was near the elevator. The Plant Operations Director was not aware at the time of the elopement, that the wander guard system did not include locking the elevator door when a resident wearing a wander guarded entered the elevator. The Plant Operations Director indicated after Resident #103 was found outside in the parking lot, he was asked by administration to check the cameras to see how the resident got out of the building. He said, "She took the elevator to first floor and then went out the door by the ER." He also said, "I immediately brought folks in who knew the system, both the elevator and the company for the wander guard system. We found that it had an outdated transponder. To make a long story short, we purchased an updated transponder and brought in the state elevator folks to approve it. We did our due diligence and now it locks and will not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 136	F 353		

move if a person with a wander guard enters the elevator." He did not know if the ankle bracelet itself was tested to see if it was working at the time of the elopement.

The Administrator and DON were interviewed on 9/12/17 at 4:16 PM. The Administrator stated Resident #103 was wearing a wander guard ankle bracelet at the time of the elopement which was effective in sounding an alarm and locking all exit doors, but that the resident had left the second floor of the facility by using the elevator. The Administrator stated that prior to the elopement in April, she had made a request for something that would prevent the elevator from working with a resident with a wander guard who attempted to get on. She also stated that since the elopement, the elevator had been fixed and residents could no longer get out of the facility that way.

Immediate jeopardy began on 4/16/17 for Resident #103, unsupervised by staff, took the elevator to the first floor, exited the building and was found in the facility parking lot. Resident #103 was located by staff after an undetermined amount of time outside of the facility and had no injuries.

3. Resident #131 was admitted to the facility on 9/4/17 upon discharge from a hospital. The resident's medical history included a fracture of her left hip with surgical repair. A review of the resident's hospital Discharge Summary dated 9/4/17 included special instructions which read, "Patient should be on strict fall precautions she will need physical therapy and occupational therapy."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 137	F 353		

A review of the facility's medical record for Resident #131 revealed her Admission Minimum Data Set (MDS) assessment and individualized care plan were not yet due for completion.

A review of the facility's Admission Nursing Summary dated 9/4/17 at 3:15 PM revealed the resident was alert. Her short and long term memory were assessed to be intact and decisions were reported to be consistent and reasonable. The resident required extensive assistance for all of her Activities of Daily Living (ADLs), with the exception of requiring limited assistance of one with dressing and being independent with eating. Resident #131 was reported to be continent of bowel and bladder.

A Fall Risk Assessment completed on 9/4/17 revealed Resident #131 was determined to be at a moderate risk for falls. She was noted to have a history of a fall at home with a left hip fracture and repair. The Fall Risk Assessment indicated the resident required, "hands-on assistance to move from place to place."

A review of Resident #131's Physical Therapy (PT) Plan of Care dated 9/5/17 included an assessment of the resident's current functional abilities. The Plan of Care indicated the resident required supervision or touching assistance for ambulation. This level of assistance was further defined as needing a helper to provide verbal cues or touching/steadying assistance as the resident ambulated, either throughout the activity or intermittently.

A review of Resident #131's Occupational Therapy (OT) Plan of Care dated 9/5/17 also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 138	F 353		

revealed an assessment of the resident ' s current functional abilities was conducted. The Plan of Care indicated the resident required supervision or touching assistance for toileting. The resident was also assessed as requiring supervision for transfer with toileting. She was determined to be at a moderate risk for balance and falls.

A review of the resident's medical record included a Nursing Note dated 9/6/17 at 2:34 PM. The note indicated the resident was able to verbalize her needs. She ambulated with a walker with the assist of one.

Review of a Nursing Note dated 9/7/17 at 8:59 AM also revealed Resident #131 ambulated with the help of a walker, but required assistance and was described as "not very steady."

Further review of Resident #131's medical record included a Nursing Note dated 9/9/17 at 12:58 AM. This note also indicated Resident #131 ambulated with a walker and the assistance of one.

An observation was conducted on 9/9/17 at 7:40 AM. Upon entering the resident ' s hallway, Resident #131's call light was observed to be lit above the door to her room and the sound of an activated call bell was heard. The resident's door was closed and she could not be viewed from the hallway. At that time, a continuous observation was made of Resident #131's door and the call light above her doorway. At 7:51 AM a Housekeeping staff member was observed as she passed by Resident #131's room. The Housekeeping staff member did not knock or look into the resident's room. The call light continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 139	F 353		

to be lit above the door to Resident #131's room. At 8:01 AM, Administrative Staff Member #1 was observed as she walked by the resident's room. The administrative staff member did not knock or look into the resident's room. The call light continued to be lit above the door to Resident #131's room. At 8:07 AM, Administrative Staff Member #2 was observed as she passed by the resident's room. The administrative staff member she did not knock or look into the resident's room. The call light continued to be lit above the door to Resident #131's room. At 8:08 AM, Administrative Staff Member #3 passed by Resident #131's room. The administrative staff member she did not knock or look into the resident's room. The call light continued to be lit above the door to the resident's room. At 8:13 AM, Resident #131's breakfast tray was delivered to her room. Within one minute of the tray delivery, the resident's call light was turned off. On 9/9/17 at 8:15 AM, Nursing Assistant (NA) #2 was observed as she came out of the resident's room and closed the door. An interview was conducted with NA #2 at that time. During the interview, the NA was asked why the resident had her call light on. The NA reported the resident needed assistance to get to the bathroom.

An interview was conducted on 9/9/17 at 3:20 PM with Resident #131. Upon inquiry, the resident recalled putting on her call light in the morning before breakfast and stated she needed to use the bathroom. Resident #131 reported she was not supposed to go to the bathroom by herself and needed assistance to do so. She did not recall what time she put on the call light that morning, but reported, "Sometimes it takes a half hour for them to come." Resident #131 stated she did not have a clock or watch to see exactly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 140	F 353		

how much time had elapsed before staff came to assist her. The resident also described "one night" earlier in the week when she put on the call light to request bathroom assistance. Resident #131 reported she waited for what seemed to be "quite a long time." The resident stated she couldn't wait any longer for staff to come because, "I just knew I would wet myself all over if I waited anymore." Resident #131 reported she used the walker in her room to walk to the bathroom unassisted and then back to bed (also unassisted). Resident #131 stated she met the facility's Administrator a couple of days ago and told her, "You need more help."

A follow-up interview was conducted on 9/10/17 at 9:40 AM with Resident #131. During the interview, the resident recalled the night her call light was not answered by staff when she needed assistance to go to the bathroom. The resident stated she had actually used the call light twice that night and ended up getting to the bathroom and back to bed by herself unassisted because no one came to help her. The resident reported she knew she shouldn't walk unassisted but didn't feel she had a choice. She reported she just didn't feel strong enough to safely walk by herself and had been instructed by therapy and staff that she should not ambulate without assistance.

An interview was conducted on 9/10/17 at 3:36 PM with the facility's Director of Nursing (DON). Upon inquiry as to who was responsible for responding to call lights, the DON responded, "All staff...we have the no-passing zone." The DON reported 'the no-passing zone' meant all staff from all departments, including housekeeping and dietary, should answer call lights. She reported if the particular staff member answering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 141	F 353		

the call light could not meet the needs of the resident, he/she should let someone know who could take care of the resident's need. When asked what her expected response time would be for staff to answer a call light, the DON stated, "Ideally, less than 5 minutes."

An interview was conducted on 9/12/17 at 11:55 AM with Physical Therapist (PT) #1. PT #1 reported he had been working with Resident #131 since her admission to the facility a little over one week ago. Upon inquiry, the PT reported the resident continued to require assist of one for ambulation and toileting. The resident's report of ambulating to/from the bathroom on her own in the night were discussed with the PT. The PT stated he, "would have wanted her to have help."

4.a. Resident #56 was admitted to the facility from the hospital as a short-term resident with diagnoses including heart failure, diabetes mellitus, and aftercare from surgery.

The admission Minimum Data Set (MDS) assessment dated 08/16/17 revealed Resident #56 was cognitively intact, required extensive assistance with toileting and personal hygiene, and was totally dependent upon staff for bathing. Resident #56 was always incontinent of bowel.

During an interview with Resident #56 on 09/09/17 at 10:34 AM, he stated he had used his call light during the week (09/03/17 through 09/09/17) to summon help after he had soiled himself with a bowel movement, and no one responded until 2 hours later. He stated he could not remember exactly what time he called for help, but it was at least 2 hours he waited before staff arrived. He added he even called his wife at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 142	F 353		

home to see if she could get to the facility to help him after no one responded for so long. He explained he felt that the staff did not care about him and did not respect his need for help. He added that he did not like sitting in his own "mess."

Upon request, there was no nursing assistant (NA) documentation provided to indicate whether toileting or incontinence care was provided for Resident #56 during the month of September 2017.
In an interview with NA #2 on 09/09/17 at 4:25 PM, she stated she worked with Resident #56 during the week of 09/03/17 but did not recall providing incontinence care for him on any specific date.

During an interview with the Director of Nursing on 9/10/17 at 4:09 PM, she agreed that lack of bowel incontinence care was a dignity issue and that nursing assistants were expected to provide incontinent care as soon as possible to their assigned residents.

On 09/12/17 at 2:16 PM an interview was conducted with Nurse #4 on 9/12/17. She stated that she always worked on the rehabilitation hall. She stated it would be her expectation that anyone who needed incontinence care should receive the care within 5 to 15 minutes, depending on how busy the staff were at that time. She added that no one should have to sit in soiled clothing and sheets for any long period.

During an interview with NA #6 on 09/12/17 at 2:40 PM, she stated she worked with Resident #56 on during the week of 09/03/17, and she did not specifically remember providing bowel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 143	F 353		

incontinence care on any specific date, but was aware of his incontinence issue. NA #6 stated that a resident might have to wait for incontinence care when she had 15 to 20 residents assigned to her as she often did. She explained she would have to prioritize who needed care the most and finish up with one resident before she could move to the next. She further explained that she tried to get to each one as soon as possible and she agreed that a resident would not want to wait a few hours to receive bowel incontinence care.

In an interview with the on-call physician on 9/12/17 at 3:18 PM he stated that bowel incontinence care should be provided as soon as possible and that he would not want his family member to lie in feces waiting for care for 2 hours or even 20 minutes.

4.b. Resident #56 was admitted to the facility on 08/09/17 from the hospital as a short-term resident with multiple diagnoses including aftercare from surgical amputation of the left foot.

A review of Resident #56's current nursing care plan dated 08/09/2017 revealed there were no problems, goals, or interventions for pain management or aftercare from surgery.

There were two physician's orders in place to provide pain relief for Residents #56 as follows:

08/09/17 - Dilaudid Tablet 2 MG give 1 milligram (mg) by mouth every 4 hours as needed for pain.

08/10/17 - Lidoderm Patch 5 %. Apply to painful area topically one time a day for pain.
Apply patch to most painful area up to 12 hours and remove per schedule.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 144	F 353		

Review of the admission Minimum Data Set (MDS) assessment dated 08/16/17 revealed Resident #56 had diagnoses which included, in part, heart failure and diabetes mellitus. The same MDS indicated Resident #56 was cognitively intact and had frequent pain which made it hard for him to sleep at night and limited his day-to-day activities. The pain intensity level recorded on the assessment was "8" on a scale of "1 through 10", with 10 representing the most severe pain.

In an interview with Resident #56 on 09/09/17 at 10:34 AM, he stated he had used his call light the previous Friday (09/01/2017) and that it took at least an hour for someone to respond to provide him with pain medication. He was unable to remember exactly what time he called for pain medication, but he knew it was a little over an hour. Resident #56 explained that he had pain from his recent foot surgery as well as pain in his back due to arthritis. He added that sometimes repositioning helped his back pain, but both his back pain and surgical pain sometimes were strong enough that he needed the Lidocaine patch or his oral pain medication, Dilaudid. He further stated that his pain in his back was at pain level 7 on a scale of 1 through 10 that Friday, but by the time he was given pain medication, his pain level was at 8. Resident #56 stated this was not the only time he had to wait a long time to receive pain medication. He explained it took a very long time for anyone to answer his call light for any of his pain issues or other needs, so staff never knew he needed pain medication until they finally answered the call light.

Review of the August 2017 Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 145	F 353		

Administration Record (MAR) revealed Resident #56 received Dilaudid 1 mg by mouth at 3:43 AM on 08/30/17 and on 08/31/17 at 8:57 PM.

A review of the September 2017 MAR revealed Resident #56 had received Dilaudid 1 mg by mouth at 8:20 PM on 09/01/2017.

An interview was conducted on 09/09/17 at 4:15 PM with the Nurse #9 who was on duty on 09/01/17 when Resident #56 reported having pain at level 7. She stated if a resident had pain issues, then she would typically refer to the care plan for pain management interventions and would check to see if pain medications were ordered. Nurse #9 explained Resident #56 had a scheduled Lidocaine patch to be given once daily, and Dilaudid ordered as needed every 4 hours to address his pain. She did not specifically recall Resident #56 complaining of pain on 09/01/17 or how long it took to respond to his call, but added that she would want to have pain medication provided in a timely way, especially if the pain level was at 7 or 8.

Nurse #4, who had worked with Resident #56 regularly, was interviewed on 9/12/17 at 2:16 pm. She stated that the resident did not ask for pain medication very often, but when he did, she would expect for pain medication to be given within 5 to 10 minutes.

In an interview with nursing assistant (NA) #6 on 09/12/17 at 2:50 PM, she stated she did recall the Resident #56 had asked for pain medication at times, but did not specifically remember answering his call light on 09/01/17 for his pain medication request. She stated that anytime a resident reported to her he had pain, she reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 146	F 353		

it to the nurse.

During an interview with NA #2 on 09/12/17 at 4:25 PM, she stated if a resident reported to her that he/she needed pain medication she would report it to the nurse as soon as she could. She explained she had been working in the facility a very short time and that she was not very familiar with the residents and which ones had pain problems. She did not remember answering Resident #56's call light when he requested pain medication on 09/01/2017.

During an interview with the on-call physician on 09/12/17 at 3:18 PM, he stated his expectation was to provide pain medication as soon as possible after the resident called for pain relief and that there is no reason for a resident to be in pain.

5. A record review of the Resident Council (RC) minutes revealed from August 2017, "I lay in bed and the nursing assistants (NAs) are not getting me up." The resident also stated that a third shift NA told him to get the NA on the next shift to help him since she was getting ready to leave. Another resident stated "They don't help with getting me dressed and my roommate will help me sometimes but sometimes they leave you wet." In July 2017, RC minutes revealed residents stated they were not getting up on time on Sunday to go to Bible Study. In June of 2017, RC minutes revealed ongoing concerns from residents about getting water in a timely manner. The aides tell residents "let me get your aide when we need help to go to the bathroom." The resident stated "we need more help so we can get to our appointments on time." The May 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 147	F 353		

RC minutes revealed the DON informed the residents that attended the meeting that 2 NAs would be starting today and agency nurses would stay for 3 months and some nurses will be leaving. The residents stated "We need good NAs and nurses." There were also staffing concerns noted in April, 2017 RC minutes as well as March, 2017.

An interview with NA #6 on 9/7/17 at 10:22 am revealed today she had 14 residents but she has had up to 18 residents on her assignment.
An interview was conducted with (NA) #1 at 3:15 pm on 9/8/17. NA #1 reported she had 9 residents on this day and that it was a manageable assignment. NA #1 stated she worked the 3:00 pm to 11:00 pm shift and reported there were usually 3 to 4 on this shift. NA #1 reported she did what she could and tried to do her best to get all the care done. NA #1 reported they need more help in order to get the care done without rushing.

An interview was conducted with Nurse #1 at 3:30 pm on 9/8/17. Nurse #1 revealed she was here with just two nurses more often than not. Nurse #1 stated she worked the 7:00 am to 7:00 pm shift and most times had 25 to 30 residents. She stated it was battle trying to meet the resident's needs and she felt overworked and burnt out. Nurse #1 continued to add that the medication pass was nonstop and it was difficult to assist with the residents and the aides. Nurse #1 reported the residents know we do the best we can, but they knew there was not enough help. Nurse #1 reported she did not feel there was enough staff in the facility and stated everyone has addressed it and had been addressing it. Nurse #1 stated we reported it to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 148	F 353		

Administrator, the Director of Nursing (DON), and even had a meeting with the CEO (Chief Executive Officer) in August, 2017 to address the staffing issues, but nothing seems to get done.

An interview was conducted with Nurse #2 at 3:45 pm on 9/8/17. Nurse #2 reported typically we have 30 residents for each of the two nurses. Sometimes we will have an extra nurse and then we will get about 20 residents, but most often it was only 2 nurses scheduled. Nurse #2 stated when we have 30 residents, it can be very difficult to manage and meet the needs of the residents, and too many things have to get passed on to the next shift. Nurse #2 stated we do not have a wound treatment nurse so we have to do all our own treatments and this can be very time consuming if there were a lot of treatments. Nurse #2 added that sometimes there was enough staff but most times there was not. Nurse #2 reported that the hospital staff very rarely came to help us.

An interview was conducted with the Dietician on 9/8/17 at 3:55 pm. The Dietician stated they don't have enough staff and it was a struggle to follow the resident's weights because the weights and heights were not always done. The Dietician stated she had reported this concern to the DON.

An interview was conducted with Nurse #3 on 9/8/17 at 4:00 pm. Nurse #3 revealed the goal was to have 3 nurses on the shift, but more recently they would be scheduled for 3, but only 2 nurses would be on the floor due call outs. Nurse #3 stated they (the DON and staff) would try and find coverage, but if they didn't we worked with what we had. Nurse #3 stated if we had 3 nurses on the day shift, it was better. Nurse#3 reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 149	F 353		

she was able to meet the needs of the residents the best she could and sometimes things got passed to next shift.

An interview with the Activities Director/NA #12 on 9/9/17 at 8:55 am revealed that there was a concern with residents being ready for activities. The AD/NA #12 added that 10:30 am was the first activity of the day. She noted lately that some of the more active people were still in bed when it was time for activities or the NA would say they did not want to get up. The AD/NA #12 reported she expressed concerns to the DON about the residents not being ready for activities. The AD/NA #12 reported sometimes it depended on who was on duty because some aides would bring them down to activities when they were ready and other residents were still in bed.
An interview was conducted with the DON on 9/9/17 at 10:15 am. The DON reported every time she came to Resident Council she would let the residents know that new staff was coming. The DON added if there were specific complaints, then she would ask for more specific information from the residents or group and if there was an issue she would take care of it right away. The DON indicated she would counsel staff if needed and conducted weekly staff meetings. The DON reported she knew there was a concern about getting residents to the Sunday church service and indicated she was told the staff were getting the residents up more often on the weekends.
An interview was conducted with the DON on 9/9/17 at 10:45 am. The DON confirmed that there were staffing concerns. She revealed at the current time they had 3 agency nurses one for 7:00 am to 7:00 pm one for 7:00 pm to 7:00 am and one to manage the Minimum Data Set (MDS). The DON stated the agency nurses had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 150	F 353		

13 week assignment. The DON reported there were normally 2 nurses on the floor but the goal was to have 3 nurses scheduled and stated if they have 3 nurses, one nurse would be assigned to do the Rehabilitation (Rehab) Unit and the other two nurses would split the remaining of the census which usually was about 20 to 25 residents. She reported the Rehab Unit usually had about 12 residents because the acuity and demands were higher for these residents. She reported staff have approached her regarding staffing needs and she was in the process of hiring 4 NAs and one nurse. At this time, they have been trying to use the staff they have, and in order to prevent burnout, they ask the staff to take a day off and work a different shift to fill in where the need may be instead of increasing hours. The DON added, at times, they would pull nursing staff from the hospital (which was located in the building) if there was staff available. She reported we try to find coverage. Her goal was to have the NAs have no more than 12 residents on their assignment. The DON reported she was aware the NAs had a larger assignment of 15 to19 residents at times. The DON confirmed that was too many to be on an assignment and deliver quality care.

An interview with NA #9 on 9/9/17 at 3:50 pm revealed she had been working at the facility for about a year and her shift was on the weekend working 16 hours each day and an 8 hour shift on Friday. NA #9 reported her assignment today was 11 or 12 and that was manageable, but at times, it has been as high as 15 or 16. NA #9 reported she does the best she can to get her job done and help the residents. NA #9 stated there were a number of call outs and the staff does try to find help, but if they cannot, we have to make

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 151	F 353		

do. NA #9 stated when this happened, the assignment was heavier and it was harder to get the care done and we would fall behind. NA #9 reported they have been short staffed ever since she started.

An interview with the CEO and the Senior Director of Post-Acute Operations was conducted on 9/9/17 at 4:44 pm. The CEO revealed there was a staff meeting in August, 2017. The CEO reported several staff (nursing and NA's) attended and complained about staffing, salaries, wages and cost of living. The CEO stated the staff was struggling with the number of staff available. He indicated, in terms of staffing, they were recently approved for 4 aides and a Nurse Manager. He further added that three aides were starting Monday and two aides accepted the position over the weekend. The CEO stated for NA coverage there should be 7 aides on the day shift, 6 aides on evening shift and 4 aides at night. The CEO and the Senior Director were unaware that some NAs had a workload of up to 19 residents on their assignment.

A record review of the census for last 18 months revealed there were multiple days that did not meet the desired amount of aides and nurses. The census varied from 45 to 60 residents. The census records were reviewed with the DON.

An interview with the DON was conducted on 9/10/17 at 11:15 am. The DON confirmed, after review of the daily census and staffing sheets, there was not enough staff on each shift. The DON reported there were 13 nurses currently on the payroll. She often had to take the third nurse off her assignment to do other tasks like scheduling, wound care and work as a NA. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 152	F 353		

stated the facility was budgeted to have 3 nurses on days. She stated there were 22 NAs on the payroll including full time, part time, per diem, and some who work weekends only. She reported since March, 2017 they have lost/terminated 12 NAs, 3 RNS, and 2 LPNs. The DON added, they have since hired 10 NAs, 3 LPNs and 1 RN. The DON confirmed the desired staffing for NAs was to have 7 on day shift, 6 on evening shift and 4 on night shift. The DON reported some of the staff left for better wages, some left due to staffing issues and some were terminated as a result of a disciplinary action. The DON reported we do offer incentive programs to the NAs and nurses.

An interview with Nurse #5 at 3:28 pm on 9/10/17 revealed she worked every other weekend 7:00 am to 7:00 pm and one day during the week for 8 hours. She reported there was usually only 2 nurses on the weekends. She reported when she was hired, she was told she was going to be the third nurse. She stated she had been at the facility since March, 2017, and there were only 2 nurses scheduled on the weekends. She reported she has had to work over her time to chart and get caught up because it was very difficult to meet the needs of the residents when there were only 2 nurses especially when she was the nurse assigned to the Rehab Unit due to the high acuity and demands. Nurse #5 stated she had been asked to stay over into the next shift to fill in, but she would refuse. Nurse #5 indicated the staffing varied for NAs on the day shift stating sometimes we would have 4 but a lot of times we had 2 or 3 on days and have been down to just one NA on evenings but usually we had 3 or 4 aides. She reported the hospital staff does not help and there are too many call outs, but management will try and find coverage. Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 353	Continued From page 153 #5 reported she was ready to quit and she reported to the CEO at the August meeting she was ready to walk out. She reported a lot of nurses and aids have left since she started due to being short staffed. An interview with NA #8 on 9/12/17 at 10:45 am revealed the facility needs more staff. NA #8 stated it was very stressful trying to get the assignment done for the residents. The NA reported she had been here for about 3 weeks and worked 7:00 am to 7:00 pm shift. NA #8 indicated on day shift there were usually on 4 to 5 aides. She reported there were frequent call outs and if they did not get coverage they would just have to take more residents on their assignment. An interview with the DON on 9/12/17 at 2:20 pm revealed her expectation was that the facility be staffed to budget to meet the needs of the facility. An interview with the Administrator on 9/12/17 at 4:00 pm revealed the need for staffing was discussed and there are ongoing concerns. She stated it was up to management to give the staff the support they needed to get the care done.	F 353		
F 354 SS=F	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 354		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 354	Continued From page 154 (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility's licensed staff schedules and staff interviews the facility failed to schedule a Registered Nurse (RN) for eight consecutive hours per day for 7 days a week for 9 out of 28 weekends reviewed (3/19/17, 4/1/17, 4/8/17, 4/9/17, 4/23/17, 5/6/17, 5/7/17, 5/20/17, and 5/21/17). Findings included: A record review of the staffing schedules revealed there was no RN coverage on Saturday and Sunday for (3/19/17, 4/1/17, 4/8/17, 4/9/17, 4/23/17, 5/6/17, 5/7/17, 5/20/17, and 5/21/17). An interview was conducted with the RN House Supervisor of the hospital on 9/10/17 at 12:05 am. The House Supervisor reported she did not deal with the Extended Care Unit (ECU) staff. She stated she was not responsible for supervision of the staff. An interview was conducted with the Director of Nursing (DON) on 9/12/17. The DON confirmed there was no RN coverage on the reviewed weekend dates. The DON revealed she did not work on any of the dates reviewed. The DON stated she thought the house supervisor from the hospital (located in the building) acted as the RN for the extended care unit. An interview with the DON on 9/17/17, at 2:45 pm revealed her expectation was to demonstrate a	F 354	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Registered nurse to be on worked schedule 8hours/day. DON did not work on the days a RN was not scheduled to work. Nurse staffing vacancies communicated to HR and CFO with need to fill vacant positions with supplemental staffing while pending new hires; must ensure RN on schedule daily 8hours/day. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Nurse staffing schedule shared with HR and CFO to review position needs. Supplemental staffing initiated to fill vacancies to limit DON working staff nurse shifts. Vacant positions posted and will be filled to ensure RN on worked schedule 8hours/day. The hours of other RNs in leadership/manager role will be captured to aide in meeting the 8hours/day of RN coverage requirement. Variance in RN coverage will be reported to Administrator promptly. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains	

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F 354	Continued From page 155 Registered Nurse was in the building 7 days a week for 8 consecutive hours.	F 354	corrected and/or in compliance with the regulatory requirements; Nurse schedule will be reviewed daily to ensure RN is assigned at least 8hours/day. Call-offs by the scheduled RN will be reported to DON promptly to determine if additional RN coverage is necessary. Worked schedule will be reviewed weekly to ensure documentation of RN coverage 8hours/day and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing or Designee	
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 356		10/24/17

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F 356	Continued From page 156 vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the facility staff posting and staff interviews, the facility failed to post accurate actual hours worked and actual staffing totals for licensed staff directly responsible for resident care per shift for five of ten days reviewed (9/9/17, 9/8/17, 9/7/17, 9/6/17, and 9/5/17). Findings included:	F 356	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Posted nurse staffing with actual worked hours and actual staffing totals for licensed staff was not posted accurately. Two separate forms are posted to report	

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F 356	Continued From page 157 A record review of the staff posting revealed inaccurate hours worked and inaccurate staffing totals for five of ten days reviewed. Upon further review, there were two different form types of the staff posting being utilized. One form recorded the staff posting for nurses for the first shift 7:00 am - 7:00 pm and second shift as 7:00 pm - 7:00 am. The other form recorded staff posting for nurses for first shift as 7:00 am - 3:00 pm, second shift as 3:00 pm - 11:00 pm, and third shift as 11:00 pm - 7:00 am. An observation of the staff on 9/12/17 at 1:00 pm posting dated 9/9/17 revealed there were two Registered Nurses (RNs) on the 7:00 am to 7:00 pm shift totaling 16 actual hours worked. The staffing schedule for 9/9/17 revealed there were no RNs on the 7:00 am - 7:00 pm shift. An interview was conducted with the Director of Nursing (DON) on 9/12/17 at 2:45 pm. The DON confirmed there were discrepancies on the staff posting and indicated there should be no RNs recorded for the 7:00 am to 7:00 pm shift and no actual hours. The DON reported she did not know why they were using two separate forms to record the staffing. The DON confirmed the nurses worked 12 hour shifts unless otherwise noted. An observation on 9/12/17 at 1:00 pm of the staff posting dated 9/8/17 revealed there was one RN on the 7:00 am - 3:00 pm shift totaling 8 actual hours worked and two RNs on the 3:00 pm - 11:00 pm shift indicating 8 actual hours worked. The staffing schedule for 9/8/17 revealed there were no RNs on the 7:00am - 3:00 pm shift and only one RN on the 3:00 pm - 11:00 pm shift.	F 356	out information required and is updated by the unit secretary. The hours posted did not match the working schedule for 5 observed dates. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The form for posting nursing staffing was revised on 09/12/17 to include the required information of facility name, current date, total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, and Resident census. In the event of changes in the schedule that affect actual worked hours, the form will be updated promptly to ensure accurate posting. Posted daily nursing staffing data will be maintained electronically for 18 months. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The unit secretary will complete form daily for next day(s) and will ensure posting in designated area. Posting of form will be reviewed at the beginning of each shift to ensure accuracy. Changes will be made to be reflective of required elements of posting and any discrepancies observed during audit will be corrected promptly. Results of audit will be reported at QAPI monthly for three months and then quarterly thereafter.	

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F 356	Continued From page 158 An interview with the DON on 9/12/17 at 2:45 pm confirmed there was no RN working on the 7:00 am - 3:00 pm shift and she indicated the staff total and actual hours worked were inaccurate. Additionally, the DON confirmed there was one RN on the 3:00 pm - 11:00 pm shift and the actual hours worked should be recorded as 4 because the RN began her shift at 7:00 pm. An observation on 9/12/17 at 1:00 pm of the staff posting dated 9/7/17 revealed there were two RNs on the 7:00 am- 3:00 pm shift totaling 16 actual hours worked and 3 RNs on the 3:00 pm - 11:00 pm shift totaling 12 hours. The staffing schedule for 9/7/17 revealed there was one RN on the 7:00 am - 3:00 pm shift and two RNs on the 3:00 pm - 11:00 pm shift. An interview with the DON on 9/12/17 at 2:45 pm confirmed there was one RN for 7:00 am - 3:00 pm shift and the actual hours worked should be recorded as 8. Additionally, the DON confirmed there were 2 RNs for the 3:00 pm - 11:00 pm shift with the accurate hours documented. An observation on 9/12/17 at 1:00 pm of the staff posting dated 9/6/17 revealed there were two RNs on the 7:00 am - 3:00 pm shift totaling 16 actual hours worked and 3 RNs on the 3:00 pm - 11:00 pm shift totaling 12 actual hours worked. The staffing schedule dated 9/6/17 revealed there was one RN on the 7:00 am - 3:00 pm shift and 2 RNs on the 3:00 pm - 11:00 pm. An interview with the DON on 9/12/17 at 2:45 pm confirmed there was one RN on the 7:00 am - 3:00 pm shift and the actual hours worked should be recorded as 8. The DON further confirmed	F 356	" The title of the person responsible for implementing the acceptable plan of correction; Administrator or Designee	

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F 356	Continued From page 159	F 356		

there were two RNs for the 3:00 pm - 11:00 pm shift with the accurate hours documented. The DON reported the Unit Ward Clerk completed the staff posting each morning based on the staffing schedule. The DON did not know why she recorded it inaccurately. The DON reported the Unit Ward Clerk was not in the facility today and was unavailable for an interview.

An observation on 9/12/17 at 1:00 pm of the staff posting dated 9/5/17 revealed there was one RN on the 7:00 am - 3:00 pm shift totaling 8 actual hours worked and 2 RNs on the 3:00 pm - 11:00 pm shift totaling 8 actual hours worked. The staffing schedule dated 9/5/17 revealed there was no RN on the shift and one RN on the 3:00 pm - 11:00 pm shift.

An interview with the DON on 9/12/17 at 2:45 pm confirmed there were no RNs on the 7:00 am - 3:00 pm shift and the actual hours worked should be recorded as 0. The DON also confirmed there was one RN on the 3:00 pm - 11:00 pm shift with the accurate hours documented.

An interview with the DON on 9/12/17 at 3:00 pm revealed the process for completing the staff posting was done daily at the beginning of the shift by the Unit Ward Clerk. The DON stated the Unit Ward Clerk used the daily staffing schedules to complete the posting. The DON could not identify why there were inaccuracies. The DON stated, in the mornings, the Unit Ward Clerk would remove the previous posting and file it. The DON reported her expectation of the Unit Ward Clerk was to complete the staff posting accurately.

An interview with the Administrator on 9/12/17 at

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F 356	Continued From page 160 3:50 pm revealed her expectation for completing the staff posting was that it be done accurately and updated as needed.	F 356		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to discard leftovers after three days and six of ten air vents were not clean. The potential for receiving food that had been held for too many days affected all residents. Findings included:	F 371	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Leftover food is stored in accordance of policy and is to be discarded after 3 days.	10/24/17

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F 371	Continued From page 161 1. On 9/05/2017 at 10:13 AM, the kitchen was inspected. One of the walk-in refrigerators contained salmon steaks in individually sealed packs dated 8-26-17, carmel sauce dated 8/28/17, meat balls and pork chops dated 8/30/17, beef enchiladas and mixed vegetables dated 8/31/17 and apple crisp dated 9/1/17. During this observation the Food Service Director said this is garbage and began to remove the items from the refrigerator. On 9/08/2017 at 8:33 AM Cook #2 said, "The date on the leftovers is the date we put the food in the refrigerator the first time. Three days later you should throw it out. Once you reheat the leftover, it should be thrown out." At this time, there were no observations of leftovers held for more than three days. 2. On 9/05/2017 at 10:13 AM, the kitchen was inspected. The vent above a reach-in refrigerator was noted to have brown mildew-like stains. On 9/08/2017 at 8:41 AM, six of ten ceiling vents in the kitchen appeared to have mildew-like staining on them. Cook #1 said Maintenance does the vents. On 9/08/2017 at 4:10 PM, the Plant Operations Director was shown the vents. He said, "These can be cleaned. A work order should be placed. I will take care of it."	F 371	On 09/05/17, leftover food was found in walk-in refrigerator with a marked date greater than 3days of when first used. All expired food was discarded on 09/05/17. Six of ten vents in the kitchen appeared to have brown mildew stain on 09/08/17. A work order was created on 09/20/17 to clean the vents with issues. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Leftover food will be stored and dated, and then discarded after 3 days. Dietary department will be educated on storage of food by CFO by 10/24/17. A daily walkthrough of all food storage areas will be completed daily and discrepancies will be noted on a food storage log by Dietary Team Lead. All vents in the kitchen were cleaned on 09/20/17. All staff were educated on how to create work orders for maintenance requests on 09/27/17. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The CFO or designee will complete weekly observation of food storage areas. Concerns observed during walkthrough will be addressed and any leftover food <3 days will be discarded, and variances will be reported to Dietary team lead for corrections. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three	

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F 371	Continued From page 162	F 371	months and then quarterly thereafter. The CFO or designee will complete weekly observation of kitchen vents to identify need for maintenance. Work orders will be created upon identification of concern. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Administrator or Designee	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,	F 428		10/24/17

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F 428	Continued From page 163 and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with of the nurse practitioner, Director of Nursing and Medical Director, the facility failed to respond to pharmacy recommendations (Resident #66) for 1 of 6 sample residents reviewed for unnecessary medications. Findings included:	F 428	"The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #66 had pharmacy recommendation on 08/22/17 for GDR of Zyprexa with goal to discontinue the PRN dose. The pharmacy recommendation	

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F 428	Continued From page 164 Resident #66 was originally admitted to the facility on 7/3/17, with diagnoses including depression and dementia without behaviors. The admission Minimum Data Set (MDS) dated 7/24/17, specified Resident #66 had moderately impaired cognition, had depression and dementia. The MDS also indicated the resident did not have any behaviors during the assessment period. The 7/24/17 MDS specified the resident was not receiving antipsychotic medications. Resident #66 was discharged to the hospital on 7/31/17. The resident was re-admitted to the nursing home on 8/2/17 with diagnoses including depression and dementia without behaviors. Record review revealed a physician's order dated 8/2/17, for Zyprexa 1.25 mg daily as needed (PRN) for agitation or anxiety. Zyprexa is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder. Review of the August Medication Administration Record (MAR) revealed Resident #66 received the PRN Zyprexa thirteen times during the month of August. A review of the resident's paper and electronic medical record revealed the target behaviors/mood were not routinely monitored or documented. A review of the resident's medical record included a Consultation Report from the consultant pharmacist dated 8/22/17. The Consultation Report indicated Resident #66 was receiving the antipsychotic	F 428	was not reviewed by attending practitioner and the record did not indicate supporting diagnosis or documented behaviors. Order to discontinue Zyprexa was received and noted on 09/30/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All August and September pharmacy recommendations for GDR for will be reviewed by 10/20/17. Pharmacy recommendations will be reviewed and signed by DON and Attending Physician within 30 days of receipt of communication. Pharmacy will communicate outstanding items to DON during monthly consultation visits. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Monthly pharmacy recommendation for GDR will be audited for accuracy of reason of declination for the next 90 days, by the Administrator or Designee. Discrepancies will be addressed for clarification. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; Administrator or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 428	Continued From page 165	F 428		

medication Zyprexa, and recommended it be discontinued. The pharmacist recommendation stated that the use of an antipsychotic medication required a qualifying diagnosis. The recommendation also stated that "as needed" antipsychotic orders in an emergency situation were limited to seven days and required documentation for the continued need of the antipsychotic medication.

Review of the September Medication Administration Record (MAR) revealed Resident #66 received the PRN Zyprexa five times between 9/1/17 and 9/9/17.

During an observation of Resident #66 on 9/9/17 at 1:45 PM, the resident did not exhibit any behaviors.

On 9/9/17 at 4:21 PM, the Medical Director was interviewed about the use of the antipsychotic medication and lack of response to the pharmacy recommendations. The Medical Director stated the resident returned from the hospital with medication orders that included the Zyprexa and to taper the use of the antipsychotic medication. He stated his plan was to introduce a different medication and discontinue the Zyprexa. The Medical Director reviewed the pharmacy Consultant Report and stated his expectation was that the Nurse Practitioner should have reviewed and responded to the pharmacy recommendation within 3-5 days. He also stated he expected whenever a PRN was administered, there had to be documentation for the reason it was used.

An interview was conducted on 9/12/17 at 12:16 PM with the Nurse Practitioner (NP) regarding the pharmacy recommendation on 8/22/17. The NP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 428	Continued From page 166 stated that the Ward Secretary, who usually took off orders, had been out on leave for the last few weeks. He stated that if he reviewed the pharmacy recommendations, he would usually write orders but since the Ward Secretary was on leave, there would be no one to transcribe the orders, so he had been waiting to review them. The NP also stated he usually reviews the pharmacy recommendations within a week but that he had been busy with some hospital admissions recently and had not addressed pharmacy recommendations at the facility.	F 428		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and	F 431		10/24/17

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F 431	Continued From page 167 that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to store medications within the temperature range specified by the manufacturer in 1 of 1 Medication Room; and, failed to label medications with the minimum identifying information required (including the resident's name) stored on 1 of 2 medication carts (Short Hall Med Cart) and in 1 of 1 Medication Room observed.	F 431	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Medication storage refrigerator temperatures were not observed to be compliance range, as well as one missing temperature recording on 09/08/17. One medication was observed unlabeled in the medication room refrigerator and two other medications were observed	

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F 431	Continued From page 168 The findings included: 1) Accompanied by Nurse #2, an observation was made of the facility's Medication Room (Med Room) on 9/7/17 at 9:58 AM. Upon opening the Med Room refrigerator door, a thermometer in the refrigerator indicated the temperature was 26 degrees Fahrenheit (F). The thermometer reading was verified by Nurse #2. A temperature log on the refrigerator indicated the temperature had been checked and recorded as 36 F on 9/7/17 (the time was not documented). The contents of the Med Room refrigerator on 9/7/17 at 9:58 AM included, in part: --3 unopened vials of Lantus insulin dispensed for Resident #30. One vial of the insulin was dispensed from the pharmacy on 6/30/17, a second vial of insulin was dispensed on 8/8/17, and the third vial of insulin was dispensed from the pharmacy on 8/13/17. A review of the manufacturer's product information indicated unopened vials of Lantus insulin should be stored between 36F to 46F ...Do not freeze. Discard if frozen. --1 unopened vial of Lantus insulin dispensed from the pharmacy on 8/18/17 for Resident #41. --1 unopened vial of Novolog insulin dispensed from the pharmacy on 8/13/17 for Resident #30. A review of the manufacturer's product information indicated unopened Novolog insulin should be stored between 36F to 46F ...Do not freeze Novolog and do not use Novolog if it has been frozen. --1 unopened vial of Humalog insulin dispensed from the pharmacy on 9/6/17 for Resident #133. A review of the manufacturer's product information indicated unopened Humalog insulin should be stored between 36F to 46F. Do not	F 431	unlabeled on medication cart. Medications stored in refrigerator and unlabeled medications in medication cart were all discarded on 09/09/17. It was determined that the medication storage refrigerator was malfunctioning and was replaced on 09/09/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Medication storage refrigerator will have daily temperature check and recorded on temperature log by charge nurse on second shift. Variances in fridge temps will be reported to DON or Designee, and the charge nurse will create a work order if indicated. Both medication carts will be checked to ensure all medications are labeled by 10/05/17 and weekly by Director of Nursing or Designee. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Weekly audits of medication storage refrigerator and temperature logs will be completed by Infection Preventionist or Designee. Medication carts will be audited weekly for 30 days by DON or Designee for unlabeled medications and then monthly for 60 days. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 431	Continued From page 169 freeze. --Six - 25 milligram (mg) promethazine suppositories (an anti-nausea medication to be administered rectally) dispensed from the pharmacy on 2/20/17 and labeled for use by Resident #71. An auxiliary label placed on the medication by the pharmacy read, "Do not freeze." --Twenty - 25 mg promethazine suppositories dispensed from the pharmacy on 6/9/17 for Resident #85. --House stock of 2 boxes (12 count in each box) and 32 individual (not in a box) 650 mg acetaminophen suppositories (an over-the-counter pain reliever to be administered rectally). A review of the manufacturer's product information indicated the suppositories should be stored between 25F to 80F; Do not freeze. --House stock of 1-vial Pneumovax 23 Single Dose Vial (a vaccine) dispensed from the pharmacy on 8/31/17. A review of the manufacturer ' s product information indicated Pneumovax 23 should be stored between 36F to 46F. --House stock of 1-vial Aplisol (a vaccine) dispensed from the pharmacy on 8/31/17 and dated as having been opened on 9/1/17. A review of the manufacturer's product information indicated Aplisol should be stored between 36F to 46F; Do not freeze. --House stock of 1-vial Prevnar 13 (a vaccine). A review of the manufacturer's product information indicated Prevnar 13 should be stored between 36F to 46F; Do not freeze; Discard if frozen. --1-vial of Perforomist (a medication used for the treatment of chronic obstructive pulmonary disease or asthma). A review of the manufacturer ' s product information indicated prior to dispensing, Perforomist should be stored	F 431	implementing the acceptable plan of correction. Infection Preventionist, DON or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 170	F 431		

in the refrigerator at 36F to 46F.

An interview was conducted on 9/7/17 at 10:00 AM with Nurse #2. Upon inquiry, the nurse stated the Med Room refrigerator's temperature was supposed to be 36 F to 46 F. The nurse was observed as she turned the temperature up on the Medication Room refrigerator. She stated the temperature would need to be watched.

On 9/7/17 at 10:30 AM, an interview was conducted with the facility's Director of Nursing (DON). During the interview, the DON stated she was told the temperature of the Med Room refrigerator was observed to be outside of the recommended range. She reported the Med Room refrigerator temperature was typically checked twice daily. The DON stated she would expect the temperature of the Medication Room refrigerator to be within the recommended range (noted on the log sheet as 36F to 46F) and the medications to be stored in accordance with the manufacturer's recommendations.

A follow-up interview was conducted on 9/7/17 at 12:31 PM with the DON upon her request. At that time, the DON reported she had called the pharmacy regarding the medications stored in the refrigerator of the Med Room. The pharmacy instructed her to call back if the refrigerator temperature remained low.

An observation was made of the refrigerator's temperature in the Medication Room on 9/8/17 at 8:16 AM. The thermometer in the refrigerator indicated the temperature was 34 F (below the recommended range of 36F to 46F). The temperature log sheet on the refrigerator did not include documentation to indicate the refrigerator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 431	Continued From page 171	F 431		

temperature had been checked on 9/8/16. The medications stored in the refrigerator were the same as those stored in the refrigerator during the observation made on 9/7/17.

Accompanied by Nurse #2, an observation was made of the refrigerator's temperature in the Medication Room on 9/8/17 at 2:30 PM. The thermometer in the refrigerator indicated the temperature was 30o F. The thermometer reading was verified by Nurse #

2. The temperature log sheet on the refrigerator did not include documentation to indicate the refrigerator temperature had been checked on 9/8/16. The medications stored in the refrigerator were the same as those stored in the refrigerator during the observation made on 9/7/17.

An interview was conducted on 9/8/17 at 2:55 PM with the DON. The DON reported she was not aware there was a continuing problem with the temperature of the Med Room refrigerator.

A follow-up interview was conducted on 9/9/17 at 12:13 PM with the DON upon her request. At that time, the DON stated the Med Room refrigerator had been replaced and all medications stored in the refrigerator were discarded.

2) An observation was made of the Short Hall Medication Cart on 9/7/17 at 9:30 AM. The observation revealed the bottom drawer of the med cart contained the following: 2 - loose, unlabeled vials of ipratropium solution for inhalation (an inhaled medication used for the management of chronic obstructive pulmonary disease); 1 - loose, unlabeled vial of 2.5 milligram (mg) per 3 milliliter (ml) albuterol solution for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 431	Continued From page 172	F 431		

inhalation (an inhaled medication used to treat asthma); and, 2 - individually wrapped, unlabeled packages of 2.5 mg/3 ml albuterol inhalation solution.

An interview was conducted on 9/7/17 at 9:35 AM with Nurse #1. Nurse #1 was the hall nurse assigned to the Short Hall Med Cart. Upon inquiry, the hall nurse stated she would probably need to throw away the unlabeled vials of medication stored on the med cart. The nurse reported the vials of medication should have been kept in a box or package that was labeled by the pharmacy with the resident's name.

An interview was conducted on 9/7/17 at 12:31 PM with the facility ' s Director of Nursing (DON). Upon inquiry as to what her expectations were for unlabeled vials of inhalation solution, the DON stated she expected all medications to be labeled appropriately.

3) Accompanied by Nurse #2, an observation was made of the Medication Room (Med Room) refrigerator on 9/7/17 at 9:58 AM. The contents of the refrigerator at the time of the observation included one vial of Perforomist (a medication used for the treatment of chronic obstructive pulmonary disease or asthma). The medication was not labeled by the pharmacy with the minimum identifying information required, including the resident's name.

An interview was conducted on 9/7/17 at 10:00 AM with Nurse #2. Upon inquiry, Nurse #2 stated she had "no idea" who the Perforomist medication belonged to.

An interview was conducted on 9/7/17 at 12:31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 431	Continued From page 173 PM with the facility's Director of Nursing (DON). Upon inquiry as to what her expectations were for unlabeled vials of inhalation solution, the DON stated she expected all medications to be labeled appropriately.	F 431		
F 441 SS=J	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 441	Continued From page 174 to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility staff: 1) Failed to disinfect a shared glucometer (device used to measure a resident's blood glucose or blood sugar level) between residents and failed to perform hand hygiene	F 441	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #55 continues to receive blood sugar monitoring and has	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 441	Continued From page 175 between residents for 1 of 3 residents observed to have their blood glucose checked (Resident #55). The facility staff also failed to wear gloves when completing a blood glucose check for 2 of 3 residents observed to have their blood glucose checked (Resident #55 and Resident #134); and, 2) Failed to perform hand hygiene after providing bowel incontinence care and before providing perineal care for 1 of 1 resident reviewed for infection control (Resident #10). Immediate jeopardy began on 9/8/17 and is ongoing. Neither the Nursing Assistant (NA) #10 observed to do blood glucose checks nor the hall nurse (Nurse #2) were trained on how to disinfect a shared glucometer between residents in accordance with the manufacturer's directions for the disinfectant. NA #10 did not perform hand hygiene between residents when doing the blood glucose checks and did not wear gloves on two separate occasions when doing the blood glucose checks. One of these occasions occurred after the nursing assistant had been instructed by the hall nurse to use gloves. Example number 2 is at no actual harm with potential for more than minimal harm that is not immediate jeopardy and the scope is isolated (D). The findings included: 1. A review of the facility policy entitled "Blood Glucose Monitoring/Treatment" (Originated June 2015) read, in part: "Clean the [Brand name of a glucometer] with approved facility disinfectant wipes after each resident use." A review of the facility's policy entitled "Hand	F 441	demonstrated no evidence of infection related to blood sugar monitoring. Resident #134 was discharged home with spouse on 9/9/2017. Prior to discharge, the resident did not demonstrate any adverse effects from breach of infection control practice related to blood sugar monitoring. Resident # 10 was provided appropriate incontinence care 09/09/17, after the deficient practice was observed. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The unit staff reviewed the policy on glucose monitor cleaning and hand hygiene and validated that they were consistent with the CDC guidelines. Thereafter, education on disinfection of glucometers was initiated on 9/8/2017 by the Director of Nursing for all to staff who complete blood glucose checks. Additional training has been conducted on glucose monitor disinfection, per the manufacturer□s instruction, to both licensed nursing staff and CNAs. Those trainings were conducted by a licensed nurse and/or infection control preventionist. The ECU protocol regarding which individuals can complete blood sugar monitoring was changed, effective 9/27/2017, to only allow only licensed nurses to complete blood glucose monitoring. By limiting the number of staff performing the blood glucose monitoring,	

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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 176 Hygiene" (Revised July 2017) read, in part: "A. Indications for Use: ...2. Use an alcohol-based hand rub in all other recommended situations below, unless hands are visibly soiled." The situations on the list included: Before and after direct patient contact and contact with the patient's environment; and, after contact with potentially infectious materials and/or bodily fluids, specimens, etc. A portion of the facility's policy on Hand Hygiene (Revised July 2017) also addressed "Other Aspects of Hand Care and Protection." This section identified situations when the use of gloves was indicated and read, in part: "Gloves should be used when: 1. Touching excretions, secretions, blood, body fluids, mucous membranes, or non-intact skin ... 4. Handling potentially contaminated items 5. It is likely that hands will come in contact with blood, body fluids, or other potentially infectious material ..." An interview was conducted on 9/8/17 at 11:05 AM with the Infection Control nurse shared by the hospital. The Infection Control nurse reported her duties included the tracking and trending of infections for the facility. The nurse also reported she provided education to staff on several infection control topics, including hand washing. A continuous observation was conducted on 9/8/17 at 4:52 PM of Nursing Assistant (NA) #10 as she did a finger stick on Resident #85 to obtain blood for a blood glucose (BG) check. NA #10 was not wearing gloves when she used the lancet to do a finger stick and completed the BG check. The NA was observed as she placed the glucometer in a plastic case (which also	F 441	there will be improved accountability of staff carrying out the procedure and maintenance of infection control standards. Training on the policy and procedure for completing blood glucose monitoring, including hand hygiene, was initiated on 9/22/2017 and conducted by the organization□s Infection Control Preventionist and/or a licensed nurse for all licensed nursing staff conducting blood glucose monitoring. Training will be completed by 9/29 for nurses routinely assigned to conduct blood glucose monitoring. Key members of the facility leadership team will have huddle meetings daily, Monday through Friday to report progress on the above actions and identify any new opportunities related to resident safety. A spreadsheet is maintained and has enhanced the organization of the meeting and strengthened the structure of the discussion. The leadership team is composed of the Administrator, Director of Nursing, Director of Quality, and Director of Human Resources. Adjunct support will be provided by the CEO, CFO, social worker, Director of Plant Operations, and others as may be needed from time to time. The Director of Nursing or Designee will educate Nurse aides on appropriate incontinence care technique and requirement to change gloves between dirty and clean procedures, by 10/24/17. The monitoring procedure to ensure that the plan of correction is effective and that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 441	Continued From page 177 contained single-use lancets, individually wrapped alcohol wipes, and BG test strips) and exited the room. On 9/8/17 at 4:54 PM, NA #10 was observed as she entered Resident #55's room with the glucometer and BG supplies in the plastic case. The NA did not disinfect the glucometer between residents. She did not wash her hands, use a hand sanitizer, or put on gloves. NA #10 put a test strip into the glucometer and turned towards Resident #55 to perform a finger stick on the resident. At that time, the NA was asked to stop the procedure and step out into the hallway. An interview was conducted on 9/8/17 at 4:55 PM with NA #10. During the interview, the NA was asked as to how she was supposed to disinfect a shared glucometer between residents. The NA hesitated before stating she needed to use "a wipe." When asked which wipes she would use, the NA stated she did not know. At that time, the NA was asked who she would go to if she had any questions regarding disinfection of the glucometer. She stated she would go to the hall nurse. The NA was observed as she approached the Nurse #2 on 9/8/17 at 4:58 PM. Nurse #2 was the hall nurse assigned to care for Resident #55. When NA #10 inquired what wipes she needed to use to disinfect a shared glucometer, Nurse #2 instructed her to use an alcohol wipe. The NA began to go back into Resident #55's room to use an alcohol wipe to disinfect the shared glucometer. At that time, a request was made for the NA to exit the resident ' s room. Nurse #2 was asked who she would go to if she had any questions regarding the disinfection of a shared	F 441	specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Infection Preventionist will complete competency observations on licensed nurses of disinfecting blood glucose monitors and use of gloves will be conducted at least 5 times per week for 30 days, then monthly for 60 days. Variances will be reported to the licensed nurse upon observation for immediate remediation. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. The Director of Nursing or designee will make observations of 2 nurse aides weekly (on various shifts to include weekends) during incontinence care to ensure appropriate care is provided with changing gloves between dirty and clean procedure. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. The title of the person responsible for implementing the acceptable plan of correction. Director of Nursing or Designee	

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F 441	Continued From page 178	F 441		

glucometer. The nurse stated she would go to the facility ' s Director of Nursing (DON).

On 9/8/17 at 4:59 PM, Nurse #2 was accompanied as she went to the DON's office and inquired which wipes needed to be used for glucometer disinfection. The DON instructed the nurse to use the wipes "with the purple top" (an approved germicidal wipe). Nurse #2 then told NA #10 she would need to get the wipes with the purple top and use those to disinfect the glucometer. While NA #10 was retrieving the germicidal wipes, the nurse was asked if gloves needed to be used when a BG check was done. Nurse #2 responded, "Of course, it's blood." Upon the NA's return with the germicidal wipes, the nurse reminded her to use gloves when doing a BG check. After NA #10 opened the new container of germicidal wipes, the NA was asked if she had been told how to use these wipes. The NA stated she had not. The NA was directed to the manufacturer directions on the label of the germicidal wipes and encouraged to ask the hall nurse or DON for further instructions, as needed. NA #10 read the directions for disinfection and was observed as she used the germicidal wipes in accordance with the manufacturer instructions to disinfect the glucometer.

A follow-up interview was conducted with NA #10 on 9/8/17 at 5:05 PM. During the interview, the NA was asked why she did not wash her hands between residents and use gloves when performing a blood glucose check. The NA stated she knew she should and did not verbalize a reason as to why she did not.

A separate observation was made on 9/8/17 at 5:18 PM of a blood glucose check being done on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 441	Continued From page 179	F 441		

a second hallway of the facility. At that time, NA #10 was observed from the hallway as she did a finger stick to complete a BG check on Resident #134. The NA was not wearing gloves. When the surveyor entered the room, NA #10 pulled out a pair of gloves she had in her pocket and put them on. She told the resident she needed to stick him again because she did not get an adequate blood supply the first time. The NA was again observed as she used a lancet to do a second finger stick on Resident #134. When the BG check was completed, NA #10 exited the room and went to the nursing station where the container of germicidal wipes had been placed. She then used the germicidal wipes to disinfect the glucometer.

An interview was conducted on 9/8/17 at 5:35 PM with the facility's DON. During the interview, the infection control concerns observed during the BG checks were discussed. The DON reported she would expect staff to wash their hands between residents, use gloves when doing a BG check, and disinfect the blood glucometer appropriately after each use.

On 9/15/17 at 1:07 PM, the facility's Director of Nursing was informed of the Immediate Jeopardy by telephone. The facility's Administrator was not available.

2. Review of the facility's Infection Control, Hand Hygiene Policy, last revised on 07/2017 revealed the following on pages 1, 2, and 3:

A."1. Indications for Use [Hand Hygiene]
"Use plain lotion soap and water, or antimicrobial soap and water if hands are visibly soiled (important to physically

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 180	F 441		

remove the material)

2. Use an alcohol-based hand rub in all other recommended use below, unless hands are visibly soiled when moving from a contaminated body site to a clean body site during patient care."

Under Other Aspects of Hand Care and Protection the following was written:

"C. e) Perform hand hygiene after removing gloves. Gloves do not replace hand hygiene."

An observation of a bath and incontinence care provided for Resident #10 was made on 09/09/17 at 11:19 AM. Nursing assistant (NA) # 7 and NA # 12 washed their hands and donned gloves and provided the bath using a washcloth, soap, and warm water. While Resident #10 lay on her back, NA #7 provided perineal care using a washcloth with soap and warm water, wiping front to back 3 times, folding the washcloth with each wipe. Some light brown color was noted on the washcloth after the second wipe. After NA #7 completed the perineal care, she rinsed the washcloth in the basin of water. The resident was turned to her side, and NA #7 noted there was a large bowel movement present. NA #7 used disposable wipes to clean most of the bowel movement, and then she continued cleaning the buttocks with the same washcloth she used for the perineal care. NA #7 dried the buttocks, drew a fresh basin of water, then continued the bath with the same washcloth that had the brown residue present and wearing the same gloves. NA # 7 did not remove her gloves or perform hand hygiene at that time. NA #7 applied a zinc paste to the buttocks. When the resident was turned to her back, perineal care was provided again to ensure all the bowel movement had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 181	F 441		

been removed. NA #7 continued to wear the same gloves and use the same washcloth to provide the perineal care. After the perineal area was dried, NA #7 applied zinc paste to the front perineal area as she continued to wear the same pair of gloves worn to clean the bowel movement. NA #7 did not wash her hands, use an alcohol based hand rub, or change gloves throughout the entire bathing, incontinence, or perineal care procedure.

In an interview with NA #7 on 09/09/17 at 11:46 AM, she stated she had not been educated to wash hands or change gloves after cleaning a bowel movement and before continuing the remainder of the bath, cleansing the perineum, or applying a zinc paste to the perineal area. She added she had not been instructed to use a clean washcloth after cleaning the rectal area and before cleansing the perineum, and she did not know that using bowel contaminated washcloths or gloves during perineal care could put the resident at risk for UTIs. NA #7 stated she had only been trained do hand hygiene and wear gloves only before providing care for a resident and after care was completed before leaving the room.

On 09/09/17 at 12:04 PM an interview was conducted with NA #12. She stated it had been a year or two since she was assigned to Resident #10, and that usually she worked in activities. She stated she remembered having a hand hygiene in-service in recent months and that she was taught to do hand hygiene only when entering a resident's room and before leaving the room. She stated she was not taught to complete hand hygiene or change gloves when moving from a contaminated body site to a clean body

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 182 site. During an interview with the Director of Nursing (DON) on 09/10/17 at 4:09 PM, she stated she would expect for the nursing assistant to wash hands and change gloves after providing bowel incontinence care and before continuing the bath or providing perineal care. She also stated she would expect the NAs to follow the infection control and perineal care policies. The DON added that zinc paste should not have been applied to the perineum using the same gloves used to clean the bowel movement and acknowledged the procedure that was used could lead to a UTI. An interview was conducted with the Infection Preventionist (IP) on 09/12/17 at 11:29 AM. The IP stated that she educated the employees on infection control upon orientation and through small sessions throughout the year. She explained there was a hand hygiene day several months earlier (May 2017) to educate the employees. The IP also stated she was not a nurse, so she did not specifically provide hand hygiene education regarding nursing procedures for patient care, such as perineal care. She added that she would probably need to collaborate with the DON to provide education regarding hand hygiene and glove use during bathing, incontinence, and perineal care for infection control.	F 441		
F 463 SS=J	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow	F 463		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 463	Continued From page 183 residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interview and record review, the facility failed to provide functioning call bells that had a light working outside of the room and an audible component at the nurses' station in the bathrooms to allow residents to call for assistance. The call bell was not working in the bathrooms for 5 of 18 bathrooms checked (Private bathrooms 201, 262, 265, 270 and shared bathroom for room 240 and 241). Immediate jeopardy began on 9/7/17 and is ongoing. Resident #66 could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheel chair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee amputation and continued need for occupational therapy for transferring, toileting and dressing the lower body. Three hours passed before hand bells were distributed to the bathrooms that had non-functioning call bells. Immediate jeopardy began on 9/8/17 and is ongoing for Resident #38 who toilets independently and had a call bell that did not	F 463	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #66 (who resided in room 262) was initially provided a hand bell to use in the bathroom. The Resident was then moved to room 263 with a functioning call bell. Parts were ordered and the call bell in room 262 was repaired on 9/15/17. The resident is content in room 263 and has remained there. Resident #38 (who resided in room 201) was provided with a hand bell to use in the bathroom and her call bell was repaired on 9/8/2017. Resident #38 (who resided in room 201) was provided with a hand bell to use in the bathroom and her call bell was repaired on 9/8/2017. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. Beginning 9/9/2017, 100% of resident rooms and bathrooms were checked for functional call bells. The check was conducted by the CEO, CFO, HR,	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 463	Continued From page 184 work. Findings included: 1. Resident #66 was admitted to the nursing home on 7/17/17. Her admission Minimum Data Assessment indicated she had diagnoses including hypertension, peripheral vascular disease, septicemia, diabetes mellitus, non-Alzheimer's dementia, depression, generalized muscle weakness, abdominal pain, kidney failure, acquired abscess of left leg below knee, surgical aftercare for below knee amputation and gastro-esophageal reflux disease. Her Minimum Data Set (MDS) assessment dated 7/24/17 indicated she was moderately impaired in cognition, required extensive assistance from one person for transfer, dressing and toilet use. She was not steady with moving on and off the toilet and only able to stabilize with staff assistance. She had no fall history and she received both occupational and physical therapy during the assessment period. A Fall Event report indicated Resident #66 had an assisted fall on Sunday, 8/27/17 at 10:00 AM. Interview with the therapy director on 9/12/17 at 11:30 AM revealed Resident #66 had assisted fall over a weekend. She was in the bathroom and her leg buckled. The therapy director said she was working that day and showed NA#10 how to transfer her using the grip bars. On 8/27/17 a Fall Risk Assessment was done. She was determined to need assistance with elimination and was unable to come to a standing position and a recent fall.	F 463	Director of Emergency Services, Director of Imaging and other staff. If a bell was identified as not functioning, a hand bell was provided to the resident or the resident was temporarily moved into a resident room with a functional bell. An additional 100% audit was completed on 9/18/2017 and there were no calls bells identified as malfunctioning. b. Call bell functionality checks are being completed daily by various departmental representatives from the organization. The Director of Imaging is coordinating these checks and has developed a schedule of assigned personnel to complete the tests. The Director of Imaging is analyzing the completed tests and initiating follow-up as needed. c. Each occupied resident room and adjacent bathroom will be checked weekly at a minimum. Variances are being immediately acted upon by either providing the resident with a hand bell, moving him or her temporarily to a room with a functional call system, or replacing the non-functional call bell with one that functions. Work orders are being given to Plant Operations for additional follow up and vendor engagement. d. The administrator and/or designee will re-educate staff on how to initiate work orders when a call bell is found to be non-functional. The staff will also be re-educated on the storage location for hand bells. This training was initiated beginning 9/26/2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 463	Continued From page 185 An aide's care record for September had entries for toilet use every shift on 9/1, 9/3, 9/5 & 9/6. According to the Occupational Therapy (OT) therapy notes dated 9/4/17, Resident #66 required substantial assistance with lower body dressing and had improved in toileting - transfers to being able to safely transfer to the toilet with supervision or touching -minimum assistance for toileting routine. Nurse Aide (NA) #6 was interviewed on 9/07/2017 at 10:22 AM about how she knows what care to provide residents. She said, "After a day or two, I get to know the routine. ... Sometimes, she (Resident #66) will pee in a diaper. Now, she likes to use the commode. She wears a diaper just in case. She will press call bell for help ..." On 9/07/2017 at 4:25 PM Resident #66 was observed in her private bathroom on her own. She was attempting to transfer back into her wheelchair. She appeared anxious and was tightly gripping the grab bar and struggling to back herself into her wheelchair. At approximately the same time NA #15 was passing by Resident #66's room. She said she had to take vital signs and blood sugars. She said Resident #66 goes to the bathroom on her own if she feels like it. At 4:30 PM Resident #66 came out of the bathroom and said in a loud and angry voice, "I LIKE TO FELL AND NEED MY BRITCHES UP." NA #15 went in the room to assist Resident #66. On 9/08/2017 at 7:54 AM Resident #66 was asked if she had put on the call bell yesterday to let the aide know she needed help. She said the	F 463	e. A supply of hand bells will be maintained at the nursing station. The storage location is identified with a sign (hand bells) and staff are aware of the location of extra bells. f. The call bell vendor was contacted on 9/8/2017 and has responded with on-site visits for repair on 9/8/2017 and 9/12/2017. The call bell vendor was called again on 9/19/2017 and requested the vendor to do a more comprehensive assessment of the current system on 9/27/2017. g. Key members of the facility leadership team will have huddle meetings daily, Monday through Friday, to report progress on the above actions and any new opportunities related to resident safety. A spreadsheet is maintained and has served to enhance the organization of the meeting and strengthen the structure of the discussion. The leadership team is composed of the Administrator, Director of Nursing, Director of Quality, and Director of Human Resources. Adjunct support will be provided by the CEO, CFO, Social Worker, and Director of Plant Operations. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Social Worker will conduct weekly interviews with Residents #66 and #38 by	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 463	Continued From page 186 call bell was not working in the bathroom. The surveyor tested the call bell and it did not light outside the door or ring at the nurses' station. On 9/08/2017 at 7:58 AM the surveyor informed the Unit Secretary that the call bell in Resident #66's bathroom was not working. She said it was the first time she had heard about it. On 9/08/2017 at 8:13 AM Contract Maintenance Person #1 and #2 arrived. One said, "It's hooked up, but not working." There were two call bells in the bathroom - one about waist height on one side of the commode and another about knee height on the other side of the commode and neither worked. The Contract Maintenance Person #1 said, "I've tried both and neither works." Surveyors initiated call bell checks on 9/08/2017 at 10:00 AM. Four more calls in bathrooms were not working. These were in rooms 201, 265, 270 and shared bathroom 240 and 241. On 9/08/2017 at 10:58 AM, the Administrator said she calls maintenance when there is a call bell in the bathroom that doesn't work. On 9/08/2017 at 11:15 AM Nurse #3 was interviewed about call bells. She said, "I am aware of a call bell reported not working. I would get in contact with the Maintenance Director. I would call his pager or leave a message. When Nurse #3 was asked about other means for the resident to use to call for help, she said, "We have bells and would have to find them". Immediately following the interview she was seen distributing hand bells to Resident #66 and to the other residents who did not have functioning call	F 463	the social worker and/or designee for 4 weeks beginning 9/20/2017, to ensure that their call bells are functional and that staff are responding to requests for assistance with toileting in an appropriate manner and time, and then monthly thereafter. Call bell functionality checks are being completed daily by various departmental representatives from the organization. The Director of Imaging is analyzing the completed tests and initiating follow-up as needed. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. The title of the person responsible for implementing the acceptable plan of correction; Administrator or Designee	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 463	Continued From page 187	F 463		

bells.

On 9/08/2017 at 11:25 AM, the Director of Plant Operations was interviewed. He said, "If we get a report about a problem, then we get a service call. We would not check other call bells. It is on an as needed basis. He confirmed that the call bell in Resident #66's bathroom room did not work.

On 9/09/2017 at 11:01 AM a hand bell was observed in Resident #66's bathroom.

On 9/08/2017 at 3:17 PM the Occupational Therapist was interviewed. She said she had worked with Resident #66 on functional transfers to toilet. She said, "Initially she needed two person assistance. Now she needed minimum assist and cues for safety and hand placement. She needed contact guard assistance. We've done safety training with nurse aides in the room. She added, "Typically, someone would be with her. She is good about calling if she needs help. I would not recommend her toileting by herself. She can self-propel in wheelchair. She is compliant. The safety awareness has already been an issue (i.e., hand placement). Safety is a huge thing."

Resident #66 was interviewed again on 9/08/2017 at 4:20 PM. She said, "I tried to get someone yesterday and couldn't find anyone. It was dangerous."

On 9/09/2017 at 10:15 AM the Director of Nurses was interviewed. She confirmed that Resident #66 required assistance from one person and needed supervision with activities of daily living. She needed a nurse aide (NA) due to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 463	Continued From page 188	F 463		

diagnosis of dementia. She can be forgetful at times. Resident #66 had some episodes of confusion. She had tried to get up. She had one assisted fall with staff. She was trying to get out of wheelchair and she did not wait for assist. The Director of Rehab provided education to the CNA.

On 9/8/17 at 12:30, the administrator was informed of the immediate jeopardy.

2. Resident #38's bathroom call bell was tested on 9/08/2017 during rounds at 10:00 AM. The resident said she used the bathroom.

Her quarterly Minimum Data Set had an assessment reference date of 7/11/17 indicated her cognition was severely impaired. Her dressing, transfer and toileting ability was independent. A care plan with a review start date of 10//17 included approaches for problems with ADLs and for falls indicated, "Encourage the resident to use bell to call for assistance" and "The resident needs a safe environment with floors free from spills and/or clutter; adequate light; a working and reachable call light and personal items within reach."

Her care plan dated 7/20/2017 indicated she was able to toilet independently.

Surveyors initiated call bell checks on 9/08/2017 at 10:00 AM. The call bell in Resident #38's bathroom did not work when tested.

On 9/08/2017 at 10:58 AM, the Administrator said she calls maintenance when there is a call bell in the bathroom that doesn't work.

On 9/08/2017 at 11:15 AM Nurse #3 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 189	F 463		

interviewed about call bells. She said she would contact the Maintenance Director if a call bell problem was noted. "I would call his pager or leave a message." When Nurse #3 was asked about other means for the resident to use to call for help, she said, "We have bells and would have to find them". Immediately following the interview she was seen distributing hand bells to Resident #38 and to the other residents who did not have functioning call bells.

On 9/08/2017 at 11:25 AM, the Director of Plant Operations was interviewed. He said, "If we get a report about a problem, then we get a service call. We would not check other call bells. It is on an as needed basis. He confirmed that the call bell in Resident #38's bathroom room did not work.

On 9/09/2017 at 11:05 AM a hand bell was observed in Resident #38's bathroom.

On 9/08/2017 at 11:25 AM, the Director of Plant Operations was interviewed. He said, "If we get a report about a problem, then we get a service call. We would not check other call bells. It is on an as needed basis.

Interview with NA#8 on 9/12/17 at 11:52 AM revealed Resident #38 was very independent with activities of daily living and used the bathroom on her own.

3. A three month history of all work orders for the Extended Care Unit was reviewed. On 7/19/17 a work order was entered. The description was "271 call light does not show on door light and 271 bathroom light rings for 261". The work order was completed on 7/19/17. On 9/08/2017 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 463	Continued From page 190	F 463		

11:25 AM, the Director of Plant Operations was interviewed. He said, "If we get a report about a problem, then we get a service call. We would not check other call bells. It is on an as needed basis.

Surveyors initiated call bell checks on 9/08/2017 at 10:00 AM. Four more calls bells in bathrooms were not working. These were in rooms 201, 265, 270 and shared bathroom 240 and 241. The resident in 201 said she used the toilet. The resident in room 265 said the "call ball isn't worth five cents here". A family member in room 270 said the light is out, but will ring at desk.

On 9/08/2017 at 10:58 AM, the Administrator said she calls maintenance when there is a call bell in the bathroom that doesn't work.

On 9/08/2017 at 11:15 AM Nurse #3 was interviewed about call bells. She said, "I am aware of a call bell reported not working. I would get in contact with the Maintenance Director. I would call his pager or leave a message. When Nurse #3 was asked about other means for the resident to use to call for help, she said, "We have bells and would have to find them". Immediately following the interview she was seen distributing hand bells to Resident #66 and to the other residents who did not have functioning call bells.

On 9/08/2017 at 11:25 AM, the Director of Plant Operations was interviewed. He said, "If we get a report about a problem, then we get a service call. We would not check other call bells. It is on an as needed basis. He confirmed, by observation with the surveyor that bathroom call bells in rooms 201, 265, and 270 and 240/241, in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 463	Continued From page 191 addition to room 262 did not work. The family member of the resident in room 270 said the light did not work. The Director of Plant Operations said two of the five bathrooms only had the visual component not working. A signal was sent to the nurses' station for room 270 and 240/241. On 9/09/2017 at 11:01 AM a hand bell was observed in each of the identified bathrooms. On 9/08/2017 at 4:10 PM, the Director of Plant Operations said the call bell in room 201 was repaired. A service request form was provided. It indicated the vendor was onsite from 9/08/2017 at 2:54 PM until 4:55 PM. It said, "Room 201 repaired. Room 240, 270 working. Rooms 262 & 265 has bad bath master and part on order." On 9/09/2017 at 10:14 AM the DON confirmed the residents in 240 & 241 do not use bathroom. Observations on 9/9/17 beginning at 11:01 AM revealed Room 265 & 262 still had manual call bells in the bathroom and the call bell in room 101 worked. On 9/09/2017 at 10:15 AM, the Director of Nurses said she had not had any concerns with call bells not working. On 9/8/17 at 12:30, the administrator was informed of the immediate jeopardy.	F 463		
F 490 SS=J	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration.	F 490		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 490	Continued From page 192 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident, staff, Pharmacy Consultant, Nurse Practitioner and Medical Director interview, the facility administration failed to provide the leadership and management necessary to ensure residents' needs were met. Immediate jeopardy began on 4/16/17 when Resident #103, unsupervised by staff, took the elevator to the first floor, exited the building and was found in the facility parking lot. Resident #103 was located by staff after an undetermined amount of time outside of the facility and had no injuries. Resident #103 was discharged to the community on 4/22/17. Immediate jeopardy began on 9/8/17 and is ongoing for Resident #38 who toilets independently and had a call bell that did not work. Findings included: This tag is cross-referred to: F224 J Based on observation, interviews with the staff, pharmacist, nurse practitioner, and Medical Director and record review, the facility neglected to answer call bells timely, provide assistance in a timely manner and provide functioning call bells in the bathrooms so if a resident needed to summon staff for assistance, they could get help and	F 490	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; An interim administrator assumed responsibility for oversight of the nursing unit effective 9/19/2017. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. Recruitment for the permanent administrator has been approved for placement on corporate internal job boards, electronic recruitment sites such as Indeed, Career Builders, and NCHA [North Carolina Hospital Association]. All applicants will be reviewed and there will be follow up for screening and interviewing of appropriate candidates in a timely manner. There is a mutual agreement between the interim administrator and the organization for a minimum 60-day assignment, with renewal options. A transition period of overlapping coverage of the interim administrator and the new permanent administrator will be coordinated once the permanent administrator is hired. This overlap will ensure continuity in unit administration as the new permanent administrator assumes this management position.	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490	Continued From page 193 prevent an accident from occurring, follow up on lab specimens to determine the course of treatment for signs and symptoms of urinary tract infection, feed a resident and provide psychiatric services and behavior monitoring necessary to evaluate the resident's needs and treatment. This affected 5 of 40 sampled residents (#10, #24, #66, #130 and #131). Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee below the knee amputation, high blood sugar on that day and a continued need for occupational therapy for transferring, toileting and dressing the lower body. On 9/7/17, three hours passed before hand bells were distributed to the bathrooms that had non-functioning call bells. F241 J Based on observation, record, review and staff and resident interviews, the facility failed to provide: Resident #66 a functioning call bell in her bathroom so she could call for assistance when needed; Resident #56 incontinence care when requested; Resident #10 a bath and incontinence care in a manner to maintain the dignity; Resident #131 timely call bell response for toileting assistance. This affected 4 of 40 sample residents reviewed for dignity (Resident #10, #56, #66 and #131).	F 490	b. On 9/25/2017, the unit engaged the services of a registered nurse certified in gerontology with extensive experience as a Director of Nursing in a skilled nursing facility and is also a Licensed Nursing Home Administrator. This individual will serve as a mentor and coach to the current Director of Nursing Services. This will be initiated immediately upon completion of required screening and on-boarding. c. On 9/25/2017, an additional contract registered nurse was engaged to provide quality assurance and staff development support. This individual began her on-boarding on 9/26/2017 and will report to the Director of Nursing. This individual will remain in place until the licensed nurse staffing level is more consistent. d. Beginning 9/23/2017, and continuing until substantial compliance is confirmed and ECU has consistent leadership, the organization will have a manager on duty each Saturday and Sunday. This person will come into the unit for a minimum of four hours; make rounds and meet with residents, families, and staff to offer additional support; and address any areas of identified concern. This responsibility will be shared by key leadership roles that may include: CEO, CFO, CNO, Administrator, DON, Director of Quality, Director of Human Resources, Directory of Imaging, Director of Surgery, and Director of Emergency Services. Any unresolved concerns from the weekend	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

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PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 490	Continued From page 194 Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. F279 J Based on observation, staff interview and record review, the facility failed to develop comprehensive care plans to address the current needs of the residents and to form the basis for the delivery of care for 4 of 18 sampled residents (Resident #8, #56, #66 and #128). Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee amputation, high blood sugar on that day and a continued need for occupational therapy for transferring, toileting and dressing the lower body. Three hours passed before hand bells were distributed to the bathrooms that had non-functioning call bells. F323 J Based on observation, resident interview, staff	F 490	will be discussed at the Monday huddle meeting. A master calendar for this coverage has been developed by the Director of Quality. Once substantial compliance is confirmed and ECU has consistent leadership roles filled, the ECU team will transition to a model that provides additional supervision and leadership oversight on weekends. e. Effective 9/11/2017, the hospital nursing supervisor has been conducting rounds on the nursing facility unit twice per shift on the 12-hour evening shift. The role of nursing supervisor during this rounding is to provide additional supervision and oversight to the ECU team as needed. As the nursing supervisor makes rounds on the unit, she will discuss any immediate needs with the licensed nursing staff. The nursing supervisor is also available to the ECU to respond to any emergency that may occur. f. The parent company for the hospital and its nursing unit is providing and will continue to provide on-site visits or conference calls at least twice per month for a minimum of 3 months to be conducted by representative of the parent company with long term care operational experience. The visits will include evaluation of on-going or new compliance and quality improvement initiatives. In addition, the corporate representatives will explore use of data analytics to assist in defining processes and systems of clinical and operational focus. An analysis	

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 490	Continued From page 195 interview and record review, the facility failed to provide functioning call bells in resident bathrooms so that if a resident needed to summon staff for assistance, they could get help and prevent an accident from occurring. The call bell was not working in the bathroom for 2 of 2 sampled residents who used the private bath in their rooms (Resident #66 & Resident #38). The facility also failed to supervise and prevent the elopement of a cognitively impaired resident, known to have wandering behavior. This affected 1 of 2 sampled residents reviewed for supervision to prevent accidents. Immediate jeopardy began on 4/16/17 for Resident #103, unsupervised by staff, took the elevator to the first floor, exited the building and was found in the facility parking lot. Resident #103 was located by staff after an undetermined amount of time outside of the facility and had no injuries. Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee amputation, high blood sugar on that day and a continued need for occupational therapy for transferring, toileting and dressing the lower body. Three hours passed before hand bells were distributed to the bathrooms that had non-functioning call bells.	F 490	summary of these visits or oversight conference calls will be submitted for additional review through the Action Plan developed by corporate and carried out collaboratively through the facility-based team and the Person Memorial Quality Council. g. A care plan policy was approved on 9/26/17 that ensures development and maintenance of person-centered comprehensive care plans that include measurable objectives and timetables to meet the residents medical, nursing, mental and psychosocial needs. To the extent practicable, the resident / resident representative will be provided with opportunities to participate in the care consultant. h. Key members of the facility leadership team will have huddle meetings daily, Monday through Friday, to report progress on the above actions and to identify any new opportunities related to resident safety. A spreadsheet is maintained and has served to enhance the organization of the meeting and strengthen the structure of the discussion. The leadership team is composed of the Administrator, Director of Nursing, Director of Quality, and Director of Human Resources. Adjunct support will be provided by the CEO, CFO, Social Worker, Director of Plant Operations, and others who may be called upon from time to time. " The monitoring procedure to ensure that the plan of correction is effective and that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490	Continued From page 196 Immediate jeopardy began on 9/8/17 and is ongoing for Resident #38 who toilets independently and had a call bell that did not work. F353 J Based on resident interviews, staff interviews and review of the staffing records, the facility failed to provide staffing in sufficient numbers to meet the needs of residents for x of x sampled residents (#66, #103, #131, and #56). Examples 1 and 2 were at the immediate jeopardy level. Examples 3 - 5 were at no actual harm with potential for more than minimal harm that is not immediate jeopardy and the scope is a pattern (E). Immediate jeopardy began on 4/16/17 for Resident #103, unsupervised by staff, took the elevator to the first floor, exited the building and was found in the facility parking lot. Resident #103 was located by staff after an undetermined amount of time outside of the facility and had no injuries. Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee amputation, high blood sugar on that day and a continued need for occupational therapy for transferring, toileting and dressing the lower body. Three hours passed	F 490	specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The ECU will completed the recommended QAPI self-assessment on 9/27/2017, and returned it to Alliant. The ECU has a commitment to work and returned it to Alliant. The ECU has a commitment to work collaboratively with Alliant Quality to refine the QAPI process to be more proactive and focused in addressing identified risks and opportunities. The CEO will complete a 90 review with permanent Administrator, once hired, to evaluate effectiveness and appropriate leadership and management. " The title of the person responsible for implementing the acceptable plan of correction; CEO or other assigned Administrative Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 490	Continued From page 197	F 490		

before hand bells were distributed to the bathrooms that had non-functioning call bells.

F441 J
Based on observations and staff interviews, the facility staff: 1) Failed to disinfect a shared glucometer (device used to measure a resident's blood glucose or blood sugar level) between residents and failed to perform hand hygiene between residents for 1 of 3 residents observed to have their blood glucose checked (Resident #55). The facility staff also failed to wear gloves when completing a blood glucose check for 2 of 3 residents observed to have their blood glucose checked (Resident #55 and Resident #134); and, 2) Failed to perform hand hygiene after providing bowel incontinence care and before providing perineal care for 1 of 1 resident reviewed for infection control (Resident #10).

Immediate jeopardy began on 9/8/17 and is ongoing. Neither the Nursing Assistant (NA) #10 observed to do blood glucose checks nor the hall nurse (Nurse #2) were trained on how to disinfect a shared glucometer between residents in accordance with the manufacturer's directions for the disinfectant. NA #10 did not perform hand hygiene between residents when doing the blood glucose checks and did not wear gloves on two separate occasions when doing the blood glucose checks. One of these occasions occurred after the nursing assistant had been instructed by the hall nurse to use gloves.

F520 J
Based on record review, observations, physician, pharmacy, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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F 490	Continued From page 198	F 490		

procedures and monitor the interventions that the committee put into place following the recertification survey on 10/6/16. Four of the nine current immediate jeopardy citations during the recertification survey on 9/12/17, were also cited on the prior recertification survey including F279 (Comprehensive Care Plan), F353 (Staffing), F441 (Infection Control), and 520 (Quality Assurance). The continued failure of the facility during 2 or more federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program.

Immediate jeopardy began on 4/16/17 for Resident #103, unsupervised by staff, took the elevator to the first floor, exited the building and was found in the facility parking lot. Resident #103 was located by staff after an undetermined amount of time outside of the facility and had no injuries.

Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee amputation, high blood sugar on that day and a continued need for occupational therapy for transferring, toileting and dressing the lower body. Three hours passed before hand bells were distributed to the bathrooms that had non-functioning call bells.

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	345004	A. BUILDING _____ B. WING _____	09/12/2017

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PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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F 490	Continued From page 199 On 9/12/17 at 3:37 PM, the Administrator and Director of Nursing (DON) were interviewed regarding the administration of resources to meet the needs of residents. Both the Administrator and the DON expressed concern about neglect and call bell response. The DON stated some education had been done with the nursing assistants (NAs) but indicated there had to be a better understanding of the definition for neglect. The Administrator stated she wanted to talk with NAs to find out if they were failing to report when a resident was not being fed a meal. The DON stated she felt that resident assessment and care planning, as well as communication with the nursing assistants were issues to be addressed by the facility. The Administrator specified that environmental rounds were being done, but call bells were not included in the rounds. The Administrator said, "We are not as effective as we have needed to be."	F 490		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514		10/24/17

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F 514	Continued From page 200 (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to accurately document the meal intake for 1 of 3 residents sampled for nutrition (Resident #24). Resident #24 was admitted on 05/01/17 with the admission diagnoses of malnutrition, diabetes mellitus and hypertension. The most recent minimum data set dated 08/10/17 revealed Resident #24 was severely cognitively impaired and required limited assistance with eating and had no swallowing problems. Her most current weight on 08/02/17 was 73 pounds. A review of the most recent care plan dated 05/01/17 revealed Resident #24 had a nutritional problem related to severe malnutrition. The goal was to maintain adequate nutritional status as evidenced by maintaining weight within 10% of 100lbs with no sign or symptoms of malnutrition	F 514	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #24 did not consume any of the lunch meal on 09/07/17 during mealtime observation. Documentation after lunch by Nurse Aide #3 noted Resident #24 consumed 25%-65%; documentation of meal intake was inaccurate. Education on ADL care and documentation was provided to Nurse Aide #3 on 09/27/17. Resident #24 was discharged on 09/09/17. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	

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F 514	Continued From page 201 and consuming greater than 50% of at least 3 meals daily. The interventions were, in part, to provide and serve her diet as ordered and to monitor, document and report if the resident refused to eat. A continuous observation was conducted of Resident #24 on 09/07/17 from 12:20 PM thru 1:50 PM, and Resident #24 had not eaten any lunch. During an interview at 2:00 pm, Aide #3 confirmed Resident #24 had not eaten any of her lunch. A review of the nutrition documentation in Point of Care (POC) for Resident #24 on 09/07/17 at 1:00PM revealed 25- 65% was consumed of the lunch meal. On 09/09/2017 at 2:57 PM, Aide #3 was interviewed via telephone and stated she had not documented the lunch meal in POC. On 09/09/2017 at 3:28 PM, the Director of Nursing (DON) stated Aide #3 had documented in POC on 09/07/17 that 25-65% of the lunch meal was consumed by Resident #24. During an interview on 09/12/2017 at 2:46 PM with the Dietitian, she indicated Resident #24 was underweight and malnourished. The Dietician stated it was very important for the documentation of the amount eaten to be accurate to determine the interventions. During an interview on 09/09/17 at 3:28 PM, the DON indicated the expectation was for the aide to offer a resident a meal and to document the intake accurately on POC.	F 514	Nurse aides will be re-educated on ADL care and documentation requirements by 10/24/17 by Director or Nursing or designee. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The MDS coordinator or designee will make observations during one mealtime and review of meal intake documentation on 5 residents weekly. Variances will be reviewed with DON and the Nurse Aide will be re-educated. Weekly audits will continue for 30 days and then monthly for 60 days. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter. " The title of the person responsible for implementing the acceptable plan of correction; MDS Coordinator or designee	
F 520 SS=J	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		10/24/17

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F 520	Continued From page 202 (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		

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F 520	Continued From page 203 This REQUIREMENT is not met as evidenced by: Based on record review, observations, physician, pharmacy, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey on 10/6/16. Four of the nine current immediate jeopardy citations during the recertification survey on 9/12/17, were also cited on the prior recertification survey including F279 (Comprehensive Care Plan), F353 (Staffing), F441 (Infection Control), and 520 (Quality Assurance). The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. Findings included: 1. F279 Based on observation, staff interview and record review, the facility failed to develop comprehensive care plans to address the current needs of the residents and to form the basis for the delivery of care for 4 of 18 sampled residents (Resident #8, #56, #66 and #128). Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. The facility was also cited at F279 during the recertification survey on 10/6/16 when the facility failed to develop a comprehensive plan of care for a resident (Resident #38) for Urinary	F 520	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The findings from the recent survey were discussed with the Medical Director on 9/9/2017. The facility held a QAPI meeting on 9/25/2017 to discuss and approve the allegation of compliance for the areas classified as immediate jeopardy. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; a. The facility will hold monthly QAPI meetings for the next 6 months to monitor the facility□s on-going efforts toward maintaining compliance with corrections for the stated deficiencies and to recommend any additional systemic changes or changes in monitoring. The monthly QAPI meeting will include at a minimum the CEO or designee, administrator, Medical Director or designee, Director of Nursing, Director of Quality and/or designee, and Director of Human Resources. b. Additional ad hoc meetings of the QAPI Committee or subcommittee will be held as new opportunities are identified. Action plans for response and correction will be monitored by the Administrator and Director of Quality. c. Alliant Quality, the QIN-QIO for	

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F 520	Continued From page 204 Incontinence and Indwelling Catheter; Falls; Dehydration/Fluid Maintenance; Pressure Ulcer; and, Pain. 2. F353 Based on resident interviews, staff interviews and review of the staffing records, the facility failed to provide staffing in sufficient numbers to meet the needs of residents for 4 of 40 sampled residents (#66, #103, #131, and #56). Immediate jeopardy began on 9/7/17 and is ongoing for Resident #66. This resident could not find staff to assist her to the toilet, she transferred independently onto the commode. She did not have a means to call for help after toileting and prior to transferring back into her wheelchair because the call bell was not functioning. She expressed anger and stated that it was dangerous. She had a high likelihood for falling and receiving a serious injury associated with her post-surgical knee below the knee amputation, high blood sugar on that day and a continued need for occupational therapy for transferring, toileting and dressing the lower body. On 9/7/17, three hours passed before hand bells were distributed to the bathrooms that had non-functioning call bells. On 9/8/17 at 12:30, the administrator was informed of the immediate jeopardy. The facility was also cited at F353 during the recertification survey on 10/6/16 when the facility failed to ensure adequate staff to provide activities of daily living care for 2 of 6 dependent residents(Resident #59 and #19) and apply splints for 1 of 1 sampled resident with contractures(Resident #1).	F 520	Georgia and North Carolina, was contacted for assistance in refining the facility QAPI process. As requested, the recommended QAPI self-assessment will be by 9/27/2017. The facility has a commitment to work collaboratively with Alliant Quality to refine the QAPI process to be more proactive and focused in addressing identified risks and opportunities. d. Beginning in September, resident group meetings will be held monthly for the next 6 months to identify opportunities for improvement and solicit and strengthen resident feedback on changes that are being implemented. The group meeting will be scheduled and facilitated by the Social Worker and the Activity Director. Minutes from the meetings will be maintained and concerns and opportunities will be followed up by the appropriate team member. A summary of these meetings, including recommendations from the residents and corrective and/or responsive actions by the staff, will be reported to the monthly QAPI Committee. e. The parent company for the hospital and its nursing unit is providing and will continue to provide on-site visits or conference calls at least twice per month for a minimum of 3 months to be conducted by representative of the parent company with long term care operational experience. f. The organization has engaged with a	

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F 520	Continued From page 205 3. F441 Based on observations and staff interviews, the facility staff: 1) Failed to disinfect a shared glucometer (device used to measure a resident's blood glucose or blood sugar level) between residents and failed to perform hand hygiene between residents for 1 of 3 residents observed to have their blood glucose checked (Resident #55). The facility staff also failed to wear gloves when completing a blood glucose check for 2 of 3 residents observed to have their blood glucose checked (Resident #55 and Resident #134); and, 2) Failed to perform hand hygiene after providing bowel incontinence care and before providing perineal care for 1 of 1 resident reviewed for infection control (Resident #10). Immediate jeopardy began on 9/8/17 and is ongoing. Neither the Nursing Assistant (NA) #10 observed to do blood glucose checks nor the hall nurse (Nurse #2) were adequately trained on how to disinfect a shared glucometer between residents. NA #10 did not perform hand hygiene between residents when doing the blood glucose checks and did not wear gloves on two separate occasions when doing the blood glucose checks. The facility was also cited at F441 during the recertification survey on 10/6/16 when the facility failed to wear gloves and gowns when entering a room with Contact Precautions for one of two residents (Resident # 31) reviewed for Contact Isolation Precautions. 4. F520 During the recertification survey on 10/6/16, the facility was cited at F520 when the facility Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that	F 520	long-term care consulting group to assist with quality systems and process development and/or refinement. The two consultants primarily assigned to the project maintain the designation of Certified QAPI Professionals. Collectively, the consulting group consists of members whom have extensive experience as long-term care registered nurses, administrators, operators and hold other certifications such as MDS nurse executives, etc. The organization had entered a contract with the consulting company in January 2017 for services to be provided upon request. On 9/9/2017, contact was made with the organization for additional support and assistance to respond to the survey findings, assist in education and re-establishing systems for sustained compliance. Continued support will be provided in collaboration with on-going support from the corporate offices. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; A summary of the Resident group meetings, including recommendations from the residents and corrective and/or responsive actions by the staff, will be reported to the monthly QAPI Committee. The corporate representatives will explore use of data analytics to assist in defining processes and systems of clinical and operational focus. An analysis summary	

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F 520	Continued From page 206 the committee put into place in December 2015. This was for one recited deficiencies which was originally cited on November 2015 on a recertification survey and on the current recertification survey. The deficiency was in the areas of splint application. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. On 9/12/17 at 3:37 PM, the Administrator and Director of Nursing (DON) were interviewed. The Administrator indicated she oversaw the Quality Assurance (QA) meetings and the DON attended all QA meetings. When informed that four of the immediate jeopardy citations had been cited on the last recertification survey on 10/6/16, the Administrator stated, "We are not as effective as we have needed to be." She indicated she had discussed staffing with the Chief Executive Officer and the Chief Financial Officer and had some incentives in place. Both the DON and the Administrator agreed they did not have enough staff, but were working on it and did have some new employees in place already. The Director of Nursing stated they had identified "holes in documentation" and had sought guidance from the state agency about a month ago. The DON indicated a comprehensive care plan was expected to capture the resident accurately and said, "it boils down to patient-centered care."	F 520	of onsite visits or conference calls will be submitted for additional review through the Action Plan developed by corporate and carried out collaboratively through the facility-based team and the Person Memorial Quality Council. " The title of the person responsible for implementing the acceptable plan of correction. Administrator or Designee	