PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391

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 483.21 at tag F279  CFR 483.25 at tag F323  CFR 483.70 at tag F333  CFR 483.70 at tag F340  CFR 483.70 at tag F341  CFR 483.90 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 156  483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF SS=C  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.	1	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
PERSON MEMORIAL HOSPITAL  (24) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATION OF LSC IDENTIFYING INFORMATION)  F 200 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 483.25 at tag F323  CFR 483.35 at tag F353  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 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 91/6/17 and 9/17/17. This had an impact on report production. CMS allowed this report to go out on 9/19/17.  F 156  SS=C  (d)(3) The facility must ensure that each resident remains informed of the name, specially, and way of contacting the physician and other primary care professionals responsible for his or her care.  §483.10(g) Information and Communication.			345004	B. WING _		0	9/12/2017	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD  INITIAL COMMENTS  A recertification and extended survey was conducted from 99/05/17 through 99/10/17 and 99/12/17, Immediate jeopardy was identified in the following areas at a scope and sevenity (J):  CFR 483.10 at tag F241  CFR 483.10 at tag F279  CFR 483.26 at tag F232  CFR 483.70 at tag F280  CFR 483.73 at tag F280  CFR 483.73 at tag F280  CFR 483.80 at tag F441  CFR 483.80 at tag F441  CFR 483.80 at tag F441  CFR 483.90 at tag F440  CFR 483					615 RIDGE ROAD			
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 483.10 at tag F242  CFR 483.20 at tag F279  CFR 483.25 at tag F323  CFR 483.70 at tag F490  CFR 483.70 at tag F490  CFR 483.70 at tag F441  CFR 483.90 at tag F4463  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 156  483.10(a) 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.	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION	
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 F224 CFR 483.12 at tag F224 CFR 483.20 at tag F279 CFR 483.20 at tag F279 CFR 483.35 at tag F353 CFR 483.35 at tag F353 CFR 483.70 at tag F490 CFR 483.75 at tag F520 CFR 483.80 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 156 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF SS=C  (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 000	INITIAL COMMENTS	3	F 0	00			
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 156 483.10(g)(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.		conducted from 09/0 09/12/17. Immediate the following areas a CFR 483.10 at tag F. CFR 483.12 at tag F. CFR 483.25 at tag F. CFR 483.35 at tag F. CFR 483.70 at tag F. CFR 483.75 at tag F.	5/17 through 09/10/17 and e jeopardy was identified in t a scope and severity (J):  241 224 279 323 353 490 520					
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 156 SS=C 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.		CFR 483.90 at tag For The tags F224, F241 Substandard Quality	and F323 constituted of Care.					
of contacting the physician and other primary care professionals responsible for his or her care.  §483.10(g) Information and Communication.		provide an acceptable immediate jeopardy I Due to a CMS software system was 9/17/17. This had ar production. CMS alle 9/19/17. 483.10(d)(3)(g)(1)(4) RIGHTS, RULES, SE (d)(3) The facility mu	e allegation of removal of the perfore the end of the survey.  are release, the ACO addown on 9/16/17 and an impact on report to go out on (5)(13)(16)-(18) NOTICE OF ERVICES, CHARGES  st ensure that each resident	F 1	56		10/24/17	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		of contacting the phy professionals respon §483.10(g) Information	sician and other primary care sible for his or her care. on and Communication.					

Electronically Signed 10/16/2017

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			SURVEY PLETED	
		345004	B. WING _			09/	/12/2017
	ROVIDER OR SUPPLIER		•	615	EET ADDRESS, CITY, STATE, ZIP CODE RIDGE ROAD XBORO, NC 27573	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	(1) The resident has a his or her rights and or governing resident conduring his or her stay (g)(4) The resident has notices orally (meaning (including Braille) in a or she understands, in (i) Required notices at The facility must furnit description of legal right (A) A description of the personal funds, undesection; (B) A description of the personal funds, undesection; (B) A description of the personal funds, undesection; (C) A list of names, and email), and telephones state regulatory and resident advocacy growing Survey Agency, the State Long-Term Carprotection and advocacy of survey Agency, the State Long-term care facing agency for information community and the Mand	the right to be informed of of all rules and regulations onduct and responsibilities in the facility.  as the right to receive and spoken) and in writing a format and a language he including:  as specified in this section.  as to each resident a written ghts which includes -  the manner of protecting in paragraph (f)(10) of this	F	156			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION		TE SURVEY MPLETED
		345004	B. WING	<del> </del>	0	9/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 156	federal nursing facility not limited to resident exploitation, misapproin the facility, non-cordirectives requiremer information regarding (ii) Information and coand local advocacy on the limited to the Stat Long-Term Care Oml (established under sea Americans Act of 196 U.S.C. 3001 et seq) a advocacy system (as as established under Disabilities Assistanc 2000 (42 U.S.C. 1500 [§483.10(g)(4)(ii) will November 28, 2017 (iii) Information regardeligibility and coverag [§483.10(g)(4)(iii) will November 28, 2017 (iv) Contact information Disability Resource Cosection 202(a)(20)(B Act); or other No Wrote [§483.10(g)(4)(iv) will November 28, 2017 (iv) Contact information Control Unit; and	ate Survey Agency ected violation of state or y regulations, including but a abuse, neglect, opriation of resident property inpliance with the advance ats and requests for returning to the community.  Intact information for State organizations including but e Survey Agency, the State oudsman program ection 712 of the Older 5, as amended 2016 (42 and the protection and designated by the state, and the Developmental e and Bill of Rights Act of older seq.) be implemented beginning Phase 2)]  Iding Medicare and Medicaid (e); be implemented beginning Phase 2)]  In for the Aging and Senter (established under ()(iii) of the Older Americans ong Door Program; be implemented beginning	F 15	56		

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
		345004	B. WING			9/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 156	grievances or complasuspected violation of facility regulations, in resident abuse, neglemisappropriation of refacility, non-compliand directives requirement information regarding (g)(5) The facility must manner accessible at residents, resident residents and telephone number agencies and advocas Survey Agency, the Sprotective services with jurisdiction in long-ter of the State Long-Ter program, the protectione and community and the Medicaid Framus (ii) A statement that the complaint with the State Concerning any suspenderal nursing facility limited to resident abmisappropriation of refacility, and non-complaint complaints and non-complaints requirements.	ontact information for filing ints concerning any of state or federal nursing cluding but not limited to ect, exploitation, esident property in the ce with the advance at and requests for returning to the community.  It post, in a form and and understandable to presentatives:  I dresses (mailing and email), ears of all pertinent State cy groups, such as the State estate licensure office, adult there state law provides for m care facilities, the Office of Care Ombudsman on and advocacy network, and control Unit; and the resident may file a	F 15	56		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		345004	B. WING _		0	9/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A: CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 156	written information, a applicants for admiss information about how Medicare and Medicareceive refunds for prosuch benefits.  (g)(16) The facility mand services to the readmission and during (i) The facility must in and in writing in a lanunderstands of his or regulations governing responsibilities during (ii) The facility must at the State-developed obligations, if any.  (iii) Receipt of such in amendments to it, mowriting;  (g)(17) The facility must are such that it is the state-developed obligations, if any.  (ii) Inform each Medicare writing, at the time of facility and when the Medicaid of-  (A) The items and senursing facility service for which the residen	ust display in the facility and provide to residents and sion, oral and written w to apply for and use aid benefits, and how to revious payments covered by ust provide a notice of rights esident prior to or upon g the resident's stay.  Inform the resident both orally aguage that the resident her rights and all rules and g resident conduct and g the stay in the facility.  Also provide the resident with notice of Medicaid rights and any ust be acknowledged in	F	156		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	· ,	TE SURVEY MPLETED
		345004	B. WING		,	09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 156	charged, and the ame services; and  (ii) Inform each Medic changes are made to specified in paragrap this section.  (g)(18) The facility must before, or at the time periodically during the available in the facility services, including ar covered under Medic facility's per diem rate  (i) Where changes in and services covered Medicaid State plan, notice to residents of reasonably possible.  (ii) Where changes a items and services the facility must inform the 60 days prior to imple (iii) If a resident dies transferred and does facility must refund to representative, or est deposit or charges al per diem rate, for the	which the resident may be count of charges for those caid-eligible resident when the items and services hs (g)(17)(i)(A) and (B) of cust inform each resident of admission, and eresident's stay, of services and of charges for those hy charges for services not are/ Medicaid or by the extremely charge are made to items by Medicare and/or by the the facility must provide the change as soon as is the resident in writing at least ementation of the change.  The interest of the facility, the eresident, resident ate, as applicable, any ready paid, less the facility's days the resident actually or retained a bed in the any minimum stay or	F 15	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345004	B. WING _			09/	12/2017
NAME OF PR	ROVIDER OR SUPPLIER		·	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				615	5 RIDGE ROAD		
PERSON	MEMORIAL HOSPITAL			RC	OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 156		refund to the resident or	F 1	156			
	the resident within 30	esident representative any and all refunds due ne resident within 30 days from the resident's ate of discharge from the facility.					
	behalf of an individua	Imission contract by or on I seeking admission to the ict with the requirements of					
	This REQUIREMENT by:	is not met as evidenced			The plan of correcting the specific		
	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.				deficiency. The plan should address the processes that lead to the deficiency cited; The Medicare and Medicaid Right in LTC poster with expired information was removed on 09/27/17. Contacted		
					Local Ombudsman to request new pos Resident Council will be educated on where to locate poster to obtain information on contact information to include list of names, mailing and ema addresses and telephone numbers for pertinent State agencies and advocacy	il	
	Medicaid Rights in Lo on 9/07/2017 at 1:16 wall down from the no	entitled, Your Medicare and ong Term Care was observed PM and was hung on the urses' station. The old telephone numbers for			groups by 10/18/17. All new admission and/or Responsible party will be inform of Resident Rights and location of post	s ied	
	the Office of the Long	ncy, the complaint number, g Term Care Ombudsman dvocacy agency. The			acceptable plan of correction for the specific deficiency cited;  The poster with required information w	ae	
	indicated it was for the Resources. There was	e NC Department of Human as no information for the rol Unit. The telephone			The poster with required information w received and posted on 09/27/17.  "The monitoring procedure to ensure to		
	numbers for the state complaints were diale	•			the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator	nat cted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345004	B. WING _			09/	12/2017
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL  SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	61	FREET ADDRESS, CITY, STATE, ZIP CODE  5 RIDGE ROAD  OXBORO, NC 27573  PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 156	asked for a copy of the informed the posting	PM the Administrator was ne posting. She was information was outdated. PM, the Administrator said it	F	156	requirements; The Social Worker will update information promptly with any changes to ensure compliance with regulatory requiremen. The Administrator will audit information poster monthly; variances will be discussed with Social Worker and reeducation will be completed. Results will be reported to QAPI monthly for the months and then quarterly thereafter.  "The title of the person responsible for implementing the acceptable plan of correction;	ts. on s ee	
F 157 SS=D	consult with the resid consistent with his or representative(s) when the consistent with his or representative(s) when the consistent with the con	Changes.  rediately inform the resident; ent's physician; and notify, her authority, the resident en there is-  ving the resident which has the potential for requiring n;  ge in the resident's physical, it is status (that is, a n, mental, or psychosocial reatening conditions or );  reatment significantly (that is,	F	1157	Administrator or Designee		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345004	B. WING			09/	12/2017
	ROVIDER OR SUPPLIER			61	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	commence a new form  (D) A decision to transesident from the facises \$483.15(c)(1)(ii).  (ii) When making notise (14)(i) of this section, all pertinent informations available and proving physician.  (iii) The facility must a resident and the re	erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment (0(e)(6); or ent rights under Federal or ns as specified in paragraph	F	157	"The plan of correcting the specific deficiency. The plan should address th 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 add not review entire order, therefore the MD was not notified of the results. Resident was treated with insulin per Management of the specific state of the results.	d #4 e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017	,
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/12/2017	
				615 RIDGE ROAD		
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE	ETION
F 157	Continued From page	e 9	F 157	7		
		et (MDS) assessment dated e had diabetes mellitus (DM) sulin injections.		orders and blood sugar improved MD was notified of results on 09/	12/17.	
	Humalog Solution 10 Lispro) was ordered of "Inject as per sliding si 131 - 180 = 2 units; 1 = 6 units; 301 - 350 = units; 401+ = 12 units doctor), subcutaneous bedtime for DM 2."  According to the blood record and the medic (MAR), the BS was of PM on 9/7/17. Twelv administered by Nurs record indicated the re the insulin administrat of 147 at 9:21 PM.  There was no progre the high blood sugar.	o units/milliliter (Insulin on 8/14/17. The order read, scale: if 70 - 130 = 0 units; 81 - 240 = 4 units; 241 - 300 = 8 units; 351 - 400 = 10 s and call MD (medical sely before meals and at a self and administration record ocumented as 499 at 5:23 re units of insulin was see #4. The BS Monitoring resident had responded to a level ses note entered regarding A progress note was made and the next one was on		"The procedure for implementing acceptable plan of correction for its specific deficiency cited; Nurse #4 was educated on regular notification of change on 09/26/11 Director of Nursing. Review of all residents records with orders as 09/07/17 that require notification elevated blood sugar will be completed blood sugar will be educed regulation of notification of change Director of Nursing staff will be educed regulation of notification of change Director of Nursing no later than a "The monitoring procedure to enthe plan of correction is effective specific deficiency cited remains and/or in compliance with the regrequirements; The DON or designee will audit 2 residents with orders to notify MD outside of ordered parameters with blood sugars and MADS reviews	ation for 7 by I current S of to MD of pleted by d. cated on e by 10/24/17. sure that and that corrected ulatory 5% of all 0 of BS II have	
	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			blood sugars and MARS reviewer for 30 days, and then 25% month days. If variances are identified the will be notified and responsible number e-educated. Results of audits reviewed for patterns and/or trender reported at QAPI monthly for three months and then quarterly thereat "The title of the person responsible implementing the acceptable plant correction;	oly for 60 ne MD urse will will be ds and he fter.	
		s expectation for being		Director of Nursing or designee		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 157	greater. He said those monitoring blood sug	nt's blood sugar was 401 or se nurses are pretty good at ars. They should call the practitioner can't take the	F 15	57	
F 224 SS=J	9/12/2017 at 3:20 PM notify the provider the done. 483.12(b)(1)-(3) PRC	<ol> <li>He said if the order says en that is what should be</li> </ol>	F 22	14	10/24/17
	abuse, neglect, misal property, and exploits subpart. This include freedom from corpora seclusion and any ph	t has the right to be free from ppropriation of resident ation as defined in this s but is not limited to al punishment, involuntary sysical or chemical restraint the resident's symptoms.			
	(b)(1) Prohibit and pr	r must develop and licies and procedures that: event abuse, neglect, and nts and misappropriation of			
	resident property,	ies and procedures to			
	§483.95, This REQUIREMENT by: Based on observation pharmacist, nurse pro	g as required at paragraph  Γ is not met as evidenced  on, interviews with the staff, actitioner, and Medical eview, the facility neglected		The plan of correcting the specific deficiency. The plan should address to processes that lead to the deficiency	he

CENTER	S FOR WEDICARE &	MEDICAID SERVICES				CIVID IV	0. 0930-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION		E SURVEY IPLETED
		345004	B. WING _			09	9/12/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
DEDSON	MEMODIAI HOSDITAI			61	15 RIDGE ROAD		
PERSON	MEMORIAL HOSPITAL			R	OXBORO, NC 27573		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 224	Continued From page	e 11	F 2	224			
		mely, provide assistance in a			cited;		
		ovide functioning call bells in			Pharmacy recommendations for GDR of	of	
		resident needed to summon			Resident #10 reviewed by NP with		
	staff for assistance, the	hey could get help and			decision to continue current orders, as		
		rom occurring, follow up on			followed by psych. Upon further review	it	
	lab specimens to dete	ermine the course of			was determined Resident #10 had seen	n	
	treatment for signs ar			LSW but not psycho recently. New orde	er		
	infection, feed a resid			for Psycho consult on 09/08/17 and			
		r monitoring necessary to			appointment was made for earliest		
		's needs and treatment.			available for November 6, 2017. Medic	cal	
		sampled residents (#10,			Director was provided education on		
	#24, #66, #130 and #	:131).			psychotropic medication regulations on 10/04/17.		
		pegan on 9/7/17 and is			Resident #24 did not consume any of the		
		#66. This resident could not			lunch meal on 09/07/17 during mealtim		
		to the toilet, she transferred			observation. Documentation after lunch	ı by	
		ne commode. She did not			Nurse Aide #3 noted Resident #24	_	
		for help after toileting and			consumed 25%-65%; documentation of		
		ack into her wheelchair			meal intake was inaccurate. Education ADL care and documentation was	on	
	expressed anger and	was not functioning. She			provided to Nurse Aide #3 on 09/27/17.		
		a high likelihood for falling			Resident #24 was discharged on	-	
	_	us injury associated with her			09/09/17.		
		elow the knee amputation,			Resident #66 was re-assessed by thera	vae	
	'	hat day and a continued			on 9/20/2017 and the resident s care	J	
	, ,	I therapy for transferring,			plan was updated on 9/21/2017 to refle	ct	
		the lower body. On 9/7/17,			the most current level and type of		
		efore hand bells were			assistance needed with transfers and		
	distributed to the bath	rooms that had			toileting. The interventions on the care		
	non-functioning call b	ells.			plan are identified as tasks and linked t	0	
					the Kardex which is reviewed by CNA		
	-	- 5 are at no actual harm			staff. Weekly interviews with resident		
		e than minimal harm that is			#66 started on 9/20/17. Resident #130		
		dy and the scope is a			was treated for UTI and later discharge	d	
	pattern (E).				on 09/22/17.		
	Findings included:				Administrative Staff #1, 2 and 3 were		
	_	as admitted to the nursing			informed Resident #131 concerns of la	ck	
		er admission Minimum Data			of call bell response and were educated	d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING _	B. WING		09/12/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	ILIZOTI
PERSON	MEMORIAL HOSPITAL				15 RIDGE ROAD OXBORO, NC 27573		
0/0.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES	- 15		PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	e 12	   F2	224			
	Assessment indicated				on the no passing zone process by		
		n, peripheral vascular			Director of Nursing on 09/15/17.		
	disease, septicemia,				The procedure for implementing the		
	non-Alzheimer's dem				acceptable plan of correction for the		
	generalized muscle w	veakness, abdominal pain,			specific deficiency cited;		
		ed abscess of left leg below			a. Beginning 9/9/2017, 100% of reside		
	knee, surgical afterca				rooms and bathrooms were checked for		
	amputation and gastr	o-esophageal reflux			functional call bells by the CEO, CFO,		
	disease.	et (MDC) essessment deted			Director of ER, Director of Imaging, and		
	I .	et (MDS) assessment dated was moderately impaired in			facility staff. If the facility found a bell t was not function, a hand bell was	nat	
		riew for Mental Status was			provided to the resident or the resident		
		ve assistance from one			was temporarily moved into a resident	•	
		ressing and toilet use. She			room with a functional bell. An addition	nal	
	1 -	noving on and off the toilet			100% audit was completed on 9/18/20		
		lize with staff assistance.			and there were no calls bells identified	as	
	She had no fall histor	y and she received both			malfunctioning.		
		sical therapy during the					
	1	The Care Area Assessment			b. Beginning 9/9/2017, training was		
	indicated activity of d				conducted on the facility abuse and		
		s would be addressed in the			neglect policy. The DON and		
	care plan to minimize	risks and avoid			Administrator initiated this education fo		
	complications.	/17 indicated all problems			ECU staff. The training was provided the Quality Director and designees to t		
		esolved. A new care plan			ancillary departments on 9/10. These	IIE	
		7. It only contained one			in-services were conducted across		
	problem for being on	-			multiple shifts and departments. The		
					in-services will continue to be offered a	ıs	
	A Fall Event report in	dicated Resident #66 had an			part of the facility orientation program f		
		ay, 8/27/17 at 10:00 AM. It			staff, staff being deployed from the		
	said, The Certified Nu				hospital, and for contracted staff. The		
	_	h transfer from bed to			original training also included discussion	n	
		sisted resident to the floor.			on the team⊡s responsibility for		
		nd the Therapy Director			responding to call bells.		
	I .	the CNA on transfers. A			Additional training was initiated		
		al therapy note dated rse Aide (NA) #10 was			<ul><li>c. Additional training was initiated</li><li>9/20/2017 on No Pass Zones to remine</li></ul>	d all	
		toilet transfer to support fall			staff of their responsibility for respondir		
	prevention during trai				to call bells. No Pass Zone signs have	•	

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING		0:	9/12/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
				615 RIDGE ROAD			
PERSON I	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 224	Continued From page	e 13	F 22	24			
	An attempt to intervie the weekends, was n 9/12/17, but it was ur			been placed throughout the ureminder to staff. This training on-going and will be included orientation for the unit. No Paprogram that encourages all states.	ng is in iss Zone is a		
	11:30 AM revealed R over a weekend. She her leg buckled. The was working that day	erapy director on 9/12/17 at esident #66 had assisted fall e was in the bathroom and therapy director said she and showed NA#10 how to		answer call bells; if the perso answers the call bell is unable the resident then the person the bell will seek the assistan resident requires. This training	n who e to assist answering ce that the ng has been		
	therapy notes dated a required substantial a dressing and had imp to being able to safel	upational Therapy (OT)		conducted by multiple and may within the organization, include DON, Nurse Executive, Corport President of Clinical Services Department Managers.  d. Resident meeting was held 9/26/17. A resident and family was also held on 9/26/17 to decurrent situation and reinforce.	ding the orate Vice t, and eld on ly meeting liscuss the		
	9:20 AM. She said, s with dignity and resp don't come and they	erviewed on 9/06/2017 at sometimes she was treated ect and added, "When they are short of help, you just neone comes and helps you		organization □s commitment to quality of life and care for the These meetings were open to residents and/or their represe Residents and family membe encouraged to provide feedbat discuss concerns, and to provide	to providing residents. o all entatives. rs were ack, to		
	"At home I used pull Here, I use the ones staff get me to the toi When I press the call the walker before I ca	18 AM, Resident #66 said, ups and used the toilet. that fasten on the side. The let two to three times a day. bell they will come. I used ame. Therapy gives me		suggestions for improvement leadership team, including the administrator, DON, Social W corporate representatives.  e. Effective 9/21/2017, the	to the e CEO, /orker, and organization		
	call them, is a proble sometimes on secon			created a task in Point of Car residents to be used by CNA review the Kardex which is lir resident s care plan to provi centered care to the resident. record will document CNA rev	staff to nked to the de person . The medical		

Facility ID: 953396

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345004	B. WING		0:	9/12/2017
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				615 RIDGE ROAD		
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 224	Continued From page	e 14	F 22	4		
	forgetfulness at times assist with activities of for oral care and mea	Requires extensive of daily Living (ADLs), set-up I tray. Blood sugar at 11:30 Ulin per sliding scale insulin		Kardex each shift. Training for staff on use of the new link wa 9/21/2017. This training is bei conducted by the Director of N and/or licensed nurse as design	s initiated ng lursing	
	observed in her priva She was attempting to wheelchair. She app tightly gripping the graph back herself into her approximately the sale passing by Resident approximately the sale passing by Resident had to take vital signs said Resident #66 go own if she feels like it came out of the bathrangry voice, "I LIKE To			f. A hold was placed on new effective 9/9/2017 and will con facility is found to be in substa compliance. The self-imposed new admissions was made on by the CEO, administrator, and representative. This hold was communicated to the Admission 9/11/17 (the next business Administrator. The Admissions has responded to each request that currently, the facility was used the needs of the applicant.	tinue until ntial hold on 9/9/2017 d corporate ons Director day) by the s Director ot stating unable to nt.	
	record and the medic (MAR), the Resident as 499 at 5:23 PM on insulin was administe On 9/08/2017 at 7:54 asked if she had put let the aide know she call bell was not work surveyor tested the coutside the door or rii On 9/08/2017 at 7:58 the Unit Secretary that	AM Resident #66 was on the call bell yesterday to needed help. She said the ing in the bathroom. The all bell and it did not lighting at the nurses' station.  AM the surveyor informed at the call bell in Resident not working. She said it was		staffing needs and established per resident day (HRD) as the accepted staffing pattern, which on the staff reasonably available resident safety and  quality of care. This 3.0 HRD reflects clinical direct care hou does not include support serving nursing management, restorated resident ambassadors, or thereflects that analysis file for Augusta taken into consideration. The reflects the staffing level for Permer Serving the staffing level for Perme	minimum ch is based ble to ensure  minimum rs only and ces such as ive nursing, apy. In a, the CMS gust 2017 That data erson dent day	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345004	B. WING	B. WING		09/	12/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2017
				6.	15 RIDGE ROAD		
PERSON	MEMORIAL HOSPITAL				OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	e 15	F	224			
	On 9/08/2017 at 11:1				UPD for the adjusted hours for actual		
		I bells. She said, "I am			HRD for the adjusted hours for actual adjustment based on reported case mi		
		ported not working. I would			The 3.0 minimum is .4 HRD over the C		
		e Maintenance Director. I			reported adjusted hours. Also, it shoul		
		or leave a message." When			be noted the 3.0 HRD is the minimum	u	
		about other means for the			accepted with 3.27 HRD being the mea	n	
		for help, she said, "We			and 3.6 HRD being optimal. The facilit		
	have bells and would	• •			has contacted multiple staffing agencie		
		the interview she was seen			to secure additional licensed nurses ar		
	_	s to Resident #66 and to the			certified CNAs.		
	_	lid not have functioning call					
	bells.				h. The facility has contacted multiple		
					staffing agencies to secure additional		
	On 9/08/2017 at 11:2	5 AM, the Director of Plant			licensed nurses and certified CNAs.		
		viewed. He said, "If we get a			Contact was initiated 9/10/2017 and wa	as	
	report about a proble	m, then we get a service			expanded on 9/19/2017 to other agend	ies.	
	call. We would not ch	neck other call bells. It is on					
	an as needed basis.	He confirmed that the call			i. Staff will be deployed from the acu	ıte	
	bell in Resident #66's	bathroom room did not			hospital staff to assist in covering servi	ce	
	work.				gaps. These individuals have been		
					screened through the hospital		
		1 AM a hand bell was					
	observed in Resident	#66's bathroom.			employment process and have beer	ı	
					included in in-service training for ECU		
		PM the Occupational			including, but not limited to, abuse and		
	•	ewed. She said she had			neglect, dignity, elopement, employee		
		#66 on functional transfers			burnout and no pass zone.		
		nitially she needed two					
	•	low she needed minimum			j. The facility has offered multiple		
		afety and hand placement.			incentives to fill vacant shifts. On		
		guard assistance. We've			9/16/2017, the offers included overtime		
		vith nurse aides in the room.			pay for a double shift incentive, retention		
		y, someone would be with			bonuses, and sign-on bonuses for CNA		
	_	out calling if she needs help.			Prior to 9/16/2017, the facility was offer referral bonuses, sign-on bonuses for	iiig	
	She can self-propel in	nd her toileting by herself.			RNs and LPNs, commitment bonuses,		
		y awareness has already			and vacant shift bonuses.		
		and placement). Safety is a			and vacant simt bolluses.		
	huae thina."	und placements. Galety is a			k. The organization approved a new		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/	/12/2017
	ROVIDER OR SUPPLIER	•		61	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD OXBORO, NC 27573	,	
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224	at 4:20 PM. She sai yesterday and could dangerous."  On 9/09/2017 at 10: was interviewed. Sh #66 required assista needed supervision She needed a nurse diagnosis of dement times. Resident #66 confusion. She had assisted fall with star of wheelchair and sh Director of Rehab pr  On 9/8/17 at 12:30, tinformed of the immed.  2. Resident #130 was admitting diagnoses aftercare, pain in left muscle weakness, gand hypertension.  The resident's admis assessment was dat cognition was model Interview for Mental required extensive a for toileting and she	terviewed again on 9/08/2017 d, "I tried to get someone n't find anyone. It was  15 AM the Director of Nurses the confirmed that Resident nice from one person and with activities of daily living. The aide (NA) due to her it. She can be forgetful at the had some episodes of tried to get up. She had one of the did not wait for assist. The ovided education to the CNA.  The administrator was rediate jeopardy.	F 2	224	position of resident ambassador to assithe 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 assignment. All four positions have reviewed and signed their job descriptions.  I. Effective 9/11/2017 the hospital nursing supervisor is to conduct rounds on the long-term care nursing facility utwice per shift on the 12-hour evening shift. The role of nursing supervisor during this round is to provide additions supervision and oversight to the ECU team as needed. The supervisor will make rounds on the unit and discuss a 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 leader team will have huddle meetings daily, Monday through Friday, to report progron the above actions and to identify ne opportunities to minimize abuse or neglect. A spreadsheet is maintained a has served to enhance the organizatio the meeting and strengthen the structure of the discussion. The leadership team	s nit al ny ship ress w and n of re	
	Resident #130 had a self-care performand mobility, limited rang	an activity of daily living (ADL) be deficit related to limited be of motion, musculoskeletal all due to fractures suffered			composed of the Administrator, Director Nursing, Director of Quality, and Director of Human Resources. Adjunct support will be provided by the CEO, CFO, Soc Worker, Corporate Vice President of	or of or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017
NAME OF P	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE	
				615 RIDGE ROAD	
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 224	Continued From page	e 17	F 224	l.	
	in a fall at home.			Clinical Services, Chief Nursing Offic and Director of Plant Operations.	er,
	8/31/2017 at 12:34 Please urination this morning urine." Her temperate normal A thorough The NP wrote, "Will for appropriate orders to On 8/31/2017 at 5:23 was written and said, white mucus discharge notified". New order of complete blood count family were notified.  On 9/2/2017 at 2:50 A was written and said, white discharge from Her vital signs are stated on 9/3/2017 at 8:24 F was written and said, white discharge from Her vital signs are stated that urinalysis (u/a) wyet be obtained. Fam himInformed him of and again about the unimediate) complete metabolic panel (BMF and sensitivity (u/a c8 Levofloxacin, was stated obtain u/a was unsucd discharge noted in conher to drink fluids and sample on second attending. Denies any	PM a Health Status Note "Resident was noted having the from vagina (NP) was was given to obtain UA and (CBC). Resident and  AM a Health Status Note "her family reports a vaginal area, np is aware. The labe and she is afebrile"  PM a Health Status Note the physician was notified as ordered on 8/31 had not filly wished to speak and see of her most recent vital signs of all the ordered STAT of blood count (CBC), basal of and urinalysis and culture of as an antibiotic, of the count of the first attempt to constitute to the count of the count o		The monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains corrand/or in compliance with the regulat requirements; A minimum of 10 resident interviews be completed weekly by the Social wor designee to solicit resident input of staff response times to call bells, if not are being met and what the facility codo better. Immediate concerns are be addressed and will be followed by the Administrator or an administrative teamember. Results of audits will be reviewed for patterns and/or trends a 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 design	that ected ory will orker n eeds ould eing e

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	BE COMPLETION	
F 224	CBC, BMP, UA & Cinfection (UTI) - Lev per oral (PO) daily for ead, in part, "Lanurse aware. First orgiven at 9:00 PM for No (signs or symptomoted."  On 9/5/17, the C&S mirabilis.  On 9/7/2017 a physic different antibiotic.  An NP progress not indicated intramusor started and the previous form. "Organism was sen however, clinically started and the previous form." Secretary would take the nurse. The fam wanted to see the NC&S. He started he clinical improvement.	&S possible urinary tract vofloxacin 750 milligrams (mg) for 5 days.  &AM a Health Status Note be results faxed in from lab, AM close of Levaquin 750 mg results favore urinary tract infection) UTI. oms) s/s of adverse reaction  & result was >100,000 Proteus  & detected 9/7/2017 at 11:52 AM cular Rocephin had been vious antibiotic was stopped. Sitive to both agents, she was not improvement and is side chair today and more on the side of the simproved with	F 22	4		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION  G	1, ,	(X3) DATE SURVEY COMPLETED		
		345004	B. WING	<del></del>	09	/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 224	Continued From pag	e 19	F 22	24			
	4:45 PM. The MD son 9/3/17. He ordern He said he did not ke collected. He said the in urine. No vital sign added, "Fortunately normal." The vital sign added, "Fortunately normal." The vital sign #130's temperature was 96.6 - 98.9 degron 9/08/2017at 7:59 interview Resident # symptoms of UTI. Solot and did not remerobservation of care.  Nurse #9 was interviated AM about her action collected the urine a around lunch time. asked how to obtain by in and out cathete was in the room. I put on time and date I saw the lady in the put label in the composifit nurse and sent three days. I came to resident was on an according to the put label in the composition of the put label in the composition was on an according to the put label in the composition was on an according to the put label in the composition was on an according to the put label in the composition was on an according to the put label in the composition was on an according to the put label in the composition was on an according to the put label in the composition was on an according to the put label in the composition was on an according to the put label in the composition was on an according to the put label in the composition was on an according to the put label in the composition was on an according to the put label in the composition was on an according to the put label in the put label in the composition was on an according to the put label in the put label in the composition was on a control to the put label in the put label in the composition was on a control to the put label in the put label in the composition was on a control to the put label in the put label in the put label in the composition was on an according to the put label in t	AM an attempt was made to 130 about her signs and he said she was sleeping a mber. She declined  ewed on 9/09/2017 at 10:50 so on 8/31/17. She said, "I had sent it to the lab. It was The NP gave me the order. I the specimen and was told erization. A family member ut a label on the specimen. I . I put it in a biohazard bag. lab. I put it in the basket. I buter. I reported off to next to lab. I was off the next back on 9/4/17 and the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 224	nurses about how we On 9/9/17 at 11:00 A #130's family member was collected on 8/3 and 3. Resident #24 was the admission of malitand hypertension. The data set dated 08/10/10/10/10 was severely impaired limited assistance with swallowing problems 08/02/17 was 73 pour A review of the most 05/01/17 revealed Reproblem related to see was to maintain adeceived by maintain 100lbs with no sign of and consuming great meals daily. The interprovide and serve her A review of the August medication administrative revealed treatment for beginning on 08/28/11. A review of a nursing revealed accepted mencouragement to clareview of the nursing 09/07/17 revealed not serve and the nursing 09/07/17 revealed on the serve and the serve and the nursing 09/07/17 revealed on the serve and the serve a	M interview with Resident or confirmed the specimen 1/17.  admitted on 05/01/17 with nutrition, diabetes mellitus ne most recent minimum 17 revealed Resident #24 dognition, and required hodining and had no Her most current weight on onds.  recent care plan dated esident #24 had a nutritional vere malnutrition. The goal quate nutrition status as ning weight within 10% of or symptoms of malnutrition er than 50% of at least 3 eventions were, in part, to or diet as ordered.  St and September 2017 ation records (MAR) or a urinary tract infection 7.  note dated 09/01/17 edication with lots of one mouth and swallow. A notes from 8/28/17 until behaviors during meals. A	F2	224			
		r summary report ending for revealed no behaviors.  PM, a continuous					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 224	observation was con- assigned to Resident delivered to the room #24 was lying in bed the room at 1:27 PM. Resident #23, the roo feeding at 1:50 PM a into the break room a  During an interview of #3 indicated that she to Resident #24. Who stated Resident #24 chicken, carrots and indicated Resident #24 chicken, carrots and indicated Resident #3 play in it and stated the spit during meals and did better with finger that she would leave feed her because sho Resident #24 because up in a bad mood.  On 09/07/17 at 2:31 #3 had not reported be her lunch. Nurse #2 Resident #24 was con daily living (ADLs) can offered her meals.  On 09/08/17 at 8:48 waking up Resident #3 repositioned her and Resident #24 pushed tongue. Aide #2 offer which she accepted be  During the observation  During the observation	ducted with Aide #3 who was #24. The trays were at 1:22PM and Resident resting. Aide #3 went into The aide woke up and fed ommate. She completed the nd left the room and went across the hall.  on 09/07/17 at 2:00 pm, Aide wasn't going to feed lunch en asked why, Aide #3 wasn't going to eat ground mashed potatoes. Aide #3 24 would just mash it up and that Resident #24 fought and downted to feed herself and foods. Aide #3 indicated the tray for the next shift to be didn't want to upset we she was old and had woke PM, Nurse #2 indicated Aide Resident #24 had not eaten	F 2	224		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1 ,	(X3) DATE SURVEY COMPLETED	
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F 224	eater and required p On 09/08/17 at 10:2 stated she expected residents. If the res to re-approach later  4. Resident #131 wa 9/4/17 upon dischar resident's medical hher left hip with surg resident's hospital D 9/4/17 included spec "Patient should be owill need physical the therapy."  A review of the facilian Resident #131 reversident #131 reversident #131 reversident #131 reversident was alert. In memory were assess decisions were reported to the facilian sistence for all of (ADLs), with the excassistance for all of (ADLs), with the excassistance of one with the excassistance of one with the excassistance of one with the excassistance of the excassista	d Resident #24 was a slow patience and time.  4 AM, the Director of Nursing I Aides to attempt to feed all ident refused, the aides were and feed.  as admitted to the facility on ge from a hospital. The istory included a fracture of pical repair. A review of the pischarge Summary dated cial instructions which read, on strict fall precautions she erapy and occupational  ty's medical record for alled her Admission Minimum essment and individualized yet due for completion.  ty's Admission Nursing /17 at 3:15 PM revealed the Her short and long term	F2	224			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 224	the resident require move from place to  A review of Resider (PT) Plan of Care drassessment of the rabilities. The Plan of required supervision ambulation. This ledefined as needing cues or touching/steresident ambulated, or intermittently.  A review of Resident Therapy (OT) Plan of revealed an assess current functional all Plan of Care indicat supervision or touch The resident was all supervision for transdetermined to be at and falls.  A review of the resident value of the resident was all supervisions for transdetermined to be at and falls.  A review of the resident value of the resident was all supervisions. She amassist of one.  Review of a Nursing AM also revealed Review of a walker was described as "refurther review of	Risk Assessment indicated d, "hands-on assistance to place."  It #131's Physical Therapy ated 9/5/17 included an resident's current functional of Care indicated the resident in or touching assistance for evel of assistance was further a helper to provide verbal eadying assistance as the either throughout the activity of the resident of the resident of Care dated 9/5/17 also ment of the resident 's conducted. The edither throughout the activity of the resident required assistance for toileting. So assessed as requiring a moderate risk for balance of the resident was a moderate risk for balance of the resident was able to verbalize bulated with a walker with the grant of the resident was able to verbalize bulated with a walker with the grant of the resident was able to verbalize bulated with a walker with the grant of the resident was able to verbalize bulated with a sistence and	F 224			

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F 224	Continued From pag	e 24	F 2	24		
		ndicated Resident #131 Iker and the assistance of				
	AM. Upon entering to Resident #131's call above the door to he activated call bell was was closed and she hallway. At that time was made of Reside light above her doon Housekeeping staff is she passed by Reside Housekeeping staff into the resident's root to be lit above the do At 8:01 AM, Adminis observed as she wall The administrative so look into the resident continued to be lit ab #131's room. At 8:00 Member #2 was obsident's room. The she did not knock or The call light continuent Resident #131's room. Administrative Staff Resident #131's room ember she did not resident's room. The above the door to the AM, Resident #131's to her room. Within delivery, the resident On 9/9/17 at 8:15 AM	member was observed as lent #131's room. The member did not knock or look om. The call light continued for to Resident #131's room. trative Staff Member #1 was ked by the resident's room. taff member did not knock or it's room. The call light flove the door to Resident 7 AM, Administrative Staff flowered as she passed by the elegation and the resident's room. The call light flower the door to Resident flower the door to Resident flower the door to the resident's room.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 224		e 25 door. An interview was 2 at that time. During the	F 22	4		
	interview, the NA was her call light on. The	s asked why the resident had  NA reported the resident o get to the bathroom.				
	with Resident #131. recalled putting on he before breakfast and	ducted on 9/9/17 at 3:20 PM Upon inquiry, the resident er call light in the morning stated she needed to use ent #131 reported she was				
	not supposed to go to and needed assistan recall what time she	n. Resident #131 reported she was d to go to the bathroom by herself assistance to do so. She did not me she put on the call light that reported, "Sometimes it takes a half				
	hour for them to com she did not have a cl how much time had e	e." Resident #131 stated ock or watch to see exactly elapsed before staff came to ent also described "one				
	night" earlier in the w light to request bathrough #131 reported she wa	eek when she put on the call com assistance. Resident aited for what seemed to be				
	couldn't wait any long because, "I just knew	The resident stated she ger for staff to come or I would wet myself all over Resident #131 reported she				
	unassisted). Resider	and then back to bed (also nt #131 stated she met the or a couple of days ago and				
	at 9:40 AM with Resi interview, the resider light was not answere assistance to go to the stated she had actual	was conducted on 9/10/17 dent #131. During the it recalled the night her call ed by staff when she needed ie bathroom. The resident lly used the call light twice up getting to the bathroom				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING  A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 224	no one came to help she knew she shoul feel she had a choic didn't feel strong end and had been instrushe should not amb.  An interview was cop M with the facility's Upon inquiry as town responding to call light staffwe have the noreported 'the no-pafrom all departments and dietary, should reported if the particute call light could not resident, he/she should take care of the asked what her experience was could take care of the asked what her experience staff to answer a "Ideally, less than 5.  An interview was cop AM with Physical Threported he had been since her admission week ago. Upon incresident continued to ambulation and toiled of ambulating to/from the night were discussions.	nerself unassisted because her. The resident reported dn't walk unassisted but didn't e. She reported she just bugh to safely walk by herself cted by therapy and staff that ulate without assistance.  Inducted on 9/10/17 at 3:36 in Director of Nursing (DON). Who was responsible for ghts, the DON responded, "All opassing zone." The DON ssing zone 'meant all staff is, including housekeeping answer call lights. She ular staff member answering but meet the needs of the build let someone know who are resident's need. When exceted response time would be call light, the DON stated,	F 224		
	3/29/16. The reside	admitted to the facility on nt ' s cumulative diagnoses tive disorder (bipolar), major			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	A review of the residence of the residen	dent's November 2016 cluded the following : risperidone (an antipsychotic s 1 tablet by mouth every ated to schizoaffective rie; e given as 1 tablet by mouth me related to schizoaffective rie; (an antidepressant) given as very day related to major r, single episode; (an antidepressant) given as 1 very day related to major r, single episode; n antidepressant) given as 1 rry day related to major r, single episode; (an antidepressant) given as 1 rry day related to major r, single episode; (an antidepressant) given as 1 rry day related to major r, single episode; (an antidepressant) given as very day related to major r, single episode; n antianxiety medication) by mouth twice daily for	F 224	DEFICIENCY	
	former physician (da response to a Cons 9/27/16) from the fa pharmacist. The Co Resident #10 receiv addition to an antips medication. The ph for four antidepress.	ated 11/15/16) written in ultation Report (dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
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NAME OF PROVIDER OR SUPPLIER PERSON MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	•	
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
discontinuing use of one citalopram or paroxetine effects. The physician of recommendation on 11/read: "Recently - psych reviewed by [Name of M changes were made."  A review of Resident #10 Orders revealed the resist he same psychotropic medical risperidone, citalopram, paroxetine, and diazepa  Further review of the resincluded a Consultation consultant pharmacist of 3/14/17. The Consultati Resident #10 received 4 addition to an antipsychemedication. The pharma indicated the need for fowith the same (or similar duplication of therapy are be re-evaluated with contapering the citalopram of declined the recommend "Long standing h/o (hister illness-meds eval (evaluation changesno med changes). A review of Resident #10 revealed the frequency of the standard review of Resident #10 revealed the frequ	led the need for four e re-evaluated. She he given to tapering and e or more (perhaps of to avoid the risk of side leclined the pharmacist's 15/16 with a notation that (psychotropic) meds ledical Center] - no 10's March 2017 Physician ident continued to receive medications in the same end in November 2016. Actions included duloxetine, Fetzima, m.  Sident's medical record Report from the ated on Report indicated entidepressants in ordic and antianxiety actist recommendation our antidepressant agents of action represented a not suggested the regimen insideration given to dose at this time. The NP dation on 4/15/17, noting ory of) mental ated) by psych with no the at this time."	F 2	24		

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F 224			F	224			
	There was no docum paper or electronic m resident's target beha	am given three times a day. entation in the resident's ledical record to indicate the aviors/mood were being sport the rationale for the					
	a Consultation Report pharmacist dated 5/1 Report indicated diazamedication and considue to the increased confusion, addiction are port acknowledged diazepam and recompiven to tapering down declined the pharmaci 7/17/17 with a notation	7/17. The Consultation repam was a long-acting idered a high risk medication risk of sedation, depression, and falls in the elderly. The the recent dose increase of mended consideration be on the dose. The NP cist's recommendation on that read: "Recently o changes were made to her					
	included a Consultaticonsultant pharmacist Consultation Report is received paroxetine, dry mouth, constipativision, and increased pharmacist also note additional antidepres an antianxiety medicarecommended considere-assessing the use for side effects. The pharmacist's recommended: "F	of dated 6/9/17. The indicated the resident which increased her risk for on, urinary retention, blurred a confusion/sedation. The indicated the resident received 3 sants, an antipsychotic and action. The report deration be given to of paroxetine due to the risk					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 224	A review of the residincluded a 7/17/17 Ca repeat recommend consultant pharmacis recommendations may consultation Report pharmacist's recommendation that read: "med rec (medication changes made - will a review of Resident Orders revealed the the same psychotropic dosages as her Nove exception of the dos 5/11/17. The psychorisperidone, citalopra paroxetine, and diaz. A review of Resident Minimum Data Set (I 8/9/17 indicated the skills for daily decision MDS reported the rescore of zero (0); Se exhibited no behavior Section N of Resident Section	g Paxil (paroxetine)."  ent's medical record consultation Report (noted as lation from 5/17/17) from the st. This report reiterated the ade in the 5/17/17  The NP declined the nendation on 8/22/17 with a Psych eval completed with reconciliation) done and no continue current regimen."  ##10's August 2017 Physician resident continued to receive bic medications in the same ember 2016 orders, with the se increase for diazepam on otropic medications included am, duloxetine, Fetzima, epam.  ##10's most recent quarterly MDS) assessment dated resident had intact cognitive on making. Section D of the sident had a mood severity ction E indicated the resident ors nor rejection of care. Int #10's assessment revealed psychotic, antidepressant, ication on 7 out of 7 days period.  ent's care plan (not dated) g area of focus: The resident	F2	224		

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F 224	ordered by physician effectiveness Q-shiftMonitor/document/r adverse reactions of unsteady gait, tardive gait, rigid muscles, sl refusal to eat, difficul depression, suicidal iblurred vision, diarrhe appetite, weight loss vomiting, behavior sy person."  A review of the reside medical record reveal behaviors/mood were documented by the massistants.  An observation and i	included: tropic medications as . Monitor for side effects and (every shift). report PRN (as needed) any psychotropic medications: e dyskinesia, EPS (shuffling haking), frequent falls, ty swallowing, dry mouth, ideations, social isolation, ea, fatigue, insomnia, loss of muscle cramps, nausea, mptoms not usual to the ent's paper and electronic alled the resident's target e not routinely monitored or furses or the nursing	F2	224		
	An interview was cor AM with the NP carin the interview, the NP Resident #10 receive medications, includin stated the resident had psychiatric disorders medications a long to Resident #10 was as psychiatric service and any changes to her in NP stated he did not	aducted on 9/8/17 at 11:30 and for Resident #10. During reported he was aware and multiple psychotropic g 4 antidepressants. He and a longstanding history of and had been on the me. The NP reported assessed and evaluated by a find they opted not to make medications at that time. The agree with the pharmacist reassess Resident #10 's				

	ATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 224	adjusted by a psycha psychiatric service he stated "No, she we evaluation." He was resident was seen to the resident was seen to the resident on 9/9/did not exhibit any to the resident on 9/9/did not exhibit any to the resident of the resident and the resident of the resident record revelocumentation to in the been seen for a psychaet was and thought perhaps consolidated. However, and thought perhaps consolidated. However, the recommendation was reported she though by psych in the pass.  An interview was consumed the facility, Resident #1 program one time of confirmed the report received by the facilindicated Resident psychiatric evaluation definitely was not a service of the state of the report received by the facility was not a service of the state of the report received by the facility was not a service of the state of the report received by the facility was not a service of the resident in the report received by the facility was not a service of the resident in the report received by the facility was not a service of the resident in the report received by the facility was not a service of the resident in the report received by the facility was not a service of the resident in the report received by the facility was not a service of the resident was not a service of the resi	he felt such meds were best hiatric service. When asked if a was following the resident, was seen as a one-time only is not certain of the date the by the psychiatric service.  Interview was conducted of 17 at 9:45 AM. The resident behaviors at that time.  Ident's paper and electronic healed there was no indicate the Resident #10 had	F 22	4	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		0	9/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 224	year and one-half (si facility).  A telephone interview facility's Medical Dire brief overview of Res and concerns regard was reviewed with the time, the Medical Directedentials of the proon 5/18/16 as a Clini Resident #10 was a Medical Director indi expected her to have along with psychiatric "We're going to need managing medication.  An interview was cor AM with the facility interview, the MDS in #10's care plan and its process.	ice at any time over the past noce her admission to the v was conducted with the ector on 9/9/17 at 4:15 PM. A sident #10's medical history ing her medication regimen e Medical Director. At that ector identified the ovider who saw Resident #10 cal Social Worker. Since long-term care resident, the cated he would have a had a psychiatric evaluation of follow up. He stated,	F 22			
	received. Upon review "There are a lot of in been added specific Nurse also reviewed documentation in Remedical record regar The MDS Nurse reponders 'Notes in the which were primarily episodes of confusion or mood issues. The would have expected	ew, the MDS nurse stated, terventions that could have to this resident." The MDS the nursing staff's sident #10 's electronic ding behaviors and mood. Orted she identified a "few" the resident's medical record focused on isolated and the most related to behavior the MDS nurse indicated she at to see more documentation use to Resident #10 's use of				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 224	at 11:35 AM with the the NP indicated it w resident was only se Worker since her adi NP acknowledged th Clinical Social Worker psychiatric evaluation also confirmed he hassumption a psychic completed for this rewrote another order Resident #10 be see psychiatric evaluation 483.10(a)(1) DIGNIT INDIVIDUALITY  (a)(1) A facility must resident in a manner promotes maintenan her quality of life receindividuality. The fact promote the rights of This REQUIREMENT by:  Based on observation and resident interview provide: Resident #6 her bathroom so she when needed; Resid when requested; Resid when requested; Resid resident #13 for toileting assistant sample residents rev #10, #56, #66 and #1	was conducted on 9/12/17 NP. During the interview, as now his understanding the en by a Clinical Social mission to the facility. The ereport written by the erecommended a higher becompleted. The NP dispersion of the NP	F 24		s o of

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _		0	9/12/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•		
				615 RIDGE ROAD			
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 241	Continued From pa	ge 35	F 2	41			
F 241	ongoing for Resider find staff to assist h independently onto have a means to caprior to transferring because the call be expressed anger ar dangerous.  Examples number 2 with potential for monot immediate jeops (D).  Findings included:  1. Resident #66 was home on 7/17/17. I Assessment indicate including hypertens disease, septicemia non-Alzheimer's de generalized muscle kidney failure, acquisited, surgical after amputation and gas disease.  Her Minimum Data 7/24/17 indicated sl cognition, required person for transfer, was not steady with and only able to sta She had no fall hist occupational and pl	as admitted to the nursing Her admission Minimum Data ed she had diagnoses ion, peripheral vascular a, diabetes mellitus, mentia, depression, weakness, abdominal pain, ired abscess of left leg below	F 2	staff.  Resident #66 (who resided was initially provided a hand the bathroom. The Resident moved to room 263 with a fubell. Parts were ordered an in room 262 was repaired on The resident is content in roth has remained there.  Weekly interviews with resident social worker and/or designed weeks to ensure that her cate functional and that staff are requests for assistance with appropriate and timely manuvariances will be communicated incontinence care on 09/09/deficient practice was obserted incontinence care on 09/09/deficient practice was obserted in the following on 09/10/17.  Administrative Staff #1 is nother than the care and infection control by Nursing on 09/10/17.  Administrative Staff #1 is nother than the care and infection control by Nursing on 09/10/17.	d bell to use in at was then unctioning call d the call bell in 9/15/17. Som 263 and dent #66 interviews will at #66 by the ee for four all bell is responding to a toileting in an iner. Any ated to the ing the huddles Monday.  If appropriate 1/17, after the eved. Nurse incontinence by Director of the longer saff # 2 and 3 and 131 concerns and were sing zone.		

PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345004	B. WING _			09/12/2017	
	ROVIDER OR SUPPLIER		•	61	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	9:20 AM. She said, swith dignity and respect don't come and they have to wait until somout."  On 9/07/2017 at 10:0 "At home I used pull Here, I use the ones staff get me to the toi When I press the call the walker before I catever exercises in my room call them, is a problet sometimes on second Nurse Aide (NA) #6 vat 10:22 AM about he provide residents. Since get to know the routin (Resident #66) will pelikes to use the compiust in case. She will The nurse aide's Doof for September 7, 201 entry for that day. It is individualized instruction to illeting.  On 9/07/2017 at 4:25 observed in her prival She was attempting the wheelchair. She app	erviewed on 9/06/2017 at sometimes she was treated ect and added, "When they are short of help, you just neone comes and helps you as AM, Resident #66 said, ups and used the toilet. The let two to three times a day. bell they will come. I used ame. Therapy gives me a sometime. Coming, when I m. Mostly on days dishift."  In was interviewed on 9/07/2017 ow she knows what care to the said, "After a day or two, I he Sometimes, she are in a diaper. Now, she hode. She wears a diaper press call bell for help"  For the waster of the pression of the said, the said of the pression of the said of the pression of the said of the pression of the said of the said of the pression of the pression of the said of the pression of the pression of the said of the pression of the said of the pression of the said of the pression of the pression of the said of the pression of the pression of the said of the pression of the pres	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 continuous 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 agree to provide additional visits for resident staff education on a date to be determined.  c. A resident meeting was held on Tuesday, 9/26/17. A resident and famil meeting was also held on 9/26/2017 to discuss the current situation and reinforthe organization scommitment to providing quality of life and care for the residents. These meetings were open 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, an corporate representatives.  d. Departmental Managers will be reminded on how to identify signs and	ed and ly rce to	

Facility ID: 953396

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION  G	I ' '	(X3) DATE SURVEY COMPLETED	
		<b>345004</b> B. WING			ng	/12/2017	
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP O	•	71272017	
				615 RIDGE ROAD			
PERSON I	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		TION SHOULD BE THE APPROPRIATE	COMPLETION DATE	
F 241	Continued From page	e 37	F 2	41			
	approximately the sai	me time NA #15 was		symptoms of stress and bu	urnout. The		
	passing by Resident	#66's room. She said she		organization has a strong e	employee		
	had to take vital signs	s and blood sugars. She		assistance program and de	epartmental		
		es to the bathroom on her		managers will be encourage	ged to offer		
	own if she feels like it	t. At 4:30 PM Resident #66		these programs to staff wh	o demonstrate		
	came out of the bathr	oom and said in a loud and		signs and symptoms of str	ess and		
		ΓΟ FELL AND NEED MY		burnout. The discussion w			
		#15 went in the room to		9/25/2017 during the Depa			
	assist Resident #66.			Stand-Up Meeting and was			
				the CEO and Director of H			
		AM Resident #66 was		Resources. Departmental			
	asked if she had put on the call bell yesterday to			provide additional education	on to their		
		needed help. She said the		respective departments.			
		ing in the bathroom. The					
	-	all bell and it did not light		e. Key members of the fa	•		
	outside the door or rii	ng at the nurses' station.		team will have huddle mee Monday through, Friday to	•		
	On 9/08/2017 at 7:58	AM the surveyor informed		on the above actions and t			
		at the call bell in Resident		opportunities to minimize a	•		
		not working. She said it was		neglect. A spreadsheet is			
	the first time she had			has enhanced the organiza			
				meeting and strengthened			
	On 9/08/2017 at 11:1	5 AM Nurse #3 was		the discussion. The leader	ship team is		
	interviewed about cal	l bells. She said, "I am		composed of the Administr	rator, Director of		
	aware of a call bell re	ported not working. I would		Nursing, Director of Quality	y, and Director		
	get in contact with the	e Maintenance Director. I		of Human Resources. Adj	unct support is		
	would call his pager of	or leave a message. When		provided by the CEO, CFC	), Social		
		about other means for the		Worker, Corporate Vice Pr			
		l for help, she said, "We		Clinical Services, Chief Nu	•		
	have bells and would			and Director of Plant Oper	ations.		
	_	the interview she was seen					
		s to Resident #66 and to the		The monitoring procedure			
		lid not have functioning call		the plan of correction is eff			
	bells.			specific deficiency cited re			
	0.0000000			and/or in compliance with			
		1 AM a hand bell was		requirements; A minimum			
	observed in Resident	#66's bathroom.		interviews will be complete	• •		
	0 0/00/00/= : : : :=	DM !! 0 ::		Social worker or designee			
	On 9/08/2017 at 3:17	PM the Occupational		resident input on staff resp	onse times to		

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OIVID IV	7. 0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/	12/2017	
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL			61	TREET ADDRESS, CITY, STATE, ZIP CODE  5 RIDGE ROAD  OXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE	
F 241	Therapist was interviworked with Residen to toilet. She said, "Il person assistance. Nassist and cues for some safety training with training of the safety training."  Resident #66 was intated the safety and could resident the safety and could resident the safety training of the safety training training of the safety tra	ewed. She said she had t #66 on functional transfers nitially she needed two Now she needed minimum afety and hand placement. guard assistance. We've with nurse aides in the room. y, someone would be with out calling if she needs help. nd her toileting by herself. n wheelchair. She is y awareness has already and placement). Safety is a  erviewed again on 9/08/2017 d, "I tried to get someone n't find anyone. It was  M, the administrator was	F 2	41	call bells, if needs are being met and the facility could do better. Immediate concerns are being addressed and wil followed by the Administrator or an administrative team member. Results audits will be reviewed for patterns an trends and reported at QAPI monthly three months and then quarterly thereafter.  The title of the person responsible for implementing the acceptable plan of correction;  Administrator or administrative design	I be of d/or or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			9/12/2017	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 241	memory were assess decisions were reported sassistance for all of head (ADLs), with the excessistance of one with independent with eat reported to be continued. A Fall Risk Assessmere revealed Resident #1 a moderate risk for fat a history of a fall at head repair. The Fall Fither esident required move from place to put the resident of the reabilities. The Plan of required supervision ambulation. This level defined as needing a cues or touching/stear resident ambulated, cor intermittently.  A review of Resident Therapy (OT) Plan of revealed an assessment of the reapilities was care indicated the record touching assistance was also assessed as	der short and long term seed to be intact and ted to be consistent and ident required extensive ner Activities of Daily Living eption of requiring limited th dressing and being ing. Resident #131 was ent of bowel and bladder.  The ent completed on 9/4/17 and the seed one with a left hip fracture	F 2	41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION	
F 241	a Nursing Note date note indicated the reher needs. She am assistance of one standard assistance of one standard assistance of one standard assistance of one standard and assistance of one standard and assistance of one standard and assistance of one standard assistance of one standard and assistance of one standard and assistance of one standard and the call light and a Housekeeping staff.	lent's medical record included d 9/6/17 at 2:34 PM. The esident was able to verbalize bulated with a walker with aff member.  Note dated 9/7/17 at 8:59 esident #131 ambulated with but required assistance and	F 241			
	At 8:01 AM, Administrative solook into the resident continued to be lit all #131's room. At 8:00 Member #2 was obs	cor to Resident #131's room. Strative Staff Member #1 was lked by the resident's room. Itaff member did not knock or It's room. The call light Cove the door to Resident To AM, Administrative Staff Served as she passed by the Even administrative staff member				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING			09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 241	The call light continuer Resident #131's room Administrative Staff Markenident #131's room member she did not be resident's room. The above the door to the AM, Resident #131's to her room. Within a delivery, the resident On 9/9/17 at 8:15 AM was observed as she room and closed the conducted with NA # interview, the NA was her call light on. The needed assistance to An interview was conwith Resident #131. recalled putting on he	look into the resident's room. ed to be lit above the door to in. At 8:08 AM, Member #3 passed by in. The administrative staff knock or look into the e call light continued to be lit is resident 's room. At 8:13 breakfast tray was delivered one minute of the tray 's call light was turned off. If, Nursing Assistant (NA) #2 is came out of the resident's door. An interview was 2 at that time. During the is asked why the resident had in NA reported the resident or get to the bathroom.  Inducted on 9/9/17 at 3:20 PM Upon inquiry, the resident or call light in the morning	F 24	41			
	the bathroom. Reside not supposed to go to and needed assistant recall what time she morning, but reported hour for them to come she did not have a classist her. The reside night" earlier in the wellight to request bathrought to request bathrought along time." I couldn't wait any long because, "I just knew	stated she needed to use ent #131 reported she was to the bathroom by herself on the call light that but on the call light that d., "Sometimes it takes a half e." Resident #131 stated took or watch to see exactly elapsed before staff came to ent also described "one eek when she put on the call com assistance. Resident eaited for what seemed to be the resident stated she ger for staff to come of I would wet myself all over Resident #131 reported she					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO. 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 241	Continued From page	e 42	F 24	1			
		er room to walk to the I and then back to bed (also					
	at 9:40 AM with Resi interview, the resider light was not answer assistance to go to the stated she had actual that night and ended and back to bed by how one came to help she knew she should feel she had a choice made her feel, the result of the safely walk by hersel therapy and staff that without assistance.  An interview was core PM with the facility's Upon inquiry as to with responding to call light staffwe have the note that the call light could not resident, he/she should take care of the	was conducted on 9/10/17 dent #131. During the nt recalled the night her call ed by staff when she needed ne bathroom. The resident illy used the call light twice up getting to the bathroom iterself unassisted because her. The resident reported in't walk unassisted but didn't e. When asked how this isident stated, "I felt bad." it didn't feel strong enough to if and had been instructed by it she should not ambulate  inducted on 9/10/17 at 3:36 Director of Nursing (DON). ho was responsible for hts, the DON responded, "All in-passing zone." The DON sing zone' meant all staff i, including housekeeping inswer call lights. She ular staff member answering it meet the needs of the uld let someone know who he resident's need. When incted response time would be					
	"Ideally, less than 5 r An interview was cor	call light, the DON stated, minutes."  nducted on 9/12/17 at 11:55 erapist (PT) #1. PT #1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/1:	2/2017	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573				
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F 241	since her admission to week ago. Upon inquesident continued to ambulation and toiletic ambulation to/from the night were discussistated he, "would have a stated he have a stated	n working with Resident #131 to the facility a little over one uiry, the PT reported the require assist of one for ing. The resident's report of the bathroom on her own in sed with the PT. The PT we wanted her to have help."  admitted to the facility on ses which included heart	F 24				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED	
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F 241	using the same wash gloves she wore whi movement. When the #7 applied a zinc past to the front perineal a same pair of gloves movement. NA #7 a Resident #10's pillow and then picked up have the resident with pull A clean top sheet was All this care was prowearing the same past wash her hands or centire procedure.  In an interview with NAM, she stated she had sor change of the batt the perineal area. Sinstructed to wash haproviding bowel incomplying clean sheet stated she had not the dignity issue for the hands and change of incontinence care and applying perineat that hand hygiene shincontinence care and incontinence care and inco	k and the back of her thighs incloth and wearing the same le cleaning the bowel in bath was completed, NA steet to the buttocks, and then area as she still wore the used to clean the bowel in pplied a clean pillowcase to or, placed it under her head, her clean shirt and assisted ing the shirt over her head. It is placed over the resident wided while NA #7 was hir of gloves. NA #7 did not hange gloves throughout the land not been educated to ge gloves after cleaning a did before continuing the in or applying a zinc paste to the added she had not been ends or change gloves after intinence care and before is to the bed. NA #7 also hought about this being a	F 2	41			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2	2017	
	ROVIDER OR SUPPLIER	,	6	STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CC	(X5) DMPLETION DATE	
F 241	Continued From page	e 45	F 241				
	11:45 AM. She state remainder of her bath used to clean her box she did not feel clean other people to see h She stated she felt as care about her basic  4. Resident #56 was the hospital as a short diagnoses including him ellitus, and aftercar  The admission Minim assessment dated 08 #56 was cognitively in assistance with toileti and was totally deper Resident #56 was alv  During an interview with toileti and was totally deper Resident #56 was alv  Call light during the with one of the with a bowel responded until 2 hound remember exactly help, but it was at leas staff arrived. He add home to see if she could home to see if she could him after no one respective explained he felt that him and did not respective added that he did not "mess."	admitted to the facility from rt-term resident with heart failure, diabetes e from surgery.  Solution Data Set (MDS) Solution 16/17 revealed Resident hatact, required extensive ing and personal hygiene, hadent upon staff for bathing.  Ways incontinent of bowel.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE)	D BE COMPLETION		
F 241	toileting or incontiner Resident #56 during 2017. In an interview with NPM, she stated she will during the week of Oproviding incontinent specific date.  During an interview on 9/10/17 at 4:09 Phowel incontinence of that nursing assistant incontinent care as assigned residents.  On 09/12/17 at 2:16 conducted with Nurs that she always work She stated it would be anyone who needed receive the care with depending on how be time. She added that soiled clothing and she soiled clothing and she she stated #56 on during the we not specifically reme incontinence care on aware of his incontinent that a resident might care when she had 1 her as she often did. have to prioritize who finish up with one resident might one resident with the properties who finish up with one resident might one res	provided to indicate whether noe care was provided for the month of September  NA #2 on 09/09/17 at 4:25 worked with Resident #56 9/03/17 but did not recall be care for him on any  with the Director of Nursing M, she agreed that lack of care was a dignity issue and ts were expected to provide oon as possible to their  PM an interview was a #4 on 9/12/17. She stated and the rehabilitation hall. We her expectation that incontinence care should	F 24				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING_			09/	12/2017
	ROVIDER OR SUPPLIER			61	TREET ADDRESS, CITY, STATE, ZIP CODE 5 RIDGE ROAD OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241 F 253 SS=D	agreed that a residen few hours to receive to the line an interview with the 9/12/17 at 3:18 PM he incontinence care sho possible and that he was member to lie in feces or even 20 minutes.	soon as possible and she t would not want to wait a powel incontinence care.  The on-call physician on the stated that bowel tould be provided as soon as the would not want his family to say waiting for care for 2 hours		2241			10/24/17
					"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 wor 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 or 09/27/17. All repairs identified during walkthrough by 10/13/17 will have work orders created. Repairs will be completed.	e k ne	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345004	B. WING			09/	12/2017
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL			61	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	the hinged side of the the metal bar was obsort the door, preventing upon attempting to classification of the door, preventing to classification of the door, preventing upon attempting to classification of the an observation of Resconducted on 9/7/17 metal bar on top of the hallway as the rodinterview was conducted on 9/7/17 metal bar on top of the hallway as the rodinterview was conducted on 9/7/17 metal bar on top of the hallway as the rodinterview was conducted on 9/7/17 metal bar on top of the hallway as the rodinterview was conducted. He state and was almost certain to repair this door. The operations stated he inability to close the rodinability to close the rodinability to close the rodinterview, #10's room door and completed so maintened the broken door. Upon the inability to close a be a concern.  An interview was con PM with Resident #10 provide additional informed on had been the exiting the room, the	ne top of the door frame on a door. The opposite end of served to hang down in front g the door from closing. ose the door, the door to the ally close and would remain as open.  Director of Plant Operations, sident #10's door was at 4:10 PM. The broken e door could be viewed from om was approached. An atted with the Director of Plant are. The Director reported be could be taken care of with a saw all work orders in none had been completed and Director of Plant was concerned about the	F	253	by 10/24/17.  "The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements;  Environmental rounds will occur weekly identify need for repairs by Maintenancor Environmental Services Director. Woorders will be created upon identification of repair need. Results of rounding audit 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 Services Director	nat cted y y to se ork on lits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345004	B. WING			09/	12/2017
	ROVIDER OR SUPPLIER		·	615 RID	ADDRESS, CITY, STATE, ZIP CODE  GE ROAD  DRO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253 F 272 SS=D	Continued From page stated she preferred t way. 483.20(b)(1) COMPR ASSESSMENTS	he door to be closed all the		253			10/24/17
	(b) Comprehensive A  (1) Resident Assessimust make a comprehensive in the comprehensive in th	ment Instrument. A facility hensive assessment of a lengths, goals, life history and le resident assessment cified by CMS. The lude at least the following:  I demographic information he. hs.  Idenographic infor					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PERSON	MEMORIAL HOSPITAL			615 RIDGE ROAD		
LINGON	MEMORIAL HOOFHAL			ROXBORO, NC 27573		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	` '	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 272	Continued From pag	e 50	F 272	2		
	include direct					
		n and communication with				
	licensed and	as communication with				
	non-licens on all shifts.	ed direct care staff members				
	-	cess must include direct imunication with the resident,				
	non-licensed direct of	ation with licensed and are staff members on all				
	i i	T is not met as evidenced				
	by: Based on staff inter	views and record reviews, the		" The plan of correcting the specific		
		lete a comprehensive		deficiency. The plan should address the	ne	
	1	dent 's problem/condition of		processes that lead to the deficiency		
	the use of psychotro	` •		cited; Resident #10□s CAA summary		
		of affecting the mind,		psychotropic drug use was reviewed a		
		vior) for 1 of 6 sampled		care plan revised to include an analys	IS	
		or unnecessary medications		for continued use of medication and	,	
	(Resident #10).			pharmacy communication on 09/30/17	•	
	The findings included	d:		Annual MDS with ARD 09/28/17 for Resident #10 will be completed by 10/06/17 with comprehensive assessr	nont	
	Resident #10 was ac	Imitted to the facility on		with each triggered CAA.	licit	
		nt's cumulative diagnoses		mar oden alggered er a		
	1	tive disorder (bipolar), major		" The procedure for implementing the		
	1	(single episode), and anxiety.		acceptable plan of correction for the specific deficiency cited;		
	A review of the resid	ent's November 2016		New MDS Coordinator is in place and	was	
	Physician Orders inc			educated of CAA completion process		
	medications, in part:	•		the Administrator on 10/05/1The MDS	·	
		speridone (an antipsychotic		Coordinator will review all current		
		1 tablet by mouth every		resident□s most recent comprehensiv	e	
	night at bedtime rela	ted to schizoaffective		assessment with CAA summaries to		
	disorder, bipolar type	e;		ensure analysis for each triggered CA	A by	
		given as 1 tablet by mouth ne related to schizoaffective		10/24/17.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/1	2/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
F 272	1 tablet by mouth every depressive disorder, security and tablet by mouth every depressive disorder, security d	n antidepressant) given as ry day related to major single episode; n antidepressant) given as 1 ery day related to major single episode; antidepressant) given as 1 ery day related to major single episode; n antidepressant) given as 1 ery day related to major single episode; n antidepressant) given as ry day related to major single episode; antianxiety medication) ery mouth twice daily for ent's medical record included esident #10's former 5/16) written in response to the dated 9/27/16) from the marmacist. The Consultation dent #10 received 4 ery dition to an antipsychotic exation. The pharmacist of four antidepressant agents ilar) action represented a and recommended the	F 27	"The monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains correand/or in compliance with the regulator requirements; The Administrator or designee will audit 25% of all comprehensive assessments, prior to submission, weekly for 30 days and the monthly for 60 days to ensure accurate CAA summary completion. Variances be reviewed with MDS Coordinator. Results to determine need for correctic Audits will be reviewed for patterns and trends and reported at QAPI monthly three months and then quarterly thereafter.  "The title of the person responsible for implementing the acceptable plan of correction;  Administrator or Designee	that ected ory nen re will ons. nd/or for		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345004	B. WING		09/12/2017
	ROVIDER OR SUPPLIER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD ROXBORO, NC 27573	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 272	A review of Residen Orders revealed the the same psychotrol dosages as her adm medications included duloxetine, Fetzima,  Further review of the included a Consultar consultant pharmaci 3/14/17. The Consultar consultant pharmaci 3/14/17. The Consultant pharmaci 3/14/17. The Consultant pharmaci 3/14/17. The Consultant pharmaci addition to an antips medication. The phindicated the need fewith the same (or sinduplication of theraphe re-evaluated with tapering the citalophe declined the recomm "Long standing h/o (illness-meds eval (exhangesno med changesno med changes-	t #10's March 2017 Physician resident continued to receive pic medications in the same hission orders. These d risperidone, citalopram, paroxetine, and diazepam.  The resident's medical record tion Report from the ist dated altation Report indicated ed 4 antidepressants in sychotic and antianxiety armacist recommendation for four antidepressant agents milar) action represented a by and suggested the regimen a consideration given to am dose at this time. The NP mendation on 4/15/17, noting thistory of) mental valuated) by psych with no	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER.		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING			09/12/2017	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP COI 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 272	be care planned for the A review of Resident Assessment (CAA) Saddressed the use of for this resident. Identhe CAA Worksheet with the following heading problem/condition; Coresident is taking; Trefor use of psychotrop consequences of ant resident; Adverse corexhibited by this resident; Adverse corexhibited by this resident. The each of these section "Resident is triggering CAA related to reside assist (assistance) with Daily Living), total as toileting and is alway incontinence care. Reantianxiety, antidepresential medication. She also with transfers and had generalized weaknessedentulous. Placing is reactions, oral pain/in Current diagnoses in failure), HTN (hyperteroveractive bladder, see (gastroesophageal reobesity, and HLD (hy care) documentation 3/15/10.	indicated the resident would his area of focus.  #10's Care Area fummary dated 3/29/17 if psychotropic medications in the second of the lasses of medication this estable/reversible reasons ic drug; Adverse ipsychotics exhibited by this insequences of anxiolytics dent; and Adverse latives/hypnotics exhibited in arrative information from its read as follows: If of Psychotropic Drug Use ent requires extensive to total with all ADLs (Activities of sist (assistance) with its incontinent requiring esident is also taking an essant and an antipsychotic has poor balance issues is decreased mobility with its. Resident is also iner at risk for falls, adverse infection and skin breakdown. Clude CHF (congestive heart ension), chronic pain, chizophrenia, GERD efflux disease), depression, inperlipidemia). POC (plan of 3/15/17, nursing 17, bowel and bladder 17, current diagnoses	F 21	72			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345004	B. WING			9/12/2017	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP COD 615 RIDGE ROAD ROXBORO, NC 27573		9.12.20.1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 272	interview 3/15/17, Word The CAA Summary of comprehensive asset use of psychotropic representation include an analysis of psychotropic medical nor did it address any lack of) the resident of Summary did not independent experienced the psychotropic medication include community pharmacist (nor respendication of antidexprecommendations for and potential side efficient and potential side efficient and potential side efficient depression, anxiety, Revised on 6/28/16), for this area of focus "Administer psychotropic medications of antidexpression, anxiety, Revised on 6/28/16), for this area of focus "Administer psychotropic medications of unsteady gait, tardiverse reactions of unsteady gait, tardiverse reactions of unsteady gait, tardiverse reactions, suicidal in blurred vision, diarrhed appetite, weight loss,	ration Record) 3/15/17, Pain eekly skin assessments."  lid not provide a ssment of Resident #10's nedications. It did not f the problem/condition the tions were intended to treat y mood/behavior patterns (or was exhibiting. The CAA icate whether or not the adverse consequences of dications used in her lly, the CAA Summary did cation from the consultant onses from the NP or erns about the potential pressant therapy, or gradual dose reductions, ects from the psychotropic eived.  Lent's care plan (not dated) of area of focus: The resident edications related to and insomnia (Initiated and The planned interventions included: tropic medications as . Monitor for side effects and	F 27				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345004	B. WING _			09/12/2017
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 272	person."  An interview was con AM with the facility's the MDS nurse review Worksheet dated 3/2 psychotropic medicat CAA Worksheet, the general assessment. psychotropic medicat resident." When ask information to be a co of the resident's probuse of the psychotropic Nurse responded, "N An interview was con PM with the facility's During the interview, identified for Residen assessment and CAA psychotropic medicat DON reported she has	inducted on 9/10/17 at 10:15 MDS Nurse. Upon request, wed the Resident #10's CAA 9/17 for the use of tions. After reviewing the MDS Nurse stated, "It's a This doesn't address the tions for this particular ed if she would consider this comprehensive assessment lem/condition and reason for bic medications, the MDS o."  Inducted on 9/10/17 at 3:36 Director of Nursing (DON). a review of concerns at #10's comprehensive A Worksheet related to tions were discussed. The	F 2	272		
F 274 SS=D	expectation was for the CAA Worksheet informand to be comprehented 483.20(b)(2)(ii) COM AFTER SIGNIFICAN (b)(2)(ii) Within 14 day determines, or should there has been a sign resident's physical or purpose of this section means a major declired.	PREHENSIVE ASSESS T CHANGE  ays after the facility d have determined, that	F2	274		10/24/17

_ ` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 274	implementing standa interventions, that he one area of the resid requires interdiscipli care plan, or both.) This REQUIREMEN by: Based on record re	ge 56 intervention by staff or by and disease-related clinical as an impact on more than dent's health status, and nary review or revision of the  T is not met as evidenced view, and staff interview and the facility failed to complete	F 274	" The plan of correcting the specific deficiency. The plan should address the		
	a significant change sampled resident (R experienced a signif from a stay in the ho Findings included: Resident #66 was o	assessment for 1 of 1 esident #66) who icant change after returning ospital.  riginally admitted to the facility oses including depression		processes that lead to the deficiency cited; Resident #66 was noted to have a significant change upon readmission f hospital on 08/02/17. A comprehensiv significant change MDS will be completely 10/13/17.  "The procedure for implementing the	rom e	
	7/24/17, specified R dementia and was of The resident was also cognitively impaired			acceptable plan of correction for the specific deficiency cited; All resident sereadmitting from the hospital or residents that have a chancondition have the potential to require significant change assessment completed. Resident is identified with	a	
	7/31/17. On 8/2/17, to the facility and ph Zyprexa 1.25/milligra agitation/anxiety. Zy symptoms of psychoschizophrenia and backeriew of a Nurse's "Resident yelling ou Review of a Nurse's the resident was contact."	Note dated 8/4/17 included,		possible need for a significant change have significant change assessment completed no later day 14 of observed change. Residents with change in condition will be reported during clinic 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 ref to baseline will have a summary documented related to the decision or why not to proceed with a significant change.	d al at curns	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 274	attending physician rebeen started on the Z sundowning." Sundow dementia characterize agitation that is more afternoon and evening.  The MDS Coordinator #66's admission MDS at readmission on 8/2 extended care unit an interview.  During an interview of Director of Nursing in assessed for changes Change in Condition at	n 9/10/17 at 11:06 AM, the evealed Resident #66 had yprexa due to "severe vning is a symptom of ed by confusion and prevalent late in the	F 274	"The monitoring procedure to ensure the plan of correction is effective and to specific deficiency cited remains corrected and/or in compliance with the regulator requirements;  The Director of Nursing or Designee word audit 25% of all residents, readmitting from the hospital or having a change in condition, to determine if a significant change assessment or documentation justify significant change was not indicated was completed, weekly for 3 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 an reported at QAPI monthly for three months and then quarterly thereafter.  "The title of the person responsible for implementing the acceptable plan of correction;	hat cted ry ill to 0 th	
F 276 SS=D	assess a resident using instrument specified by CMS not less frequent months.  This REQUIREMENT by:  Based on record revious passed on record revious instruments.	Assessment. A facility must ng the quarterly review by the State and approved uently than once every 3 is not met as evidenced ew and staff interviews, the	F 276	" The plan of correcting the specific	10/24/17	
	facility failed to compl	ete a quarterly Minimum		deficiency. The plan should address th	le	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING	<del> </del>	,	09/12/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PERSON I	MEMORIAL HOSPITAL			615 RIDGE ROAD			
LINGON				ROXBORO, NC 27573			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 276	Continued From page	e 58	F 27	6			
	assessment for 1 of 1	n 92 days of the most recent 9 sampled residents sessments (Resident #111).		processes that lead to the deficiencited; Resident #111 Quarterly MDS with 8/23/17 was completed 09/13/17.	-		
	5/16/17 from a hospit diagnoses which inclusive weakness, and malnut. A review of Resident (MDS) records reveat assessment was come Reference Date (AREs next clinical assess quarterly MDS assess 8/23/17. As of 9/8/17 MDS ARD date), Rest assessment had not 10 An interview was conwith the facility's MDS nurse reported on completion of the Resident #111.  An interview was conpM with the facility's Upon inquiry, the DO assessments to be controlled in the completing the assessments.	dmitted to the facility on all with a cumulative uded osteoarthritis, muscle utrition.  #111's Minimum Data Set led her Admission MDS upleted with an Assessment D) of 5/23/17. The resident 'ment was scheduled as a sment with an ARD date of (108 days after the last ident #111's quarterly MDS been completed.  ducted on 9/8/17 at 4:43 PM S nurse. Upon inquiry, the she was "a little bit behind"		"The procedure for implementing acceptable plan of correction for the specific deficiency cited; All residents requiring a MDS has potential for this deficient practice audit was completed on 09/09/17 again on 09/26/17 to determine make assessments by Director of Coperations, LTC; information was communicated to MDS coordinate assessment schedules will be in compliance by 10/06/17.  "The monitoring procedure to ensure the plan of correction is effective aspecific deficiency cited remains of and/or in compliance with the regrequirements; The Administrator or designee will the MDS schedule for all schedule assessments at least weekly to entimely compliance of MDS completinterdisciplinary team. Any assess noted to be missed or late will be completed by the MDS coordinate 24hours. Audits will continue wee weeks and then monthly for 60 dad Results of audits will be reviewed patterns and/or trends and reported QAPI monthly for three months are quarterly thereafter.	the the . 100% and dissing or clinical or. MDS sure that and that corrected ulatory I review ed nsure etion by sments or within kly for 4 ays. for ed at and then		
				" The title of the person responsib			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345004	B. WING			09/	12/2017
	ROVIDER OR SUPPLIER			6′	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD COXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 276	3 483.20(g)-(j) ASSESSMENT		F:	F 276 correction; Administrator or Designee			
F 278 SS=E			F	278			10/24/17
		esments. The assessment of the resident's status.					
	(h) Coordination A registered nurse mu each assessment with participation of health						
	(i) Certification (1) A registered nurse the assessment is con	e must sign and certify that mpleted.					
		no completes a portion of the n and certify the accuracy of sessment.					
	(j) Penalty for Falsifica (1) Under Medicare a who willfully and know	nd Medicaid, an individual					
		and false statement in a is subject to a civil money nan \$1,000 for each					
	and false statement in	dividual to certify a material a resident assessment is by penalty or not more than assment.					
	(2) Clinical disagreem material and false sta	nent does not constitute a tement.					

PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/	12/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		12.2411	
PERSON	MEMORIAL HOSPITAL				15 RIDGE ROAD OXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 278	by: Based on record rev facility failed to code assessment accurate residents (Resident # Findings included:  1. Resident #92 was home on 5/10/17. The resident was 254 pour weight record.  A Nutrition Assessment 5/10/2017at 5:29 PM included his admitting pontine myelinolysis hypertension, hypoth mellitus. The assess medications included indicated the resident weight and eat health current diet order was sodium diet. The molb. on 5/10/2017. The the resident had lost admission and was to plan was established and encourage weight. The weekly weights weight of 5/23/17 was the Minimum Data S.	iew and staff interview, the the Minimum Data Set ely for 5 of 20 sampled 16, #10, #62, #66 and #92).  admitted to the nursing ne admission weight for this ands (lbs) according to the ent note was entered on Excerpts of the note glagnoses including central (a neurological disorder), yroidism and type II diabetes ment acknowledged his a diuretic. The note towas trying to cut back, lose hier since his stroke. The sa cardiac, diabetic, low strecent weight was 254.3 as assessment acknowledged weight since a previous rying to lose more weight. A to weigh the resident weekly not loss.  In the experimental of the experimental	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 of Residents #6 and #62 on 10/01/1. MD were modified with corrections for Resident #10 on 10/03/17 and Resident #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 at 12300.  " The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements; The Administrator or designee will audit 25% of all MDS completed for accuracy sections K0300, N410, G0110J1 and 12300 weekly for 30 days, then monthly 60 days. The MDS coordinator will notion of errors and MDS will be corrected and submitted timely. Results of audits will reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter.	for S in the stand what the steed by the stand of the stand of the stand of the standard of th		

Facility ID: 953396

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345004	B. WING		09/12/2017			
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION			
F 278	9/08/2017 at 8:06 Al gives a list of reside with percentages and Wednesdays and The know what they were "We would identify a second review reveat the symptoms of as schizophrenia and would indicate wou	M. She said the dietitian hts who had weight loss along d timeframes on nursdays. She said I don't e doing in May. She added, weight loss".  itian was interviewed on AM. She said she didn't sign ssment. It would have been coordinator. She said it accurate coding.  is re-admitted to the nursing the diagnoses including mentia without behaviors.  aled a physician's order 1.25 mg daily as needed or anxiety. Zyprexa is used to be proposed for anxiety. Zyprexa is	F 278	"The title of the person responsible implementing the acceptable plan of correction;  Administrator or Designee				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09	/12/2017
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 278	Continued From page did not indicate the reantipsychotic medica	esident had received an	F 27	78		
	at 2:25 PM. She spect the facility for a month completed Resident was no longer workin Coordinator reference 7/18 through 7/24/17 received the antipsychave been coded on During an interview of Director of Nursing st	or was interviewed on 9/12/17 cified she had only worked at the and the person who had #66's MDS dated 7/24/17, go at the facility. The MDS and stated the resident had shotic twice and it should the MDS.  In 9/12/17 at 3:40 PM, the cated a comprehensive care to capture the resident's				
	diagnoses of hemiple osteoarthritis and dep Review of the annual 07/13/17 revealed Reimpaired cognition ar assistance with bed r dependent on staff for and bathing. The cod was supervised for perfect the Care A 07/13/17 triggered ar and activity of daily lingeneralized weakness	Minimum Data Set dated esident #6 had moderately and required extensive mobility and was totally r transfer, dressing, toileting ding indicated Resident #6				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (	CONSTRUCTION		) DATE SURVEY COMPLETED			
		345004	B. WING			9/12/2017		
	ROVIDER OR SUPPLIER		61	STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 278	On 09/06/17 at 11:00 observed in bed. Sh assistance of staff for On 09/12/17 at 2:15 resident #6 required of daily living. On 09 Administrative Staff coding was incorrect resident #6, the corresident #6, the corresistance with persistance with	o AM Resident #6 was e revealed she required the or personal hygiene. PM Aide #8 indicated assistance with all activities 9/12/17 at 2:21 PM Member #3 indicated the tror personal hygiene of ect coding was extensive sonal hygiene. She revealed ous assessments for coding terviewed the staff when ce in the assessment.  admitted to the facility on ital. Her cumulative Alzheimer's disease and ressive disorder. The ospice services related to her ner's disease.  at #62's July 2017 Medication rd (MAR) revealed the ensincluded, in part: 25 odone (an antidepressant is one tablet by mouth every mg quetiapine (an may be indicated as an or treat major depressive ne tablet by mouth twice the tablet by mouth twice the tablet by mouth three the same thablet by mouth three thablet by	F 278					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345004	B. WING		09/12/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION		
F 278	resident receiving an during the 7 day look  An interview was cor with the facility's MD interview, the omissis medication on Resid dated 7/14/17 was di MDS Nurse reported for this assessment vupon review of Resid the MDS nurse reported for this assessment in the MDS nurse reported for the MDS nurse reported for the MDS nurse reported took back period. The would expect Section the resident received on 7 out of 7 days du.  An interview was cor Director of Nursing (I During the interview, antianxiety medication #62's MDS assessminguiry, the DON staffor the MDS assessminguiry, the DON staffor the MDS assessmappropriately for the  5. Resident #10 was 03/29/16 with diagnor failure, hypertension.  A review of the documedical record indicaturinary tract infection dated 07/26/2017 revutil due to the bacter.	There was no report of the antianxiety medication a back period.  Inducted on 9/8/17 at 4:46 PM S Nurse. During the con of an antianxiety ent #62's MDS assessment scussed. At that time, the the 7-day look back period was from 7/8/17 to 7/14/17. Ident #62's July 2017 MAR, ted the resident received an on each day during this 7-day the MDS nurse stated she on N of the MDS to indicate an antianxiety medication uring the look back period.  Inducted with the facility's DON) on 9/9/17 at 12:13 PM. The omission of an on in Section N of Resident ent was discussed. Upon the ted her expectation would be ments to be coded medications.	F 278				

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '			X3) DATE SURVEY COMPLETED	
	345004	B. WING _			9/12/2017	
			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		-	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETION DATE	
The July 2017 Medicarevealed Resident #1 (antibiotic) one gram, 07/27/10 through 07/3 In a review of the modata set (MDS) assess diagnosis section rev (UTI) (Last 30 days) of the Modata set (MDS) assess diagnosis section rev (UTI) (Last 30 days) of the Modata set (MDS) assess diagnosis section rev (UTI) (Last 30 days) of the conducted with the Mexplained that had we a month to fill the term nurse, and the former the diagnosis section assessment dated 08 that the diagnosis of the should have been cappuring an interview of (DON) on 09/10/17 at was her expectation to be completed accurated 483.20 (d);483.21 (b) (COMPREHENSIVE (Massessments complements in the resider results of the assessments revise the resider plan.	ation Administration Records 0 had received Rocephin once daily beginning 31/2017 to treat a UTI.  St recent quarterly minimum sement dated 08/09/17 the ealed Urinary Tract Infection was not checked.  AM, an interview was DS Coordinator. She orked in the facility for about aporary position as the MDS of MDS Nurse had completed of the quarterly MDS of MOS Nurse had completed of the quarterly MDS of the UTI (Last 30 days) petured as a diagnosis.  With the Director of Nursing of 4:09 PM, she stated that it that the MDS assessments tely.  1) DEVELOP CARE PLANS  St maintain all resident ted within the previous 15 of sactive record and use the ments to develop, review on the sactive care				10/24/17	
(b) Complehensive C	are i lans					
	ROVIDER OR SUPPLIER  SUMMARY ST.  (EACH DEFICIENC REGULATORY OR I  Continued From page The July 2017 Medica revealed Resident #1 (antibiotic) one gram, 07/27/10 through 07/3  In a review of the modata set (MDS) assest diagnosis section rev (UTI) (Last 30 days) v  On 09/10/17 at 9:37 // conducted with the Mexplained that had we a month to fill the tern nurse, and the former the diagnosis section assessment dated 08 that the diagnosis of is should have been care  During an interview w (DON) on 09/10/17 at was her expectation to be completed accurated as a section of the section of the completed accurated as a section of the section of the completed accurated as a section of the completed accurated as a section of the section of	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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.	A BUILDIN  345004  B. WING  ROVIDER OR SUPPLIER  WEMORIAL HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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. 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ROWIDER OR SUPPLIER  MEMORIAL HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES  [EACH DEFICIENCY MUST BE PRECEDED BY PILL  REGULATORY OR LSC IDENTIFYING INFORMATION)  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 that 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.  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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345004	B. WING		0	9/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 279	comprehensive perseach resident, consists each resident's and psychosocial network comprehensive assect and psychosocial network comprehensive assect each plan must describe that or maintain the resident physical, mental, and required under §483.  (ii) Any services that under §483.24, §483 provided due to the runder §483.10, inclute the transfer of the provide as a result of recommendations. If findings of the PASA rationale in the resident's representations.	develop and implement a on-centered care plan for stent with the resident rights c)(2) and §483.10(c)(3), that objectives and timeframes medical, nursing, and mental eds that are identified in the ssment. The comprehensive ribe the following -  are to be furnished to attain ent's highest practicable dipsychosocial well-being as .24, §483.25 or §483.40; and would otherwise be required 0.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6).  Services or specialized is the nursing facility will for PASARR a facility disagrees with the RR, it must indicate its ent's medical record.  The the resident and the ative (s)-	F 279	,			
	desired outcomes.  (B) The resident's pr future discharge. Fac	eals for admission and eference and potential for cilities must document 's desire to return to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY
		345004	B. WING _		,	09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 615 RIDGE ROAD ROXBORO, NC 27573	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 279	local contact agencie entities, for this purpose of the resident the delivery of care for (Resident #8, #56, #6). Immediate jeopardy to ongoing for Resident find staff to assist her independently onto the have a means to call prior to transferring because the call bell expressed anger and dangerous. She had and receiving a serio post-surgical knee ar on that day and a coroccupational therapy dressing the lower before hand bells we bathrooms that had receiving a serio post-surgical knee ar on that day and a coroccupational therapy dressing the lower before hand bells we bathrooms that had receiving a serio post-surgical knee ar on that day and a coroccupational therapy dressing the lower before hand bells we bathrooms that had receiving a serio post-surgical knee ar on that day and a coroccupational therapy dressing the lower before hand bells we bathrooms that had receiving a serio post-surgical knee ar on that day and a coroccupational therapy dressing the lower before hand bells we bathrooms that had receiving a serio post-surgical knee ar on that day and a coroccupational therapy dressing the lower before hand bells we bathrooms that had receiving a serior post-surgical knee ar on that day and a coroccupational therapy dressing the lower before hand bells we bathrooms that had receiving a serior post-surgical knee ar on that day and a coroccupational therapy dressing the lower before hand bells we better the properties of the purpose	ssed and any referrals to s and/or other appropriate ose.  In the comprehensive care in accordance with the in in paragraph (c) of this  I is not met as evidenced  In, staff interview and record led to develop plans to address the current is and to form the basis for or 4 of 18 sampled residents of and #128).  I began on 9/7/17 and is #66. This resident could not into the toilet, she transferred the commode. She did not for help after toileting and ack into her wheelchair was not functioning. She is stated that it was a high likelihood for falling us injury associated with her inputation, high blood sugar intinued need for for transferring, toileting and ody. Three hours passed	F 2	The plan of correcting the deficiency. The plan should processes that lead to the cited; Resident #8s had ESRD with dialysis care; updated with ESRD/dialy 09/08/17 by MDS coordi #56 did not have a complan completed; resident 09/09/17 and unable to complete the most current I assistance needed with the toileting. The intervention plan are identified as tast the Kardex which is revisitaff.  Resident #128 did not have comprehensive care plan resident discharged 09/0 to correct deficiency.  The procedure for implemance plan of correspecific deficiency cited;  a. Training on develop	ould address the ne deficiency diagnosis of care plan was ysis care on inator. Resident orehensive care t discharged correct deficiency. Seessed by not the resident sees and type of transfers and ons on the care sks and linked to ewed by CNA ave a n completed; 06/17 and unable menting the action for the	

PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09	/12/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD			
				615 RIDGE ROAD			
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 279	Continued From pag	ge 68	F 2	79			
	Findings included:  1. Resident #66 was home on 7/17/17. H Assessment indicate including hypertensid disease, septicemia, non-Alzheimer's den generalized muscle kidney failure, acquirknee, surgical aftercamputation and gast disease.  Her Minimum Data Sassessment dated 7 moderately impaired extensive assistance transfer, dressing an steady with moving able to stabilize with fall history and she rand physical therapy period. The Care Aractivity of daily living falls would be addreminimize risks and a The Care Area Asse associated with MDS would be initiated to loss/dementia, activity potential, urinary inc status, dehydration/fulcer, psychotropic of The MDS section of indicated Resident #return anticipated on A care plan dated 8/	s admitted to the nursing der admission Minimum Data ed she had diagnoses on, peripheral vascular diabetes mellitus, mentia, depression, weakness, abdominal pain, red abscess of left leg below are for below knee tro-esophageal reflux  Set (MDS) admission /24/17 indicated she was in cognition, required a from one person for ad toilet use. She was not on and off the toilet and only staff assistance. She had no ecceived both occupational or during the assessment rea Assessment indicated and in the care plan to avoid complications.  Sesment dated 7/28/17 above indicated a care plan address cognitive ty of daily living rehabilitation ontinence, falls, nutritional fluid maintenance, pressure drug use and pain. The electronic medical record fe6 was discharged with a 17/31/17.		person-centered care plans we conducted for the interdisciplin no later than 9/28/2017. The the interdisciplinary team on person-centered care plans we facilitated by a long-term care certified in MDS and QAPI.  b. Effective 9/21/2017, the chas created a task in Point of residents to be used by CNA review the Kardex which is linguisted the Kardex which is linguisted to the resident. The medical record will document of the Kardex each shift. Trait CNA staff on the use of the new initiated 9/21/2017 by the DO continue to be administered by or a designated licensed nurse.  c. The organization has cornal second nurse to provide supplied to a second nurse to second nurse to provide supplied to a second nurse to a second n	inary team training to  will be e consultant  organization Care for all staff to nked to the de person The CNA review ining for the ew link was N and will by the DON se.  Intracted with pport to the s on care plans, changes in g tasks be linked to in care plan ind/or their was entation to remain in current and  lity leadership gs daily,		
	assessment dated 7 moderately impaired extensive assistance transfer, dressing an steady with moving able to stabilize with fall history and she rand physical therapy period. The Care Aractivity of daily living falls would be addreminimize risks and a The Care Area Asse associated with MDS would be initiated to loss/dementia, activity potential, urinary inc status, dehydration/fulcer, psychotropic of The MDS section of indicated Resident # return anticipated on	defrom one person for ad toilet use. She was not on and off the toilet and only staff assistance. She had no eccived both occupational during the assessment rea Assessment indicated in the care plan to exoid complications. Seement dated 7/28/17 above indicated a care plan address cognitive ty of daily living rehabilitation ontinence, falls, nutritional fluid maintenance, pressure drug use and pain. The electronic medical record ef66 was discharged with a 17/31/17.		of the Kardex each shift. Trai CNA staff on the use of the neinitiated 9/21/2017 by the DO continue to be administered by or a designated licensed nurse.  c. The organization has corea second nurse to provide sufficiently MDS coordinator with a focused eveloping person centered of updating the care plans with oresident conditions, identifying within the care plan that will be the Kardex, and participating meetings with the residents a representative. This person we employed 9/26/2017 after ories the facility. This position will place until all care plans are only to date.  d. Key members of the facility.	ining for the ew link was N and will by the DON se.  Intracted with pport to the s on care plans, changes in g tasks be linked to in care plan ind/or their was entation to remain in current and  lity leadership gs daily,		

Facility ID: 953396

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION		E SURVEY PLETED
		345004	B. WING_		09	/12/2017
NAME OF PI	ROVIDER OR SUPPLIER	1	'	STREET ADDRESS, CITY, STATE, ZII	•	
				615 RIDGE ROAD		
PERSON I	MEMORIAL HOSPITAL			ROXBORO, NC 27573		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLETION DATE
F 279	Continued From pag	e 69	F 2	279		
F 279	The MDS section of (EMR) indicated Rest the nursing home on A new care plan was contained one probled diet.  A Kardex located unthe EMR included or Use lifting device, dreduce friction. Moni Pressure], P [Pulse], [Temperature]).  A Current Care Recoplan tab within the Enurse aides to docur format this form is casurey Report v2. In an intervention/task. the shift and the subthe days of the mont coding was located be section. The Docum for the month of Sep Resident #66. The Inpart, "Transferring," There were no individual commentation was September 1 - 7, 20 one time on second from two staff. There	the electronic medical record sident #66 was readmitted to 8/2/17 sinitiated on 8/7/17. It only em for being on a therapeutic der the care plan tab within the instruction for transfer. * aw sheet, etc. etcetera) to tor Vitals All (BP [Blood	F 2	on the above actions and opportunities to minimize neglect. A spreadsheet has enhanced the organimeeting and strengthene the discussion. The lead composed of the Adminis Nursing, Director of Qual of Human Resources. A provided by the CEO, CF Worker, Corporate Vice I Clinical Services, Chief N and Director of Plant Open The monitoring procedur the plan of correction is especific deficiency cited and/or in compliance with requirements; The Director of Nursing a audit the completion of 1 plans for triggered CAAs centered care needs on Variances will be reported audits will be reviewed for trends and reported at Q three months and then q thereafter.  The title of the person re implementing the accept correction;  Director of Nursing or Definition of the person of th	e abuse or is maintained and ization of the ed the structure of ership team is strator, Director of lity, and Director djunct support is FO, Social President of Nursing Officer, erations.  The to ensure that effective and that remains corrected in the regulatory or Designee will 00% of care and other person a weekly basis. It is a weekly basis of or patterns and/or API monthly for uarterly  sponsible for able plan of	
	Sunday, 9/3, night sh was the same for Tu 9/6. Documentation	nift documented "NA." This esday, 9/5 and Wednesday was reviewed for toilet use 7, 2017. On 9/1 toilet use			<b>V</b> ==	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	l ` ′	FIPLE CONSTRUCTION  NG	(X3	) DATE SURVEY COMPLETED
		345004	B. WING			09/12/2017
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, 615 RIDGE ROAD ROXBORO, NC 27573	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 279	dependence from on made on Saturday, 9 9/7. On Sunday, 9/3 "total dependence from the same for Tuesda Documentation was September 1 - 7, 201 one time on second from one staff. There Saturday, 9/2, Monda Sunday, 9/3, night sh was the same for Tue 9/6.  On 9/07/2017 at 10:0 "At home I used pull Here, I use the ones staff get me to the to When I press the cal Nurse Aide (NA) #6 vat 10:22 AM about he provide residents. S get to know the routin (Resident #66) will plikes to use the comr just in case. She will Nurse #4 interview wat 10:33 AM. She had couple of weeks. She looks at the chart and nurse aides are given nurse aides document record. She pulled ut there was only one p	n second shift with total e staff. There was no entry 1/2, Monday, 9/4 or Thursday , night shift documented om one person." This was y, 9/5 and Wednesday 9/6. reviewed for dressing from 17. On 9/1 dressing occurred shift with total dependence e was no entry made on ay, 9/4 or Thursday 9/7. On nift documented "NA." This esday, 9/5 and Wednesday  08 AM, Resident #66 said, ups and used the toilet. that fasten on the side. The illet two to three times a day.	F	279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017		
	ROVIDER OR SUPPLIER	•	6	STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 279	read in part, alert an forgetfulness at time assist with activities for oral care and me  On 9/07/2017 at 4:2: observed in her privates the was attempting wheelchair. She applicated to take vital signing by Resident had to take vital signing said Resident #66 grown if she feels like came out of the bath angry voice, "I LIKE BRITCHES UP." Nassist Resident #66.  The MDS Nurse was 3:34 PM. She said sess than a month and She confirmed that 18/1/17 and returned plan problems were the previous care playiewable to staff. She problem was restarted should have a whole linterview with Nurse revealed Resident #She needed assistant still working with the	d dated 9/7/2017 at 2:39 PM d oriented times three with s Requires extensive of daily Living (ADLs), set-up al tray.  5 PM Resident #66 was ate bathroom on her own. to transfer back into her beared anxious and was rab bar and struggling to wheelchair. At ame time NA #15 was #66's room. She said she as and blood sugars. She best to the bathroom on her it. At 4:30 PM Resident #66 aroom and said in a loud and TO FELL AND NEED MY A #15 went in the room to sinterviewed on 9/08/2017 at the had worked there a little and didn't know the residents. Resident #66 discharged on on 8/2/17. She said all care discontinued on 8/1/17 and an problems were not the said the therapeutic diet ed. She said Resident #66 e lot of care plans.  #3 on 9/08/2017 at 11:15 am 66 was alert and oriented. The work was alert and oriented.	F 279				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED			
		345004	B. WING	<del></del>	09/12/2017	
	ROVIDER OR SUPPLIER		619	REET ADDRESS, CITY, STATE, ZIP CODE 5 RIDGE ROAD DXBORO, NC 27573	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	O BE COMPLETION	
F 279	worked with Reside to toilet. She said, 'person assistance. assist and cues for She needed contact done safety training She added, "Typica her. She is good at I would not recomm She can self-propel compliant. The safe been an issue (i.e., huge thing."  Resident #66 was ir at 4:20 PM. She sa yesterday and could dangerous."  On 9/09/2017 at 10: was interviewed. Si #66 required assistanceded supervision She needed a nurse diagnosis of dementimes. Resident #66 confusion. She had assisted fall with sta of wheelchair and si Director of Rehab p  On 09/09/2017 at 3: interviewed. She wishe found out how to by shift report from a sometimes from the never used any writ	riewed. She said she had nt #66 on functional transfers Initially she needed two Now she needed minimum safety and hand placement. It guard assistance. We've with nurse aides in the room. It y, someone would be with bout calling if she needs help. It is end her toileting by herself. In wheelchair. She is ety awareness has already shand placement). Safety is a safety awareness has already shand placement. It was set to get someone In't find anyone. It was set to get in the confirmed that Resident ance from one person and with activities of daily living. It is aide (NA) due to her tia. She can be forgetful at the shad some episodes of tried to get up. She had one of the did not wait for assist. The rovided education to the CNA.	F 279			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	was informed of the problem.  The Physical Therap 9/12/2017 at 11:41 A assisted fall the reside and how she provide said one thing I thou a resident comes in guide in the closet set to do. She said this Administrator. She a is a care guide, but to entering the informat working on getting the care record.  On 9/12/2017 at 12:3 interviewed regardin said we knew it was working with corpora have all of the comp  2. Resident #128 was Her admitting diagnoral aftercare, hypertensicongestive heart failingulmonary disease,	M, the Chief Executive Officer immediate jeopardy for this by director was interviewed on M. She described an dent have over a weekend ed training to NA #11. She ght was important was when new, they should have a care to the aides would know what was brought up to the added that in the EMR, there does not know who is tion onto it. She said we are ne individualization onto the set to figure out whether we onents to the EMR.  The sa admitted on 8/16/2017. The ses included orthopedication, chronic diastolic cure, chronic obstructive pain in left shoulder, muscle lities of gait and mobility,	F 2	79		
	interventions including	ted 8/19/17 was for by to evaluate and treat with ng activities of daily living functional deficits as a result				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _	<del></del>		09/12/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	assessment reference assessed as cognitive toilet use and person supervision by one personsupervision and physical therapy. Her Care Area Assessindicated a care plant address activity of dapotential, psychosoc status, dental, pressonsupervision and the care plant dated. The care plant dated one was for falls and therapeutic Diet.  The only instruction of that the resident was footwear when ambust wheelchair and follow. The Documentation include any individual bathe the resident. The bathing." On Sundabath was given that mone person. A Look for September. On Subathing entry was blasseptember 3, 2017, not applicable.	num Data Set with an the date of 8/23/17. She was ely intact. For dressing, al hygiene she required erson. Her balance was not octional limitation on one side She was totally dependent om one person. She was I received both occupational  ssment dated 9/5/17 would be initiated to ally living rehabilitation fal well-being, falls, nutritional are ulcer, and pain.  8/17/17 had two problems. If the other for being on a  on the Kardex was ensure wearing appropriate lating or mobilizing in or facility fall protocol.  Survey Report v2 did not lized instructions for how to The intervention/task was any, August "20th, it indicated a equired total assistance from Back Report was provided Sunday, August 27, 2017 the	F 2	79		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/12/2017	
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	•		
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F 279	her own teeth. She she before she got dress. She said she could but not waist up. She teeth. Three times I Sunday it was after a she had a bad skin of She said she was conchurch friends would packed up and ready the interview, therefor had not been made.  NA #6 was interview. She said she needed she always gave here.  The MDS Nurse was 10:37 AM about the the resident. She accare plan for activities behind on my care president had been in twenty-two days.  Nurse #3 was interview on 9/10/2017 at PT would communic nurses would communic nurses would communic nurses would communicated on 9/10/2017 at PT would communicated on 9/10/2017 at	care. She said she cleaned said it would be after 3:00 PM sed unless the therapist did it. bathe from her waist down, e said, "It was like pulling did not get a bath. Every 3:00 PM." She added that disease and it has an odor. Inscious of the odor when a see her. The resident was by to be discharged following ore an observation of care sed on 9/08/2017 at 11:23 AM. It diele with bathing and that	F 2	79			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER		6	STREET ADDRESS, CITY, STATE, ZIP CODE 115 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 279	Continued From page	ge 76	F 279			
	(MDS) dated 06/08 she had a diagnosis received dialysis treatherapeutic diet.  Record review of a 08/16/17 revealed a and a right femoral times per week.  On 09/07/2017 at 5 Resident #8 was a conductive of the cord (MAR) when dialysis.  On 09/07/2017 at 5 that she referred to record (MAR) when dialysis.	rterly Minimum Data Set //17 for Resident #8 revealed s of chronic renal disease, ratment and was on a  discharge summary dated a left thigh fistula on 08/13/17 catheter and dialysis three  19 PM Aide #1 indicated dialysis patient.  51 PM, Nurse #9 indicated the medication administration she cared for residents with				
	on 6/8/17.  4. Resident #56 wa facility on 11/30/15 a 12/02/15. Resident facility again on 08/0	as originally admitted to the and was discharged on #56 was admitted to the 09/17 with diagnoses which offercare, diabetes mellitus, of gait and mobility.				
	08/09/2017 revealed present as follows: 'decreased mobility, medication usage" a therapeutic diet of d	ent nursing care plan dated d there were 2 problems "constipation related to use/side effects of and "resident is on a liabetic, cardiac due to past The problem of constipation				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573	)DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT	(X5) COMPLET DATE		
F 279	11/30/15, and the professed on 08/16/17. problems addressed care plan.  Review of the admiss (MDS) assessment of Resident #56 had dia part, heart failure, dia other specified afteroulcer, muscle weakned. The same MDS indic cognitively intact, requit bed mobility, toil and was totally depended with bed mobility, toil and was totally depended with the same M #56 had frequent paid to sleep at night and activities. The pain in the resident was "8" of with 10 representing.  The Care Area Asses 08/23/17 revealed the triggered for care pla would be care planned.	ted and last revised on oblem regarding the initiated on 12/01/15 and last. There were no other on the resident's current.  Sion Minimum Data Set ated 08/16/17 revealed agnoses which included, in abetes mellitus, encounter for are, non-pressure chronic ares, and abnormality of gait. ated Resident #56 was uired extensive assistance eting and personal hygiene, andent upon staff for bathing. In DS indicated that Resident in which made it hard for him limited his day-to-day intensity level assessed for on a scale of 1 through 10, the most severe pain.  Issment Summary signed on a following care areas anning, and that each area add: ADL function, falls, ssure ulcers, pain, and	F 27					
	plan of 08/09/2017 re areas of ADL function and return to the com	sident #56's current care evealed it did not address the a, falls, pressure ulcers, pain, imunity.						
		he received physical and						

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345004	B. WING _			09/12/2017	
NAME OF PROVIDER OR SUPPLIER PERSON MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573	DE		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
activities of daily living. frequent pain due to his surgery to amputate his to wait a long time to remedication to relieve hi not recall participating i the staff after his admis 08/09/17. Resident #50 been a resident in the frequency and he was going current stay in the facili.  On 09/10/17 at 9:37 AM conducted with the MD explained that she recefacility to fill the tempor nurse, and that she was MDS assessments and residents. She explained the care plan for Reside comprehensive and bas MDS assessment dated nurse reviewed Reside stated it was inadequat resident had a previous 2015, and that the interlast updated 11/30/15 in current needs. She stated develop his care plan least, the care plan sho problems and intervent current triggered care a orders, and Resident #stated that interventions surgical aftercare, active	thelp him with is core the his ability to perform his He also explained he had a arthritis and his recent a foot, and at times he had beceive repositioning or pain a pain. He added he did an a care plan meeting with a sion to the facility on a further stated he had not a caility since December of a to be discharged from his a ty on 09/09/17.  M, an interview was S Coordinator. She and yosition as the MDS a working on a backlog of a care plans for the facility's and that she was aware that and that she was aware that and the sed upon his admission and 08/16/17. The MDS and #56's care plan and be. She added that the a damission to the facility in a vention for constipation and that at the very and that at the very and have included a ions based upon the areas, the physician a fo's diagnoses. She also as to address his needs for a ities of daily living, a his skin conditions should	F 2	79			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		•	615 RIDG	DDRESS, CITY, STATE, ZIP CODE E ROAD RO, NC 27573	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	(DON) on 09/10/17 at the facility was trying assessments and car comprehensive asses a temporary MDS nur completing all compreso that care plans conthe residents' needs. 483.24, 483.25(k)(l) FOR HIGHEST WELL 483.24 Quality of life Quality of life is a fundapplies to all care and residents. Each residents. Each residents. Each residents at large and residents are an area to a services to attain or in practicable physical, well-being, consistent comprehensive assessment of care is a fundapplies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profession practice, the comprehensive and the resident plan, and the resident not limited to the facility Pain Management (k) Pain Management	rith the Director of Nursing 4:09 PM, she stated that to provide MDS e plans based upon the saments. She indicated that se was hired to help with chensive MDS assessments ald be individualized to meet PROVIDE CARE/SERVICES BEING  damental principle that discrives provided to facility lent must receive and the he necessary care and haintain the highest mental, and psychosocial that the resident's assent and plan of care.  endamental principle that he and care provided to ed on the comprehensive dent, the facility must ensure the treatment and care in essional standards of tensive person-centered sidents' choices, including following:		309	DEFICIENCY)		10/24/17
	-	re that pain management is who require such services,					

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F 309	the comprehensive and the residents' g  (I) Dialysis. The fact residents who requiservices, consistent of practice, the compart of practice, the c	essional standards of practice, person-centered care plan, oals and preferences.  dility must ensure that re dialysis receive such with professional standards prehensive person-centered esidents' goals and  IT is not met as evidenced eview and staff, resident, and staff, the facility failed to provide for pain dent #56.)  Idmitted to the facility on ospital as a short-term le diagnoses including cal amputation of the left foot.  It #56's current nursing care interventions for pain	F 30	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 chain or complete pain assessment. Nh #4 and Nurse Aides #2 and 6 were educated on pain management policy 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 affeby this deficient practice. Nursing state educated on pain management poly 10/13/17. All new hires nursing state will be educated on pain management during orientation. 100% residents with ordered pain medication will have a coplan audit to ensure a care plan is in for pain management by 10/24/17. Incorporation of the pain scale will be added for residents to evaluate pain I twice daily.	are urse by  ected ff will licy aff t th are place

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345004	B. WING			09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	·		
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F 309	(MDS) assessment dia Resident #56 had dia part, heart failure and same MDS indicated cognitively intact and made it hard for him this day-to-day activitive recorded on the asse of "1 through 10", with severe pain.  In an interview with R 10:34 AM, he stated the previous Friday (09/0) least an hour for som him with pain medicate remember exactly who medication, but he knour. Resident #56 of from his recent foot so back due to arthritis. repositioning helped the back pain and surgical strong enough that he patch or his oral pain further stated that his level 7 on a scale of 10 by the time he was gipain level was at 8. Froot the only time he hereceive pain medicativery long time for any for any of his pain iss	ion Minimum Data Set ated 08/16/17 revealed gnoses which included, in diabetes mellitus. The Resident #56 was had frequent pain which o sleep at night and limited es. The pain intensity level asment was "8" on a scale in 10 representing the most esident #56 on 09/09/17 at the had used his call light the 1/2017) and that it took at eone to respond to provide tion. He was unable to at time he called for pain ew it was a little over an explained that he had pain turgery as well as pain in his He added that sometimes his back pain, but both his all pain sometimes were eneeded the Lidocaine medication, Dilaudid. He pain in his back was at pain through 10 that Friday, but wen pain medication, his Resident #56 stated this was ad to wait a long time to on. He explained it took a one to answer his call light uses or other needs, so staff d pain medication until they	F 30	"The monitoring procedure to e the plan of correction is effective specific deficiency cited remains and/or in compliance with the re requirements; 25% of residents ordered pain medication will hav plan and pain medication mana- plan audited weekly for 30 days monthly for 60 days. Results of be reviewed for patterns and/or and reported at QAPI monthly fe months and then quarterly there "The title of the person respons implementing the acceptable pla- correction;  Director of Nursing or Designee	e and that s corrected egulatory with ve care gement and then audits will trends or three eafter. sible for an of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		LE CONSTRUCTION	\ , ,	(X3) DATE SURVEY COMPLETED	
		345004	B. WING	<del> </del>	ا ا	9/12/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	#56 received Dilaudion 08/30/17 and on 0 A review of the Septe Resident #56 had recommouth at 8:20 PM on An interview was cor PM with the Nurse #8 09/01/17 when Residual level 7. She stated	t 2017 Medication rd (MAR) revealed Resident d 1 mg by mouth at 3:43 AM 08/31/17 at 8:57 PM.  ember 2017 MAR revealed reived Dilaudid 1 mg by 1 09/01/2017.  rducted on 09/09/17 at 4:15 9 who was on duty on lent #56 reported having pain d if a resident had pain	F 30	9			
	plan for pain manage would check to see if ordered. Nurse #9 e scheduled Lidocaine and Dilaudid ordered address his pain. Sh Resident #56 compla how long it took to re that she would want	and typically refer to the care ement interventions and a pain medications were explained Resident #56 had a patch to be given once daily, as needed every 4 hours to be did not specifically recall aining of pain on 09/01/17 or spond to his call, but added to have pain medication way, especially if the pain					
	regularly, was intervishe stated that the remedication very ofter would expect for pair within 5 to 10 minute.  In an interview with n 09/12/17 at 2:50 PM, Resident #56 had as times, but did not speanswering his call lig	nursing assistant (NA) #6 on she stated she did recall the ked for pain medication at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		, 30.122011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 312 SS=D	buring an interview of 4:25 PM, she stated that he/she needed report it to the nurse explained she had be very short time and of with the residents ar problems. She did of Resident #56's call limedication on 09/01  During an interview of 09/12/17 at 3:18 PM was to provide pain possible after the resident that there is no pain.  483.24(a)(2) ADL Concept DEPENDENT RESIDENT RESIDEN	with NA #2 on 09/12/17 at if a resident reported to her pain medication she would as soon as she could. She een working in the facility a that she was not very familiar and which ones had pain not remember answering ight when he requested pain /2017.  with the on-call physician on he stated his expectation medication as soon as sident called for pain relief reason for a resident to be in ARE PROVIDED FOR DENTS  De is unable to carry out any receives the necessary good nutrition, grooming, and regione.  To is not met as evidenced  Dens, record review, and staff was, the facility failed to a manner to promote at #10) and failed to provide executed assistance with	F 31		e ent	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.12.20.1	
				615 RIDGE ROAD		
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 312	Continued From page	e 84	F 312			
				will be educated on appropriate ADL c	are	
	1. Resident #10 was	admitted to the facility on		and the ADL care policy by 10/13/17.		
		ses which included heart		and the second pency by server in		
	failure, hypertension,			" The procedure for implementing the		
	, ,,	,		acceptable plan of correction for the		
	A review of the most i	recent quarterly minimum		specific deficiency cited;		
	data set (MDS) asses	ssment dated 08/09/17		All residents that require assistance w	ith	
	revealed Resident #1	0 was cognitively intact, was		incontinence care and/or showers hav	e	
	incontinent of her blad	dder and bowel, and that		the potential to be affected by this		
		ndent upon staff for toilet use		deficient practice. Nurse aides will be		
		ident required extensive		re-educated on ADL care and		
		ff member for personal		incontinence care policies to prevent U	JTI	
	hygiene and for dress	sing.		by Director of Nursing or Designee by		
	A	-41		10/24/17. Care will provided as require		
		ath and incontinence care		and documented in POC as completed	1.	
	-	t #10 was made on 09/09/17		"The manifering precedure to ensure	that	
		g assistant (NA) # 7 and NA h using a washcloth, soap,		" The monitoring procedure to ensure the plan of correction is effective and t		
		ile Resident #10 lay on her		specific deficiency cited remains corre		
		perineal care using a		and/or in compliance with the regulato		
	-	and warm water, wiping front		requirements;		
		ng the washcloth with each		The Director of Nursing or designee w	ill	
		vas noted on the washcloth		make observations during incontinenc		
		e. The resident was turned		care on 2 nurse aides weekly to ensur		
	•	NA #7 noted there was a		appropriate practice. The Director of		
	large bowel movemer	nt on the buttocks. NA #7		Nursing or designee will make		
	used disposable wipe	es to clean most of the bowel		observations of residents scheduled to	be	
	movement, and then	she continued cleaning the		showered/shaved on 5 residents week	ily	
	buttocks with the was	shcloth with soap and water.		to ensure showers/shaves were provide		
		cks, drew a fresh basin of		as assigned and documented. Weekly		
		I bathing Resident #10's		audits will continue for 30 days and the		
		and the back of her thighs		monthly for 60 days. Results of audits		
	_	cloth and wearing the same		be reviewed for patterns and/or trends		
	gloves she wore while			and reported at QAPI monthly for three	•	
		nd NA #12 turned Resident		months and then quarterly thereafter.		
		re-bathed the perineal area				
		el movement had been		"The title of the person responsible fo	<u> </u>	
		rearing the same gloves and cloth that had been soiled		" The title of the person responsible fo implementing the acceptable plan of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING	<del></del>		09/12/2017
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C 615 RIDGE ROAD ROXBORO, NC 27573	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 312	completed, NA #7 approved the resident #10's pillow and then picked up the resident with pull A clean top sheet was All this care was prowearing the same pactean the bowel moved. In an interview with I AM, she stated she wash hands or chan bowel movement an remainder of the bat been instructed to us cleaning the rectal aperineum.  During an interview (DON) on 09/09/17 awould expect for the hand hygiene and us providing bowel incocontinuing the bath of the continuing the bath of the continuing the care and activity of daily I The most recent Mir quarterly assessment Resident #22 was mimpaired and require hygiene and total definitions.	nt. When the bath was oplied a clean pillowcase to w, placed it under her head, her clean shirt and assisted ling the shirt over her head. as placed over the resident. wided while NA #7 was air of gloves she used to	F3	correction; Director of Nursing or Desi	gnee	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING	<del></del>		09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 312	a plan of care for AD deficit related to den assistance by staff vor Review of the Karde documentation with showering.  Record review of the Resident # 22 revea Monday and Thursof Review of the shower revealed Resident # shower between 7:00 the shower sign off swas given.  Review of the point revealed no bathing documented for this for 09/04/17 reveale #22 7 AM-11 AM ar 11:00 AM- 3:00 PM.  On 09/05/2017 at 1:0bserved with an union of the deficiency of the point of the point revealed no bathing documented for this for 09/04/17 reveale #22 7 AM-11 AM ar 11:00 AM- 3:00 PM.	plan dated 8/16/17 revealed DLs self-care performance nentia. He required extensive with bathing and shower.  Ex dated 09/08/17 revealed no regards to bathing or  E shower schedule for led a scheduled shower on ays.  Er assignment for 09/04/17 22 was scheduled for a 0 AM -7:00 PM. Review of sheet revealed no shower  of care documentation or hygiene of any sort day. Review of the schedule d Aide #2 cared for Resident and Aide #4 care for him from	F 3:	12		
	showers.  On 09/07/2017 10:0 she was the shower	7:39 AM, Aide #5 indicated team. There was a list of showers each day, she				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			OATE SURVEY OMPLETED		
		345004	B. WING _			09/12/2017
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 312	completed. Shaving The aids also shaved facial hair. Showers and Saturdays. She worked on 09/04/17 Resident #22.  On 09/07/2017 12:57 showers were not do so short.  On 09/08/17 at 2:45 she cared for Reside 7:00 AM until 11:00 A and hands that day. She indicated the sh showers, shaved and care. She indicated facility for a week an shower were handle shower team.  On 09/08/17 at 2:50 there wasn't a shower had intended to shave unable to get to the to there wasn't a shower time to give showers residents.  On 09/09/17 at 11:26 indicated the expectateam to do the assign do the showers when team.	named after a shower was a was done in the shower. It when there was a lot of were scheduled on weekdays a indicated she had not and had not showered  7 PM, Aide #3 revealed that one because the staffing was  AM, Aide #2 indicated that one because the staffing was  AM, Aide #2 indicated that one had not shaved him. It was a worked for the did provided residents nail she had worked for the did wasn't sure how the ed when there was no  PM, Aide #4 indicated that were team on 09/04/17. She we Resident #22 but was ask. She revealed when were team there wasn't enough and provide care to all the shower on the showers and the staff to an there wasn't a shower wasn't a shower on there wasn't a shower on there wasn't a shower on there wasn't a shower of the shower on there wasn't a shower of the shower on there wasn't a shower of the shower of the shower on there wasn't a shower of the shower o	F3	312		
F 315 SS=D	483.25(e)(1)-(3) NO RESTORE BLADDE	CATHETER, PREVENT UTI, R	F 3	115		10/24/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRU AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	1 00/12/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 315	Continued From pag	e 88	F 31	5	
	continent of bladder a receives services and continence unless his or becomes such that to maintain.  (2)For a resident with on the resident's comfacility must ensure to the indwelling catheter is resident's clinical concatheterization was resident who entindwelling catheter of is assessed for remotas possible unless the	ters the facility without an not catheterized unless the notion demonstrates that			
	receives appropriate	incontinent of bladder treatment and services to infections and to restore ent possible.			
	on the resident's comfacility must ensure to incontinent of bowel treatment and service bowel function as possible.	receives appropriate es to restore as much normal			
		on, record review, nurse		" The plan of correcting the specific	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				E SURVEY PLETED	
		345004	B. WING _			09	/12/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		-
DEDCON	MEMORIAL LICERITAL			61	5 RIDGE ROAD		
PERSONI	MEMORIAL HOSPITAL			R	OXBORO, NC 27573		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 315	Continued From page		F3	15			
		physician (MD) interview,			deficiency. The plan should address th	е	
		nt and family interview, the			processes that lead to the deficiency		
		up on a urinalysis and			cited;		
	•	(UA C&S) that was ordered			Resident #130 was treated for UTI and		
		had experienced signs and			later discharged on 09/22/17. Residen	t	
		y tract infection. The facility			#10 was treated for UTI and is		
	-	perineal care in a manner to			asymptomatic as of 10/1/17.		
		rinary tract infection (UTI) had a history of UTIs. This			" The procedure for implementing the		
		ed residents reviewed for			acceptable plan of correction for the		
		vent and identify urinary tract			specific deficiency cited;		
		#10). Findings included:			All residents have the potential to be		
		o,agee.aaea.			affected by this deficient practice. Lab		
	1. Resident #130 wa	s admitted on 8/16/17. Her			results are reported directly in EHR an	d	
	admitting diagnoses i				are to be reviewed timely by the charge		
		shoulder, pain in right wrist,			nurse. Nurses were educated on lab		
	muscle weakness, ga	it and mobility abnormalities			results tab on 09/25/17. New nurses w	ill	
	and hypertension.				be educated on lab results process du	ring	
					orientation. Nurse aides #7 and 13 we	ere	
		et assessment was dated			educated on appropriate ADL care by		
		t's cognition was moderately			10/13/17 by the Director of Nursing.		
	•	Interview for Mental Status					
		uired extensive assistance			" The monitoring procedure to ensure to		
	•	oileting and she was not			the plan of correction is effective and the		
		d off the toilet. She was			specific deficiency cited remains correct		
		sident #130 had an activity elf-care performance deficit			and/or in compliance with the regulator requirements; Lab results will be recon-	•	
		oility, limited range of motion,			on MAR and results will be reviewed vi		
		irment and pain all due to			lab/results tab in EHR. Lab tracking for		
	fractures suffered in a	•			will be utilized to track ordered labs to		
					ensure completion and review of result	ts.	
	A nurse practitioner (	NP) progress note dated			The Director of Nursing or Designee w		
		M stated in part, "Her (family			audit 100% labs weekly for 30 days an		
		patient complaint of painful			then 50% monthly for 60 days.		
		and she noted pink tinge to			•		
		ure was taken and it was			The Director of Nursing or designee wi	II	
	normal A thorough	assessment was performed.			make observations of 2 nurse aides		
		ollow up on lab tests with			during incontinence care weekly for 30		
	appropriate orders to	follow"			days then monthly for 60 days to ensur	re	

Facility ID: 953396

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			9/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 315	On 8/31/2017 at 5:23 was written and said, white mucus discharg notified". New order complete blood count family was notified.  On 9/2/2017 at 2:50 A was written and said, white discharge from Her vital signs are stated on 9/3/2017 at 8:24 F was written and said that urinalysis (u/a) wyet be obtained. Fam himInformed him o and again about the ubasal metabolic pane antibiotic, Levofloxaci attempt to obtain u/a white discharge noted Encouraged her to drobtain u/a sample on results pending. Deni A telephone order wa CBC, BMP, UA & C& infection (UTI) - Levor per oral (PO) daily for On 9/4/2017 at 9:16 A read, in part, "Lab read, in	PM a Health Status Note "Resident was noted having the from vagina (NP) was was given to obtain UA and (CBC). Resident and  AM a Health Status Note "her family reports a vaginal area, np is aware. table and she is afebrile".  PM a Health Status Note the physician was notified as ordered on 8/31 had not tily wished to speak and see of her most recent vital signs tal. He ordered STAT CBC, I (BMP) and U/A c&s, an on, was started. "The first was unsuccessful, noted of in collection tube. The first was unsuccessful, noted of in collection tube. The first was unsuccessful, noted of in collection tube. The first was unsuccessful, noted of in collection tube. The first was unsuccessful, noted of in collection tube. The first was unsuccessful, noted of in collection tube. The first was unsuccessful, noted of in collection tube. The first was able to second attempt. STAT labs the samp pain or discomfort." The first was unsuccessful, noted of the collection tube. The first was able to second attempt. STAT labs the samp pain or discomfort." The first was able to second attempt. STAT labs the samp pain or discomfort." The first was able to second attempt. STAT labs the samp pain or discomfort." The first was able to second attempt. STAT labs the samp pain or discomfort." The first was able to second attempt. STAT labs the samp pain or discomfort. The first was able to second attempt. STAT labs the samp pain or discomfort. The first was able to second attempt. STAT labs the samp pain or discomfort. The first was able to second attempt. STAT labs the samp pain or discomfort. The first was able to the samp pain or discomfort. The first was able to the samp pain or discomfort. The first was able to the samp pain or discomfort. The first was able to the samp pain or discomfort. The first was able to the samp pain or discomfort. The first was able to the samp pain or discomfort.	F3	appropriate practice. Var shared with the Nurse Air for remediation. Results reviewed for patterns and reported at QAPI monthly months and then quarter.  " The title of the person reimplementing the accept correction;  Director of Nursing or Description.	de immediately of audits will be d/or trends and y for three ly thereafter. esponsible for able plan of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 315	different antibiotic.  An NP progress note indicated intramuscul started and the previor "Organism was sensi however, clinically shable to sit up in bedsimentally clear." Shable to sit up in bedsimentally clear Shable to sit up in bedsimentally shable to	dated 9/7/2017 at 11:52 AM ar Rocephin had been ous antibiotic was stopped. tive to both agents, e was not improving. With owing improvement and is de chair today and more he has improved with a simproved with a simproved with a simproved with a series of a simproved with a simproved another UA on Levaquin. She had no then put her on Rocephin. The sident. He said it would have a sident. He said it would have a sident. He said it would have a sident and a UA C&S. Now why the sample was not be family said there was pushes suggested a problem. He he labs CBC & BMP were in record indicated Resident ange from 8/31/17 - 9/3/17	F 315			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE (X7) MUL		(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017
	ROVIDER OR SUPPLIER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD ROXBORO, NC 27573	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 315	On 9/08/2017at 7:59 interview Resident # symptoms of UTI. Solution and did not reme observation of care.  Nurse #9 was interv AM about her action collected the urine a around lunch time. asked how to obtain by in and out cathete was in the room. I proceed the process of the collected that the collected the urine a process of the collected that the collected the urine and urine urin	ge 92  2 AM an attempt was made to e130 about her signs and the said she was sleeping a mber. She declined  iewed on 9/09/2017 at 10:50 as on 8/31/17. She said, "I and sent it to the lab. It was the NP gave me the order. I the specimen and was told erization. A family member out a label on the specimen. I e. I put it in a biohazard bag.	F 315		
	I saw the lady in the put label in the companies shift nurse and sent three days. I came resident was on an a On 9/09/2017 at 10: said Nurse #9 claims specimen and took in the companies of the put label in the companies and sent label in the put label in the companies and sent label in the put label in the	lab. I put it in the basket. I puter. I reported off to next to lab. I was off the next back on 9/4/17 and the			
	sample was obtaine She said there shou back to process. I've nurses about how w	d. I am still investigating." Id not be a delay. "It goes had conversations with			
	member confirmed to on 8/31/17. On 9/9/	he specimen was collected 17 at 11:00 AM Resident er confirmed the specimen			
	03/29/16 with diagnoral failure, hypertension	s admitted to the facility on oses which included heart and hyperlipidemia. A sented diagnoses in the			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345004	B. WING			09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 315	urinary tract infection 07/26/2017 revealed to the bacteria found. The July and August Administration Record had received Rocept once daily beginning 08/02/2017 to treat at A review of the most data set (MDS) asservealed Resident #1 incontinent of her blashe was totally dependent bathing. The resussistance of one stathygiene.  An observation of a begrowing for Residen at 11:19 AM. Nursing #13 provided for Residen at 11:19 AM. Nursing #13 provided the bath and warm water. Whosek, NA #7 provided washcloth with soap to back 3 times, folding wipe. Some light browashcloth after the set the washcloth in the least three was a large both buttocks. NA #7 use most of the bowel mocontinued cleaning the washcloth with soap washcloth with soap washcloth with soap.	sted she had a history of s, and a lab report dated Resident #10 had a UTI due in stool, E. Coli.  2017 Medication ds for revealed Resident #10 hin (antibiotic) one gram, 07/21/10 through UTI.  recent quarterly minimum asment dated 08/09/17 0 was cognitively intact, was dder and bowel, and that hident upon staff for toilet use sident required extensive off member for personal was made on 09/09/17 gassistant (NA) # 7 and NA the using a washcloth, soap, hile Resident #10 lay on her diperineal care using a and warm water, wiping front hing the washcloth with each win color was noted on the econd wipe. NA #7 rinsed to be as in of water. The resident e, and then NA #7 noted well movement on the didisposable wipes to clean ovement, and then she he buttocks with the same and water. NA #7 dried the	F3	15		
		h basin of water, then ith the same washcloth that				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345004	B. WING			9/12/2017	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 315	same gloves. NA #7 buttocks. When the r back, perineal care w all the bowel moveme #7 continued to wear the same washcloth t NA #7 then applied zi area as she continue gloves worn to clean #7 did not wash her r throughout the entire care procedure, or pe In an interview with N AM, she stated she h wash hands or chang bowel movement and remainder of the bath applying a zinc paste added she had not be washcloth after clean cleansing the perineal that using bowel cont gloves during perineal at risk for UTIs.  During an interview w (DON) on 09/09/17 at would expect for the hands and change gli incontinence care and or providing perineal would expect the NAs procedure. The DON should not have beer using the same glove	e present and wearing the applied a zinc paste to the resident was turned to her was provided again to ensure ent had been removed. NA the same gloves and use to provide the perineal care. Sinc paste to the front perineal d to wear the same pair of the bowel movement. NA mands or change gloves bathing and incontinence erineal care procedure.  IA #7 on 09/09/17 at 11:46 and not been educated to ge gloves after cleaning and before continuing the ence instructed to use a clean ing the rectal area. She ere instructed to use a clean ing the rectal area, before um, and she did not know the aminated washcloths or all care could put the resident with the Director of Nursing the force continuing the bath care. She also stated she in applied to the perineal care in applied to the perineal care in applied to the prineum is used to clean the bowel owledged the procedure.	F 3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 319 SS=E	MENTAL/PSYCHOSO  483.40(b) Based on to assessment of a resist that-  (b)(1) A resident who with mental disorder difficulty, or who has post-traumatic stress appropriate treatment assessed problem on practicable mental art This REQUIREMENT by:  Based on interviews nurse practitioner, and record reviews, the fapsychiatric service to resident 's needs and psychotropic medicat capable of affecting to behavior) in the treatment residents reviewed for (Resident #10).  The findings included Resident #10 was ad 3/29/16. The resident included schizoaffect depressive disorder (A review of the resident physician Orders included physician Orders included in part:2 milligrams (mg) risident who with the resident physician (mg) risident physician (mg)	the comprehensive dent, the facility must ensure displays or is diagnosed or psychosocial adjustment a history of trauma and/or disorder, receives t and services to correct the to attain the highest ad psychosocial well-being. It is not met as evidenced with the staff, pharmacist, and Medical Director, and acility failed to provide a assess and evaluate the did the appropriate use of the	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 psychotropy medications. Pharmacy recommendation for GDR reviewed by NP with decision continue current orders, as followed by psych. Upon further review it was determined Resident #10 had seen LS' but not psycho recently. Attending practitioner will review Resident #10s psychotropic medications by 10/10/17. New order for Psycho consult on 09/08 and appt scheduled for October 23, 20.  "The procedure for implementing the acceptable plan of correction for the specific deficiency cited; All residents with orders for psychotropy medications and recent denial for GDR will have a psych consult. Pharmacy recommendations will be reviewed and signed by DON and Attending Physicia.	pic pins to W	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE C  A. BUILDING		CONSTRUCTION	· /	ATE SURVEY MPLETED	
		345004	B. WING			,	09/12/2017
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	07.12/2011
				61	15 RIDGE ROAD		
PERSON I	MEMORIAL HOSPITAL				OXBORO, NC 27573		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
F 319	Continued From pag	e 96	F3	319			
	disorder, bipolar type	à:			within 30 days of pharmacy review.		
		given as 1 tablet by mouth			Pharmacy will communicate outstandi	na	
		ne related to schizoaffective			items to DON during monthly consulta		
	disorder, bipolar type				visits. Medical Director was provided		
		an antidepressant) given as			education on psychotropic medication		
	_	ery day related to major			regulations by the Director on Nursing	on	
	depressive disorder,			10/04/17; other attending practitioners			
	30 mg duloxetine (a			were provided education by Quality			
	capsule by mouth ev			Director on 10/4/17.			
	depressive disorder,						
	,	antidepressant) given as 1			"The monitoring procedure to ensure		
	tablet by mouth ever			the plan of correction is effective and t			
	depressive disorder,			specific deficiency cited remains corre			
		an antidepressant) given as			and/or in compliance with the regulato	гу	
	· ·	ery day related to major			requirements; The Director of Nursing will qudit Mon	·hlv	
	depressive disorder,	antianxiety medication)			The Director of Nursing will audit Moni pharmacy recommendation for GDR for	-	
		y mouth twice daily for			accuracy of reason of declination by	,,	
	bipolar and anxiety.	y moder twice daily for			attending practitioner for the next 90 d	avs	
					Discrepancies will be addressed for	٠,٠.	
	A review of the resid	ent's medical record included			clarification. Results of audits will be		
	a notation made by F	Resident #10's former			reviewed for patterns and/or trends an	d	
		15/16) written in response to			reported at QAPI monthly for three		
	a Consultation Repo	rt (dated 9/27/16) from the			months and then quarterly thereafter.		
	facility's consultant						
		reported Resident #10			" The title of the person responsible fo	r	
		ssants in addition to an			implementing the acceptable plan of		
		tianxiety medication. The			correction;		
	pharmacist indicated				D: / (N) :		
		ts with the same (or similar)			Director of Nursing		
	•	duplication of therapy and eed for four antidepressant					
	agents be re-evaluat	•					
	consideration be give						
	_	· ·					
	discontinuing use of one or more (perhaps citalopram or paroxetine) to avoid the risk of side						
		an declined the pharmacist's					
		11/15/16 with a notation that					
		ych (psychotropic) meds					

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  EACH DEFICIENCY MUST BE PRECEDED BY FULL  EEGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PROVIDER'S PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 319	changes were made.  A review of Resident Orders revealed the resume psychotropic merisperidone, citalopra paroxetine, and diaze.  Further review of the included a Consultatic consultant pharmacis 3/14/17. The Consult Resident #10 receive addition to an antipsy medication. The phaindicated the need fowith the same (or similar duplication of therapy be re-evaluated with tapering the citalopra declined the recomme "Long standing h/o (hillness-meds eval (ev changesno med charmal consultant pharmacis 3/14/17. The	#10's March 2017 Physician resident continued to receive ic medications in the same lered in November 2016. dications included m, duloxetine, Fetzima, spam.  resident's medical record on Report from the t dated ration Report indicated d 4 antidepressants in chotic and antianxiety rmacist recommendation r four antidepressant agents illar) action represented a r and suggested the regimen consideration given to m dose at this time. The NP endation on 4/15/17, noting istory of) mental aluated) by psych with no ange at this time."	F3				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 319	pharmacist dated 5/7 Report indicated diagram dication and considue to the increased confusion, addiction report acknowledged diazepam and recomgiven to tapering down declined the pharma 7/17/17 with a notation assessed by psychorolog term psych medical diazepam)."  Further review of the included a Consultation Report received paroxetine, dry mouth, constipation vision, and increased pharmacist also note additional antidepresion antianxiety medical recommended consideresises for side effects. The side effects. The side effects. The side effects are made to her lond Paxil (paroxetine)."  A review of the residal a 7/17/17 Consultation from consultant pharmacist recommendations medical recommendation recommendations medical recommendations medical recommendations med	rt from the consultant 17/17. The Consultation repam was a long-acting idered a high risk medication risk of sedation, depression, and falls in the elderly. The I the recent dose increase of mended consideration be with the dose. The NP cist's recommendation on on that read: "Recently no changes were made to her is including Valium  resident's medical record ion Report from the st dated 6/9/17. The indicated the resident which increased her risk for on, urinary retention, blurred if confusion/sedation. The did the resident received 3 reants, an antipsychotic and ation. The report deration be given to of paroxetine due to the risk NP declined the pharmacist ' in 7/17/17 with a notation that ressed by psych-no changes ring term psych meds included on Report (noted as a repeat in 5/17/17) from the st. This report reiterated the	F3	19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING	<del></del>	09/12	/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		-
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 319	notation that read: "med rec (medication changes made - will  A review of Resident Orders revealed the the same psychotrop dosages as her Novexception of the dos 5/11/17. The psychorisperidone, citalopra paroxetine, and diaz  A review of Resident Minimum Data Set (18/9/17 indicated the skills for daily decision MDS reported the rescore of zero (0); Se exhibited no behavior Section N of Residers she received an anti-	nendation on 8/22/17 with a Psych eval completed with reconciliation) done and no continue current regimen."  ##10's August 2017 Physician resident continued to receive bic medications in the same ember 2016 orders, with the enderease for diazepam on otropic medications included am, duloxetine, Fetzima, repam.  ##10's most recent quarterly MDS) assessment dated resident had intact cognitive for making. Section D of the sident had a mood severity ction E indicated the resident for nor rejection of care.  ##10's assessment revealed psychotic, antidepressant, incation on 7 out of 7 days	F 3			
	dated) included the fresident uses psychologoper depression, anxiety, Revised on 6/28/16)  An interview was con AM with the NP caring the interview, the NF Resident #10 received medications, including stated the resident had an expectation of the stated the resident had a state	ent's current care plan (not collowing area of focus: The cotropic medications related to and insomnia (Initiated and collowing for Resident #10. During or reported he was aware end multiple psychotropic and a longstanding history of and had been on the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017
	ROVIDER OR SUPPLIER		61	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD OXBORO, NC 27573	,
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 319	Resident #10 was a psychiatric service a any changes to her NP stated he did no recommendations to medications and correductions because adjusted by a psychiatric service he stated "No, she we evaluation." He was resident was seen but A review of the resident was seen but A review of the resident was seen but A review of the resident was seen for a psychiatric service documentation to in been seen for a psychiatric service with the fact The pharmacist reported she though the program of the past An interview was conformed the facility, Resident #10 program one time or confirmed the report received by the facility the facility of the program one time or confirmed the report received by the facility the facility of the facility of the program one time or confirmed the report received by the facility the facility of the fa	sime. The NP reported ssessed and evaluated by a and they opted not to make medications at that time. The tagree with pharmacist preassess Resident #10's nsider gradual dose he felt such meds were best iatric service. When asked if a was following the resident, was seen as a one-time only is not certain of the date the py the psychiatric service.  Ident's paper and electronic alled there was no dicate the Resident #10 had chiatric evaluation.  In was conducted on 9/9/17 at cility's consultant pharmacist. Forted she was aware in multiple antidepressants is these could be ever, the pharmacist reported was addressed, her is declined. The pharmacist at the resident was being seen	F 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  B	1 ' '	(X3) DATE SURVEY COMPLETED	
		345004	B. WING	<del> </del>	09	/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 319	definitely was not a proposition of the proposition	n. The DON stated, "It most beychiatric evaluation." The dent #10 had not been seen ice at any time over the past ince her admission to the vas conducted with the actor on 9/9/17 at 4:15 PM. A sident #10's medical history ing her medication regimen e Medical Director. At that ector identified the ovider who saw Resident #10 cal Social Worker. Since long-term care resident, the cated he would have had a psychiatric evaluation of follow up. He stated, on-going assistance for ins from psych."  was conducted on 9/12/17 NP. During the interview, as now his understanding the en by a Clinical Social mission to the facility. The ereport written by the er recommended a in be completed. The NP deen working under the atric evaluation had been sident. The NP stated he on 9/8/17 and requested in by a psychologist for a	F 31	9		
F 323 SS=J		n and medication review. -(3) FREE OF ACCIDENT ISION/DEVICES	F 32	23		10/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345004	B. WING _	<del></del>	09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 323	Continued From page	e 102	F3	23		
	(d) Accidents. The facility must ensu	ure that -				
	(1) The resident envii from accident hazard	ronment remains as free s as is possible; and				
		eives adequate supervision es to prevent accidents.				
	appropriate alternative bed rail. If a bed or simust ensure correct in	ails, including but not limited				
	(1) Assess the reside from bed rails prior to	nt for risk of entrapment installation.				
	` '	and benefits of bed rails with nt representative and obtain or to installation.				
	This REQUIREMENT by: Based on observation interview and record provide functioning capathrooms so that if a summon staff for ass and prevent an accided bell was not working	sident's size and weight.  is not met as evidenced  in, resident interview, staff review, the facility failed to all bells in resident a resident needed to istance, they could get help ent from occurring. The call in the bathroom for 2 of 2		The plan of correcting the specific deficiency. The plan should addre processes that lead to the deficiencited;  a. Resident #103 was discharge on 4/22/2017 with family. There we further documentation of or attemptions from the 4/40/2017.	ss the ncy ed home was no ot to	
	their rooms (Residen facility also failed to s	no used the private bath in the thick the thic		elope from time of the 4/16/2017 i until discharge. Following the inci 4/16/2017, the Director of Plant Operations performed an assessn	dent of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From page 103 (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			the elopement system by ter alarm sensors and found the working properly. The elevations re-positioned to provide sensitivity to the resident branches along the system.	em to be ator sensor e greater acelets. The	
	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.			elevator RoamAlert system enhanced to provide automa when a sensor is in the sensor.  b. Resident #38 resided in 9/8/2017, the resident was phand bell to use in the batter.	ated shut-off sitivity zone. In room 201, on provided with a room. Her call	
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			c. Resident #66 i. Resident #66 i. Resident #66, was re-a therapy on 9/20/2017 and the care plan was updated on 9 reflect the most current leve assistance needed with tran toileting. The interventions plan are identified as tasks a the Kardex which is reviewe staff. ii. Resident #66 (who resident) 262) was initially provided a use in the bathroom. The R then moved to room 263 with functioning call bell. Parts w and the call bell in room 262 on 9/15/17. The resident is room 263 and has remained	ssessed by the resident solution is resident solution in the care and linked to the dot of the care solution is resident was the action of the care solution in the care solution in the care solution is resident was the action in the care ordered action in the resident in the care ordered action in the resident in the care ordered action in the resident solution is repaired to the care ordered action in the resident solution in the resident so		
		as admitted to the nursing er admission Minimum Data d she had diagnoses		iii. Weekly interviews with started on 9/20/17. Weekly be conducted with Resident social worker and/or design weeks to ensure that her ca functional and that staff are	interviews will #66 by the ee for four Il bell is	

Facility ID: 953396

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345004	B. WING _	B. WING		09/	12/2017
	IDER OR SUPPLIER			61	TREET ADDRESS, CITY, STATE, ZIP CODE  15 RIDGE ROAD  OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 323 Co	ontinued From page	e 104	F:	323			
ind district and d	cluding hypertension sease, septicemia, on Alzheimer's demonantial	in, peripheral vascular diabetes mellitus, entia, depression, reakness, abdominal pain, ed abscess of left leg below re for below knee o-esophageal reflux  et (MDS) assessment dated was moderately impaired in tensive assistance from one ressing and toilet use. She moving on and off the toilet lize with staff assistance. y and she received both sical therapy during the The Care Area Assessment ally living, urinary would be addressed in the risks and avoid  /17 indicated all problems esolved. A new care plan risks and avoid  /17 indicated diet.  ional therapy (OT) notes, working with occupational oals were set for lower body giene and toileting transfer. It is needing assistance in lower body		323	requests for assistance with toileting in appropriate and timely manner. Any variances will be communicated to the facility leadership team during the hudwhich 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 ri assessment. If the risk assessment determines that the resident is at risk of elopement, the resident is plan of care will be updated to include interventions 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 assessment will be completed on admission / re-admission, quarterly, and whenever resident experiences a significant char in condition that would impact their risk elopement. Elopement risk assessment are completed by a licensed nurse.  b. The facility has reviewed, revised, 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 9/28/20. The Plant Operation Director also order additional bracelets for residents, an additional testing device, and provided	sk of es the nge for nts and or	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		I DENTIEICATION NUMBED:		MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED	
		345004	B. WING			9/12/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	.071272017	
				615 RIDGE ROAD			
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From page	e 105	F 32	23			
. 020	Continued From page	. 100	1 32	additional training materials	to the unit		
	A Fall Event report in	dicated Resident #66 had an		The training materials includ			
		ay, 8/27/17 at 10:00 AM. It		on proper application of the			
	said, The Certified N			storage of the transponders.			
	· ·	h transfer from bed to					
	_	sisted resident to the floor.		c. The facility protocol for	checking the		
	There was no harm a	and the Therapy Director		resident safety bracelets and			
	provided education to	the CNA on transfers. A		of doors that have alarms wa	as reviewed		
		cal therapy note dated		on 9/21/17 by the DON and			
		rse Aide #10 was "trained in		multiple huddle meetings. A			
	_	fer to support fall prevention		worn by residents will be che			
	_	attempt to interview NA		placement during each shift.			
		the weekends, was made at		bracelets will be checked for			
	director on 9/12/17	. Interview with the therapy		each week. These placeme functionality checks and will			
		sisted fall over a weekend.		documented in the resident			
		oom and her leg buckled.		record (Point of Care) by the			
		said she was working that		began on 9/25/17. Non-func			
		#10 how to transfer her using		bracelets or bracelets that ha			
	the grip bars.	3		removed will be replaced im	mediately		
				upon discovery. The DON of	or a designee		
	On 8/27/17 a Fall Ris	sk Assessment was done.		will monitor the electronic da	shboard at		
		to need assistance with		least 3 times per week in the			
	elimination and was uposition and a recent	unable to come to a standing fall.		medical record to identify va	riances.		
				d. An additional supply of l			
		I for September had entries		transponders for the Roam A	-		
	for toilet use every sh	nift on 9/1, 9/3, 9/5 & 9/6.		are maintained at the nurses			
		(0.7)		accessibility when a resident	t is		
		upational Therapy (OT)		determined to be at risk.			
	therapy notes dated s			o The organization (#ili-sa	n the Beem		
	· ·	assistance with lower body proved in toileting - transfers		e. The organization utilizes  Alert Intelligent system that			
		y transfer to the toilet with		monitors the functionality of		<b> </b>	
		ng -minimum assistance for		elevator alarms. In the even			
	toileting routine.			malfunction in the door or ele			
	15.151.19 1541.16.			an alert shows on a designar	,		
	Resident #66 was int	erviewed on 9/06/2017 at		located at the nursing station			
		sometimes she was treated		an alert, staff will immediatel			

Facility ID: 953396

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING _	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (  (EACH CORRECTIVE A:  CROSS-REFERENCED TO  DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	don't come and they have to wait until som out."  On 9/07/2017 at 10:0 "At home I used pull there, I use the ones staff get me to the toi When I press the call the walker before I caexercises in my room call them, is a problet sometimes on second Nurse Aide (NA) #6 wat 10:22 AM about he provide residents. Staget to know the routin (Resident #66) will pelikes to use the commigust in case. She will The nurse aide's Doof for September 7, 201 entry for that day. It a individualized instruction toileting.  A Health Status Note read in part, alert and forgetfulness at times assist with activities of for oral care and mea AM 236, receives insorder.  On 9/07/2017 at 4:25 observed in her prival	ect and added, "When they are short of help, you just neone comes and helps you  8 AM, Resident #66 said, ups and used the toilet. that fasten on the side. The let two to three times a day, bell they will come. I used time. Therapy gives me sometime. Coming, when I m. Mostly on days	F3	Operations for repair and maintained for the reside On 9/21/2017, the Director Operations contacted the company of the alarm systems were functional. of the alarm function trace be completed beginning 19/25/2017.  f. Key members of the team have huddle meeting through Friday to report proportional above actions and to idea opportunities to minimize neglect. A spreadsheet is has enhanced the organismeeting and strengthenes the discussion. The leader composed of the Adminism Nursing, Director of Qualtof Human Resources. As will be provided by the Claurical Services, Chief Nand Director of Plant Operations of Plant Operations and to idea opportunities to minimize neglect. A spreadsheet is has enhanced the organismeeting and strengthenes the discussion. The leader composed of the Adminism Nursing, Director of Qualtof Human Resources. As will be provided by the Claurical Services, Chief Nand Director of Plant Operation of Plant Operation is expecific deficiency cited in and/or in compliance with requirements;  The Director of Quality or Director	nts during repair. or of Plant e service stem and icated that all Weekly review king system will the week of  facility leadership ngs daily, Monday progress on the ntify new abuse or s maintained and zation of the d the structure of ership team is strator, Director of ity, and Director djunct support EO, CFO, Social President of Jursing Officer, erations.  been heightened interviews, and above. e to ensure that emains corrected in the regulatory		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING			9/12/2017	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		<u> </u>	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 323	tightly gripping the griback herself into her approximately the salpassing by Resident had to take vital signs said Resident #66 go own if she feels like it came out of the bathrangry voice, "I LIKE BRITCHES UP." NA assist Resident #66.  According to the bloorecord and the medic (MAR), the Resident as 499 at 5:23 PM or insulin was administed Interview with Nurse revealed Resident #65. She needed assistant still working with them.  On 9/08/2017 at 7:54 asked if she had put let the aide know she call bell was not work surveyor tested the coutside the door or rid.  On 9/08/2017 at 7:58 the Unit Secretary that #66's bathroom was at the first time she had.  On 9/08/2017 at 8:13 Person #1 and #2 arrup, but not working."	eared anxious and was ab bar and struggling to wheelchair. At me time NA #15 was #66's room. She said she is and blood sugars. She is to the bathroom on her it. At 4:30 PM Resident #66 room and said in a loud and FO FELL AND NEED MY #15 went in the room to wide sugar (BS) monitoring reation administration record #66's BS was documented in 9/7/17. Twelve units of ered by Nurse #4. #3 on 9/08/2017 at 11:15 am 66 was alert and oriented. It is a more with transfer and she was apy.  AM Resident #66 was on the call bell yesterday to eneeded help. She said the sting in the bathroom. The all bell and it did not light and at the nurses' station.  AM the surveyor informed at the call bell in Resident mot working. She said it was	F 32	conduct unannounced missin drills at least weekly for 4 wee beginning the week of 9/25/20 day and evening shift, and the thereafter. Staff responses to be documented to identify are improvement and additional expensive other correction will be made Results of audits will be revier patterns and/or trends and re QAPI monthly for three month quarterly thereafter.  The title of the person respons implementing the acceptable correction;  The Director of Quality or Design of the person for the person f	eks, 017, on both en monthly the drills will eas for education or as needed. wed for ported at ns and then sible for plan of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING (X3) DATE SUF			ATE SURVEY DMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	·	
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F 323	side of the commode height on the other sineither worked. The Person #1 said, "I've works."  Surveyors initiated cat 10:00 AM. Four monot working. These wand shared bathroom.  On 9/08/2017 at 10:5 she calls maintenance the bathroom that does on 9/08/2017 at 11:1 interviewed about cal aware of a call bell reget in contact with the would call his pager of Nurse #3 was asked resident to use to call have bells and would Immediately following distributing hand bells other residents who obells.  On 9/08/2017 at 11:2 Operations was interviewed about a proble call. We would not chan as needed basis.	and another about knee de of the commode and Contract Maintenance tried both and neither  all bell checks on 9/08/2017 ore calls in bathrooms were vere in rooms 201, 265, 270 240 and 241.  8 AM, the Administrator said e when there is a call bell in esn't work.  5 AM Nurse #3 was I bells. She said, "I am ported not working. I would e Maintenance Director. I or leave a message. When about other means for the for help, she said, "We have to find them". I the interview she was seen to Resident #66 and to the lid not have functioning call  5 AM, the Director of Plant viewed. He said, "If we get a m, then we get a service neck other call bells. It is on He confirmed that the call bathroom room did not	F3	23		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION		
F 323	Therapist was interviewed with Resider to toilet. She said, "person assistance. assist and cues for some safety training. She needed contact done safety training. She added, "Typical her. She is good about a would not recomme she can self-propel compliant. The safe been an issue (i.e., huge thing."  Resident #66 was in at 4:20 PM. She sayesterday and could dangerous."  On 9/09/2017 at 10: was interviewed. She sayesterday and could dangerous."  On 9/09/2017 at 10: was interviewed. She heeded supervision She needed a nurse diagnosis of dementimes. Resident #66 confusion. She had assisted fall with sta of wheelchair and she Director of Rehab proposed in the same shadow in	7 PM the Occupational riewed. She said she had at #66 on functional transfers Initially she needed two Now she needed minimum safety and hand placement. It guard assistance. We've with nurse aides in the room. It, someone would be with rout calling if she needs help. It is wheelchair. She is sety awareness has already thand placement). Safety is a sterviewed again on 9/08/2017 id, "I tried to get someone in't find anyone. It was the confirmed that Resident ance from one person and with activities of daily living. It is aide (NA) due to her in the confirmed that Resident ance from one person and with activities of daily living. It is aide (NA) due to her in the confirmed that for get up. She had one of the did not wait for assist. The rovided education to the CNA. It is administrator was rediate jeopardy.	F 323				

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	•	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 323	assessment reference her cognition was some dressing, transfer a independent. A care of 10//17 included a ADLs and for falls i resident to use bell "The resident need floors free from spill light; a working and personal items with Her care plan dated able to toilet independent of the bathroom did not work on 9/08/2017 at 10 she calls maintenant the bathroom that contact the Mainter problem was noted leave a message."	num Data Set had an noce date of 7/11/17 indicated severely impaired. Her and toileting ability was e plan with a review start date approaches for problems with indicated, "Encourage the to call for assistance" and is a safe environment with its and/or clutter; adequate if reachable call light and in reach."  If 7/20/2017 indicated she was endently.  Call bell checks on 9/08/2017 call bell in Resident #38's tork when tested.  Its AM, the Administrator said ince when there is a call bell in doesn't work.  Its AM Nurse #3 was call bells. She said she would mance Director if a call bell.  It would call his pager or When Nurse #3 was asked	F 323			
	for help, she said, " to find them". Immshe was seen distri #38 and to the othe functioning call bell On 9/08/2017 at 11	for the resident to use to call tWe have bells and would have ediately following the interview buting hand bells to Resident er residents who did not have s.  25 AM, the Director of Plant erviewed. He said, "If we get a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING			09/	12/2017
	ROVIDER OR SUPPLIER		•	61	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	call. We would not chan as needed basis. bell in Resident #38's work.  On 9/09/2017 at 11:0 observed in Resident On 9/08/2017 at 11:2 Operations was intervreport about a problet call. We would not chan as needed basis.  Interview with NA#8 or revealed Resident #3 activities of daily living her own. 3. Resident #103 was 4/10/17 with multiple dementia. The resident was disc 4/22/17.  The attending physici 4/10/17, had early on There was no written, Resident #103's clinic A Nurse's Note, writte 4/14/17 at 7:52 AM st times on PM (evening attempting to go in otknocking. Combative shift. Hitting and kicki provided. Refused pa	m, then we get a service neck other call bells. It is on He confirmed that the call bathroom room did not  5 AM a hand bell was #38's bathroom.  5 AM, the Director of Plant viewed. He said, "If we get a m, then we get a service neck other call bells. It is on  10 9/12/17 at 11:52 AM  11 8 was very independent with g and used the bathroom on admitted to the facility on diagnoses including charged to the community on an's admission note dated set, advanced dementia.	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
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F 323	A Nurse's Note, writt 4/15/17 at 8:31 AM, become combative a dose of Haldol 5 mill administered at 6:16 an antipsychotic drug psychosis.  The facility was unat Assessment for Resi about when a wande Resident #103.  The admission comp Set (MDS) was in pre completed.  The Nurse's Notes w 4/16/17 at 3:30 PM r from facility. Pt locate of ER (Emergency R building as the nursi back to floor. Skin in also stated the Direct physician, House Su Representative had resident was wearing bracelet on her right elopement.  A Safety/Security Ev specified the resident the facility and was f of the ER. It also sta her right ankle and th alarm to lock. On the	en by Nurse #10, dated revealed the resident had and a one-time intramuscular igrams (mg) was AM for agitation. Haldol is	F 32	23	

STATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345004	B. WING		09/12/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFINED DEFICIENCY)	D BE COMPLETION	
F 323	The Follow-up Action Event form was date indicated that Mainte company had been of the facility provided 4/17/17, in which the Operations Director effort to establish a to the response was, elevator on the first foutside the ER by Cl 3:03."  When asked for an in the facility provided a #2 that was dated 4/2 stated which staff per Resident #103 and visearched. It also staff found sitting on the coparagraph was signed Nurse #1, who had printerviewed on 9/12/2 said, "I think [Nurse is [Resident #103] was other people's rooms pretty well. The wand or if it had been tested the search for Resident #103 other resident rooms the resident was weather resident was weather resident was weather resident was weather the search for Resident #103 other resident was weather resident was weat	email correspondence dated DON asked the Plant to review the camera in an meline for the elopement. The resident came off the loor at 2:38. She was found NA's (Nursing Assistants) at exception of the incident, a note, handwritten by Nurse 20/17 (no time). It simply resons had tried to locate where each person had the resident had been the body the nurse.  Participated in the search was 17 at 2:28 PM. Nurse #1 did at 2 PM. Nurse #1 did 3 PM. Nurse #1	F 32			

	AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345004	B. WING _			09/12/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	GE ROAD	
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F 323	Admissions Coordinations assigned to Restocked for 5 or 10 millooking, if I remember brought her back up Coordinator specifies made aware of the elopement.  The Plant Operation 9/12/17 at 4:54 PM. Director stated he had for a few weeks at the said that prior to the alarm that was near sound if the resident Plant Operations Director of the elopement are sident weak entered the elevator.	not locked in place. The ator did not know which NA sident #103 but said, "We inutes. By the time we were er, it was the ER [staff who]." The Admissions d the ER staff had been nissing resident due to a spaged overhead in the ed the resident and what she cicipated in the search was 17 at 2:46 PM. NA #9 said, hard to keep up on resident unable to remember e incident.	F3	23		

PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED	
	345004	B. WING _			09/	12/2017
			615	5 RIDGE ROAD		
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outside in the parking administration to check the resident got out of took the elevator to fir the door by the ER." It brought folks in who kelevator and the compaystem. We found that transponder. To make purchased an updated in the state elevator foour due diligence and move if a person with elevator." He did not itself was tested to set time of the elopement. The Administrator and 9/12/17 at 4:16 PM. The Administrator and 9/12/17 at 4:16 PM. The Administrator and exit doors, but that the second floor of the fact the Administrator state elopement in April, shomething that would working with a resider attempted to get on. Since the elopement, the elections are side to the elopement, the election in the election of the fact that the second floor of the fact that the second floo	lot, he was asked by the cameras to see how the building. He said, "She st floor and then went out He also said, "I immediately the system, both the board for the wander guard to it it had an outdated to a long story short, we do transponder and brought blks to approve it. We did now it locks and will not a wander guard enters the know if the ankle bracelet the if it was working at the the Administrator stated the aring a wander guard time of the elopement which ding an alarm and locking all the resident had left the collity by using the elevator. The data prior to the the had made a request for prevent the elevator from the with a wander guard who the also stated that since the evator had been fixed and	F	323			
that way. 483.45(d)(e)(1)-(2) DFFROM UNNECESSA 483.45(d) Unnecessa Each resident's drug i	RUG REGIMEN IS FREE RY DRUGS ry Drugs-General. regimen must be free from	F	329			10/24/17
	Continued From page outside in the parking administration to check the resident got out of took the elevator to fir the door by the ER." He brought folks in who kelevator and the compaystem. We found that transponder. To make purchased an updated in the state elevator foour due diligence and move if a person with elevator." He did not itself was tested to se time of the elopement.  The Administrator and 9/12/17 at 4:16 PM. The Administrator and 9/12/17 at 4:16 PM. The Administrator and 9/12/17 at 4:16 PM. The Administrator and 10/12/17 at 4:16 PM. The Administrator and 10/12/17 at 4:16 PM. The Administrator state elopement in April, shomething that would working with a resider attempted to get on. Since the elopement, the elevator in the elopement, the elevator in the elopement in April, shomething that would working with a resider attempted to get on. 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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.  483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE	A BUILDIN  345004  B. WING  ROVIDER OR SUPPLIER  WEMORIAL HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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. 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Each resident's drug regimen must be free from	A BUILDING  345004  ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  483.45(d) Unnecessary DRUGS  ABUILDING  ST  ST  ST  ST  ST  ST  ST  ST  ST  S	A BUILDING  345004  345004  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  615 RIDGE ROAD  ROXBORO, NO. 27573  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEPTICIENCY MUST BE PRECEDED DY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  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. The ldd 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 91/21/7 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 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.  483.45(d)(e)(T1/2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  A 54500 A 100	A BUILDING  345094  345094  345094  345094  345094  345096  345096  345096  345097  SIMMARY STATEMENT OF DEFICIENCIES SIRCH THE PROVIDERS PLAN OF CORRECTION ROXBORO, NO. 27573  SUMMARY STATEMENT OF DEFICIENCY BY THILL REGULATORY OR LSC IDENTIFYING INFORMATION)  PROVIDERS PLAN OF CORRECTION (RICACH CORRECTION PARTY TAG)  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 wend 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 how it locks and will not move if a person with a wander guard enters the 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. The 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; #10/3 was wearing a wander guard and he 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 since the elopement, the elevator had been fixed and residents could no longer get out of the facility that way, 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  EACH COMPAND AND ADMINISTRATION OF THE ADMINISTRATION OF TH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	therapy); or  (2) For excessive dur  (3) Without adequate  (4) Without adequate  (5) In the presence of which indicate the dod discontinued; or  (6) Any combinations paragraphs (d)(1) through the facility management of the facility manag	ation; or monitoring; or indications for its use; or adverse consequences se should be reduced or of the reasons stated in ough (5) of this section.  ic Drugs. ensive assessment of a nust ensure that ve not used psychotropic nese drugs unless the	F	3329	DEFICIENCY)		
	gradual dose reduction interventions, unless an effort to discontinuthis REQUIREMENT by: Based on observation pharmacist, nurse pra	clinically contraindicated, in			" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	e	

		ATE SURVEY DMPLETED				
		345004	B. WING _			09/12/2017
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F 329	possibility of gradual resident's antipsycholantianxiety medication facility also failed to support a clinical rationed medication, failed to failed respond to pha (Resident #66). This residents reviewed for (Resident #10 and R.  The findings included 1. Resident #10 was 3/29/16. The resider included schizoaffect depressive disorder of A review of the resider included schizoaffect depressive disorder of A review of the resider included schizoaffect depressive disorder included included schizoaffect depressive disorder included schizoaffect depressive disorder included schizoaffect depressive disorder included schizoaffect included schizoaffect depressive disorder included includes included includes included includes included includes included includes includ	aviors and evaluate the dose reductions (GDRs) of a stic, antidepressant, and ons (Resident #10). The document evidence to conale for an antipsychotic monitor target behaviors and armacy recommendations affected 2 of 6 sample or unnecessary medications esident #66).  d:  admitted to the facility on ont's cumulative diagnoses give disorder (bipolar), major (single episode), and anxiety.  The special points of the facility on ont's not an antipsychotic of tablet by mouth every ted to schizoaffective experience of the facility of the diagnoses of the facility on ont's cumulative diagnoses of the facility on ont's cu	F3	cited; Resident #10 has psychotropic medication recommendations for GI NP with decision to cont orders, as followed by preview it was determined had seen LSW but not p New order for Psycho coand appointment was mavailable for November Resident #66 had pharm recommendation on 08/2 Zyprexa with goal to discuse. The pharmacy recowns not reviewed by attending the record did not in diagnosis or documente Order to discontinue Zypreceived and noted on 0 "The procedure for implacceptable plan of correspecific deficiency cited; orders for psychotropic recent denial for GDR was consult. Pharmacy recorder teviewed and signed Attending Physician with pharmacy review. Pharmacy review. Pharmacy monthly consultar	orders for s. Pharmacy DR reviewed by inue current sych. Upon further d Resident #10 sycho recently. It is possible to make the property of th	
	depressive disorder, 40 mg Fetzima (an tablet by mouth ever depressive disorder,	antidepressant) given as 1 y day related to major		"The monitoring proced the plan of correction is specific deficiency cited and/or in compliance wit requirements; Monthly p recommendation for GD	effective and that remains corrected th the regulatory harmacy	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 329	depressive disorder,5 mg diazepam (ar given as one tablet to bipolar and anxiety.  A review of the resid a notation made by I physician (dated 11/ a Consultation Report received 4 antidepre antipsychotic and an pharmacist indicated antidepressant agen action represented a recommended the nagents be re-evaluat consideration be give discontinuing use of citalopram or paroxe effects. The physicia recommendation on read: "Recently - ps reviewed by [Name of changes were made  A review of Resident Orders revealed the the same psychotropy dosages as those or The psychotropic me risperidone, citalopra paroxetine, and diaz  A review of the resid	ery day related to major single episode; an antianxiety medication) by mouth twice daily for ent's medical record included Resident #10's former 15/16) written in response to out (dated 9/27/16) from the pharmacist. The reported Resident #10 ssants in addition to an autianxiety medication. The It the need for four ts with the same (or similar) and duplication of therapy and even for four antidepressant ted. She suggested en to tapering and one or more (perhaps etine) to avoid the risk of side and declined the pharmacist's 11/15/16 with a notation that yoch (psychotropic) meds of Medical Center] - no ."  It #10's March 2017 Physician resident continued to receive bic medications in the same dered in November 2016. edications included am, duloxetine, Fetzima,	F 329	for accuracy of reason of declination the next 90 days by the Administrat Designee. Discrepancies will be addressed for clarification. Results audits will be reviewed for patterns trends and reported at QAPI month three months and then quarterly the "The title of the person responsible implementing the acceptable plan occorrection;  Administrator or Designee	or or  of and/or ly for ereafter

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	Resident #10 receive addition to an antipsy medication. The phat for four antidepressal similar) action repress therapy and suggeste re-evaluated with conthe citalopram dose at the recommendation standing h/o (history (medications) eval (e (psychiatry) with no othis time."  A review of Resident revealed the frequence was increased on 5/1 daily to 5 mg diazepa. There was no docum paper or electronic more ident's target behamonitored and supposincrease.  A review of the reside a Consultation Report pharmacist dated 5/1 Report indicated diazepam and recomgiven to tapering dow declined the pharmacon 7/17/17 with a notation and to a strength of the pharmacon forms of the pharmacon form	tation Report indicated and 4 antidepressants in vehotic and antianxiety rmacist indicated the need ant agents with the same (or ented a duplication of ed the regimen be asideration given to tapering at this time. The NP declined on 4/15/17, noting "Long of) mental illness-meds valuated) by psych changesno med change at #10's medical record cy of her diazepam dosing 11/17 from 5 mg given twice am given three times a day. The enterior in the resident's needical record to indicate the enviors/mood were being and the rationale for the dose ent's medical record included at from the consultant 7/17. The Consultation risk of sedation, depression, and falls in the elderly. The the recent dose increase of mended consideration be on that read: "Recently o changes were made to her	F3	29		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO. 615 RIDGE ROAD ROXBORO, NC 27573			
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F 329	included a Consultatic consultant pharmacist Consultation Report is received paroxetine, dry mouth, constipativision, and increased pharmacist also note additional antidepres an antianxiety medicarecommended considere-assessing the use for side effects. The pharmacist's recommendation that read: "If psych-no changes we psych meds including A review of the reside a Consultation Report recommendation from consultant pharmacist reiterated the recommendation that read: med rec (medication changes made - will of the same psychotrop dosages as her Nove	resident's medical record on Report from the st dated 6/9/17. The indicated the resident which increased her risk for on, urinary retention, blurred I confusion/sedation. The d the resident received 3 sants, an antipsychotic and ation. The report deration be given to of paroxetine due to the risk NP declined the nendation on 7/17/17 with a Recently assessed by ere made to her long term g Paxil (paroxetine)."	F 32	29			
		tropic medications included m, duloxetine, Fetzima, epam.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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F 329	Continued From pag	e 121	F 3	29		
	Minimum Data Set (18/9/17 indicated the skills for daily decision required supervision assistance for bed mand was totally depetoileting, and bathing reported the resident of 0; Section E indicate behaviors nor rejection Resident #10's assessing received an antipsycontianxiety medication the look back period.	obility and personal hygiene, ndent on staff for transfers, . Section D of the MDS: had a mood severity score ated the resident exhibited no on of care. Section N of ssment revealed she hotic, antidepressant, and on on 7 out of 7 days during				
	dated) included the fresident uses psychologoper (depression, anxiety, Revised on 6/28/16), included monitoring the effectiveness every services. A review of the residence of t	shift. ent's paper and electronic aled the resident's target e not routinely monitored or				
	An observation and in the resident on 9/6/1 did not exhibit any between An interview was consulted with NA #7. NA #7 with frequently assigned to	nterview was conducted of 7 at 9:30 AM. The resident ehaviors at that time.  Inducted on 9/7/17 at 2:00 PM vorked 1st shift and was to care for Resident #10.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017
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F 329	a resident. NA #7 in typically exhibit any  An interview was co AM with the NP caris the interview, the NF Resident #10 receiv medications, including stated the resident in psychiatric disorders medications a long to Resident #10 was as psychiatric service at any changes to here NP stated he did not recommendations to medications and correductions because adjusted by a psychiatric service he stated "No, she we evaluation." He was resident was seen but A review of the resident was seen but A review of the resident to include the resident on 9/9/1 did not exhibit any but A telephone interviewed.	any changes in behaviors for dicated the resident did not behaviors.  Inducted on 9/8/17 at 11:30 and for Resident #10. During Preported he was aware end multiple psychotropic and 4 antidepressants. He had a longstanding history of and had been on the ime. The NP reported assessed and evaluated by a and they opted not to make medications at that time. The agree with the pharmacist preassess Resident #10's asider gradual dose he felt such meds were best fatric service. When asked if was following the resident, was seen as a one-time only and certain of the date the sy the psychiatric service.  Interview was conducted of 7 at 9:45 AM. The resident ehaviors at that time.  We was conducted on 9/9/17 at cility's consultant pharmacist.	F 32	29	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL		·	STREET ADDRESS, CITY, STATE, 2 615 RIDGE ROAD ROXBORO, NC 27573	ZIP CODE		
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F 329	each time the issue were commendation was reported she thought being seen by psych. received from the prohaving received a received from the prohaving received a received a received at the evaluation to have May of 2016.  An interview was con AM with the facility's review of Resident #10 DON reported that sir facility, Resident #10 program one time onle confirmed the report of received by the facility indicated Resident #10 psychiatric evaluation definitely was not a performed to the poon one-half (sir facility). The DON states with the Medical Directly education of provider medications, the monand making adjustment as to how resident be DON reported her exit to document a reside she administered a performance of the record.	rer, the pharmacist reported vas addressed, her declined. The pharmacist in the past the resident was	F	329			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345004	B. WING	<del> </del>		09/12/2017	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573			
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F 329	brief overview of Res and concerns regard was reviewed with the time, the Medical Direct credentials of the proon 5/18/16 as a Clinic long-term care reside indicated he would have had a psychia psychiatric follow up. need on-going assist medications from psy.  An interview was con AM with the facility's interview, the MDS N staff's documentation medical record regard. The MDS Nurse reponsives in the which were primarily episodes of confusion or mood issues. The would have expected of behaviors/mood duantipsychotic medical. A follow-up interview at 11:35 AM with the the NP indicated it was resident was only see Worker since her adm. NP acknowledged the Clinical Social Worker psychiatric evaluation also confirmed he has assumption a psychiatric and confirmed he has assumption a psychiatric evaluation also confirmed in a psychiatric evaluation and confirmed he has assumption a psychiatric evaluation and confirmed he has a sumption a psychiatric evaluation and confirmed he has a sumption a psychiatric evaluation and confirmed he has a sumption and confirmed he has a	ctor on 9/9/17 at 4:15 PM. A ident #10's medical history ing her medication regimen e Medical Director. At that ector identified the vider seen by Resident #10 cal Social Worker. As a ent, the Medical Director ave expected Resident #10 atric evaluation along with He stated, "We're going to ance for managing rch."  Iducted on 9/10/17 at 10:15 MDS Nurse. During the lurse reviewed the nursing in Resident #10's electronic ding behaviors and mood. In the stated on isolated in the properties of the seem of the division of the seem of	F 32	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	Resident #10 be see psychiatric evaluation 2. Resident #66 was facility on 7/3/17, with depression and dem The admission Minin 7/24/17, specified Resimpaired cognition, however, the MDS did not have any behassessment period.  Resident #66 was dia 7/31/17.  The resident was rehome on 8/2/17 with depression and dem Record review revea 8/2/17, for Zyprexa 1 (PRN) for agitation of treat the symptoms of as schizophrenia and A new MDS assessment period.  A new MDS assessment period as schizophrenia and A new MDS assessment period as schizophrenia and A new MDS assessment period one problem initiated on 8/7/17 for contained one problem the PRN Zyprexa on month of August. A reand electronic medical properties and electronic medical properties are provided to the problem.	on 9/8/17 and requested in by a psychologist for a in and medication review. Originally admitted to the in diagnoses including entia without behaviors.  The diagnoses including entia without behaviors and esident #66 had moderately ad depression and also indicated the resident enviors during the escharged to the hospital on admitted to the nursing diagnoses including entia without behaviors.  The diagnoses including entia without behaviors are dated and enviored ential without behaviors.  The diagnoses including ential without behaviors are dated and ential without behaviors.	F 32	29		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 615 RIDGE ROAD ROXBORO, NC 27573	IP CODE		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG		TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	a Consultation Report pharmacist dated 8/2 Report indicated Restantipsychotic medical recommended it be depharmacist recommended it be depharmacist recommended in the depharmacist recommended in an antipsychotic medical from the antipsychotic medication and required documented of the antipsychological pharmacist recommended in the resident returned medication and lack of recommendations. The resident returned medication orders that to taper the use of the He stated his plan was medication and discommended in the resident returned medication and discommended in the stated his plan was medicated in the Nurse Practition and responded to the within 3-5 days. He as whenever a PRN was be documentation for An interview was considered.	ent's medical record included to from the consultant 2/17. The Consultation ident #66 was receiving the tion Zyprexa, and iscontinued. The indation stated that the use edication required a The recommendation also d' antipsychotic orders in an invere limited to seven days entation for the continued notic medication.  In of Resident #66 on 9/9/17 ent did not exhibit any  If the Medical Director was a use of the antipsychotic of response to the pharmacy in the Medical Director stated from the hospital with at included the Zyprexa and a antipsychotic medication. The introduce a different intinue the Zyprexa. The	F3	329			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
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F 329	stated that usually he recommendations with been busy with some recently and had not recommendations at	dation on 8/22/17. The NP reviews the pharmacy hin a week but that he had hospital admissions addressed pharmacy		329 353			10/24/17
SS=J	STAFF PER CARE P  483.35 Nursing Service The facility must have the appropriate component of the approp	es sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care umber, acuity and ity's resident population in acility assessment required assessment, §483.70(e), will ming November 28, 2017					10/2-4/11
	(ii) Other nursing pers limited to nurse aides	sonnel, including but not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 353	Continued From pag		F 353			
	this section, the faci	waived under paragraph (e) of lity must designate a licensed charge nurse on each tour of				
	nurses have the spe sets necessary to ca	ust ensure that licensed cific competencies and skill are for residents' needs, as sident assessments, and n 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					
	and review of the stafailed to provide stafameet the needs of reresidents (#66, #1031 and 2 were at the Examples 3 - 5 were potential for more the	nterviews, staff interviews affing records, the facility fing in sufficient numbers to esidents for 4 of 40 sampled 8, #131, and #56). Examples immediate jeopardy level. e at no actual harm with an minimal harm that is not and the scope is a pattern ed:		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 care plan was updated on 9/21/2017 to reflect the most current level and type assistance needed with transfers and toileting. The interventions on the care plan are identified as tasks and linked	□s o of	
	home on 7/17/17. H Assessment indicate including hypertensi disease, septicemia non-Alzheimer's der generalized muscle kidney failure, acqui knee, surgical aftero	nentia, depression, weakness, abdominal pain, red abscess of left leg below		the Kardex which is reviewed by CNA staff. Resident #66 was initially provide hand bell to use in the bathroom while room 262. The Resident was then mo 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. Weel	ed a in ved . ne s	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345004	B. WING _			09/	12/2017
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PERSON MEMORIAL HOSPITAL				I5 RIDGE ROAD OXBORO, NC 27573		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
7/24/17 indicated she was cognition (Brief Interview 11), required extensive person for transfer, dress was not steady with mo and only able to stabilize She had no fall history a occupational and physical assessment period. The indicated activity of daily incontinence and falls was care plan to minimize riscomplications.  According to the Occupatherapy notes dated 9/4 required substantial assed dressing and had improst to being able to safely the supervision or touching to to being able to safely the supervision or touching to to be in the said, sor with dignity and respect don't come and they are have to wait until some out."  On 9/07/2017 at 10:08 at "At home I used pull up Here, I use the ones the staff get me to the toilet."	(MDS) assessment dated as moderately impaired in w for Mental Status was assistance from one using and toilet use. She wing on and off the toilet e with staff assistance. and she received both cal therapy during the e Care Area Assessment y living, urinary would be addressed in the sks and avoid  ational Therapy (OT)  4/17, Resident #66  sistance with lower body wed in toileting - transfers ransfer to the toilet with -minimum assistance for  viewed on 9/06/2017 at metimes she was treated and added, "When they e short of help, you just one comes and helps you  AM, Resident #66 said, and used the toilet. The two to three times a day, well they will come. I used	F	353	interviews will be conducted with Resid #66 by the social worker and/or design for four weeks to ensure that her call be is functional and that staff are respond to requests for assistance with toileting an appropriate and timely manner. An variances will be communicated to the facility leadership team during the hud 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: overtim pay, double shift incentives, retention bonuses, and sign-on bonuses for LPN 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 assithe 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 descriptions. These individuals have be screened through the hospital employment process and have been included for in-service training in the Eincluding, but not limited to, abuse and neglect, dignity, elopement, employee burnout and No Pass Zone.	ee ell ing j in y dles e sist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09	/12/2017	
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
				61	15 RIDGE ROAD			
PERSON	MEMORIAL HOSPITAL			R	OXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 353	Continued From pag	ne 130	F3	353				
	call them, is a proble				Resident #103 was discharged home of	on		
	sometimes on secon				4/22/2017 with family. There was no			
					further documentation of or attempt to			
	A Health Status Note	e dated 9/7/2017 at 2:39 PM			elope from time of the 4/16/2017 incide	ent		
	read in part, alert an			until discharge.				
	•	s Requires extensive						
	assist with activities			Resident #56 was informed of expecta	tion			
	for oral care and me			to have call bell answered timely. Resident #56 was discharged on				
	order.	sulin per sliding scale insulin			09/09/17.			
		5 PM Resident #66 was			Resident #131 was informed of			
		ate bathroom on her own.			expectation to have call bell answered			
		to transfer back into her beared anxious and was			timely. Resident #131 was discharged 09/22/17.	on		
	1	rab bar and struggling to			Resident Council meeting was held on			
	back herself into her				09/26/17; concerns related to staffing			
	approximately the sa	ame time NA #15 was			voiced and addressed by Director of			
		#66's room. She said she			Nursing.			
	_	s and blood sugars. She bes to the bathroom on her			The precedure for implementing the			
	_	it. At 4:30 PM Resident #66			The procedure for implementing the acceptable plan of correction for the			
		room and said in a loud and			specific deficiency cited;			
		TO FELL AND NEED MY			a. A hold was placed on new admiss	ions		
	BRITCHES UP." NA	4#15 went in the room to			effective 9/9/2017 and will continue un	til		
	assist Resident #66.				facility is found to be in substantial			
	_				compliance. The self-imposed hold on			
		4 AM Resident #66 was			new admissions was made on 9/9/201			
		on the call bell yesterday to			by the CEO, administrator and corpora	te		
		e needed help. She said the king in the bathroom.			representative. This hold was communicated to the Admissions Direction	etor		
	Can ben was not wor	ang in the bathloom.			on 9/11 (the next business day) by the			
	On 9/08/2017 at 3:1	7 PM the Occupational			Administrator. The Admissions Director			
	I .	iewed. She said she had			has responded to each request stating			
		nt #66 on functional transfers			that currently, the facility was unable to			
		Initially she needed two			meet the needs of the applicant.			
	1 -	Now she needed minimum						
		afety and hand placement.			b. Staff will be deployed from the act			
	She needed contact	guard assistance. We've			hospital staff to assist in covering servi	ce		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING		0	09/12/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		071272017	
				615 RIDGE ROAD			
PERSON I	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 353	Continued From page	e 131	F 3	53			
	She added, "Typically her. She is good about I would not recomme She can self-propel in compliant. The safet	with nurse aides in the room.  y, someone would be with but calling if she needs help.  nd her toileting by herself.  n wheelchair. She is y awareness has already and placement). Safety is a		gaps. These individuals ha screened through the hospi employment process and h included in in-service trainir including, but not limited to, neglect, dignity, elopement, burnout, and No Pass Zone c. Starting 9/11/2017, the	ital ave been ng for ECU , abuse and , employee		
	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."			nursing supervisor has bee rounds on the long-term cal facility unit, twice per shift, evening shift. The role of n supervisor during this round	re nursing on the 12-hour ursing		
	was interviewed. She #66 required assistar needed supervision v She needed a nurse diagnosis of dementia times. Resident #66	5 AM the Director of Nurses e confirmed that Resident nce from one person and with activities of daily living. aide (NA) due to her a. She can be forgetful at had some episodes of tried to get up. She had one		additional supervision and of ECU team as needed. The make rounds on the unit an immediate needs with the linursing staff. The supervisor available to the ECU to respense, and the may occur.	e supervisor will ad discuss any icensed or is also pond to any		
	assisted fall with staff of wheelchair and sho Director of Rehab pro Immediate jeopardy b	f. She was trying to get out e did not wait for assist. The ovided education to the CNA.		d. Responsibility for comp staff schedule has been re- temporarily to the Chief Fin for Person Memorial Hospit department will manage an	assigned ancial Officer tal. The clinical d update the		
	find staff to assist her independently onto the have a means to call prior to transferring b	#66. This resident could not to the toilet, she transferred ne commode. She did not for help after toileting and ack into her wheelchair was not functioning. She		daily schedule. Call-outs w directly to the DON or Admi Staffing needs are reviewed through Friday, during the le team huddle meetings.	inistrator. d daily, Monday		
	expressed anger and dangerous. She had and receiving a serior post-surgical knee be high blood sugar on t			g. The CEO is holding sm meetings beginning 9/27/20 the employees of the surve the organization sefforts a commitment to improve sta and engagement. During the	017 to inform y findings and and ff recruitment		

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/1	12/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/		
				615 RIDGE ROAD			
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 353	Continued From page	e 132	F 35	3			
	toileting and dressing three hours passed b distributed to the bath non-functioning call b administrator was info jeopardy.  2. Resident #103 wa 4/10/17 with multiple dementia. The resident was disc 4/22/17. The attending physici	the lower body. On 9/7/17, efore hand bells were prooms that had ells. On 9/8/17 at 12:30, the primed of the immediate and admitted to the facility on diagnoses including charged to the community on an's admission note dated set, advanced dementia.		the staff are being reminded of the expectations regarding performance accountability to the improvement of quality of life for the residents.  h. Key members of the facility least team will have huddle meetings dain Monday through Friday, to report pon the above actions and any new opportunities related to resident satisfactorial spreadsheet is maintained and has enhanced the organization of the mand strengthened the structure of the discussion. The leadership team is composed of the Administrator, Dir Nursing, Director of Quality, and Director of Plant Operations.	of the addership addership addership addership around a control of the addership and a contro		
	4/14/17 at 7:52 AM st times on PM (evening attempting to go in oth knocking. Combative shift. Hitting and kicki provided. Refused pashift redirected X2[tw/Observed sleeping in A Nurse's Note, writte 4/15/17 at 8:31 AM, rubecome combative ar dose of Haldol 5 millig administered at 6:16 an antipsychotic drug psychosis.	AM for agitation. Haldol is		Prior to the survey, Person Memori Hospital ECU was actively recruitin full-time, part-time, and travel licens nurses and CNAs. Two jobs fairs been conducted in the community one or 6/29/2017 and on 8/29/2017 for bol licensed nurses and CNAs. Since survey, the search has been broad. The monitoring procedure to ensure the plan of correction is effective ar specific deficiency cited remains condition and/or in compliance with the regul requirements; The Director of Nursing will communication vacancies to CFO and/or Person Resources upon change in staffing Position control will be monitored deficiency will be monitored deficiency cited remains condition vacancies to CFO and/or Person resources upon change in staffing Position control will be monitored deficiency cited remains conditions.	al g for sed have  th the ened. e that nd that brrected atory  nicate Human needs.		

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 353	Resident #103. The admission completed.  The Nurse's Notes we 4/16/17 at 3:30 PM in from facility. Pt locate of ER (Emergency Fullding as the nursi back to floor. Skin in also stated the Direct physician, House St. Representative had resident was wearing bracelet on her right elopement.  A Safety/Security Every specified the resident was to find the ER. It also stated the facility and was an of the ER. It also stated the facility and was an of the ER. It also stated the facility and was an of the ER. It also stated the facility and was an of the ER. It also stated the facility and was an of the ER. It also stated the facility and was an of the ER. It also stated the facility and was an of the EV. It also stated the facility and was a full company had been of the facility provided 4/17/17, in which the Operations Director effort to establish a to the response was, the facility provided the	er guard was placed on orehensive Minimum Data rogress but had not yet been written by Nurse #2 dated read, "Pt (Patient) eloped red sitting on curbing in front Room which was in the same right of the fact. Denies pain." The note rote of Nursing (DON), right of the fact of Nursing (DON), right of the fact	F3	Director of Nursing and varia reported no less than weekly Administrator. Results of aux reviewed for patterns and/or reported at QAPI monthly for months and then quarterly the The title of the person responsimplementing the acceptable correction;  Administrator or Designee	y to the dits will be trends and r three nereafter.	
	specified the resider the facility and was to of the ER. It also state her right ankle and to alarm to lock. On the Witnesses/Parties In The Follow-up Action Event form was date indicated that Mainte company had been of the facility provided 4/17/17, in which the Operations Director effort to establish a to The response was, in elevator on the first the state of the facility and the company had been of the facility provided 4/17/17, in which the Operations Director effort to establish a to the response was, in elevator on the first the facility and was the facility and the faci	at had wandered outside of found sitting on a curb in front lated a wander guard was on that it did not trigger the door to be form, the Section for explored stated "Not Specified" and on the Safety/Security and 4/27/17 by the DON and the explored and the wander guard contacted.  The email correspondence dated to pool asked the Plant to review the camera in an timeline for the elopement.				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345004	B. WING		0	9/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 615 RIDGE ROAD ROXBORO, NC 27573	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 353	the facility provided a #2 that was dated 4/2 stated which staff per Resident #103 and w searched. It also state found sitting on the c paragraph was signe  Nurse #1, who had pr interviewed on 9/12/1 said, "I think [Nurse # [Resident #103] was other people's rooms pretty well. The wand when she passed cer not know if the wand or if it had been teste  The Admissions Coor the search for Reside 9/12/17 at 2:38 PM. stated, Resident #103 other resident rooms the resident was wea bracelet, but when th floor elevator, it had r Admissions Coordina was assigned to Resi looked for 5 or 10 min looking, if I remembe brought her back up.' Coordinator specified made aware of the m "Code Pink" that was	evestigation of the incident, note, handwritten by Nurse 20/17 (no time). It simply issons had tried to locate here each person had ed the resident had been urb in front of the ER. The diby the nurse.  Participated in the search was 7 at 2:28 PM. Nurse #1 etc. a wanderer and went into and she could ambulate the guard helped by alarming thain zones." Nurse #1 did er guard had malfunctioned did.  Polythia did the search was interviewed on the Admissions Coordinator awas known to wander in and in the halls. She stated ring a wander guard ankle the resident left via the second and locked in place. The tor did not know which NA dident #103 but said, "We mutes. By the time we were re, it was the ER [staff who]	F 35	53			

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	ATE SURVEY DMPLETED
		345004	B. WING			09/12/2017
	IDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N/ int "T na Re Ni #1 by Th ass of Th 9/ Di fo sa ali sco Pl tin sy wl er Di ou ac th to th br ele	terviewed on 9/12 They are in and it's ames." NA #9 was esident #103 or the urse #2, who was 103 on day of elopy phone for an interest the elopement.  The Plant Operation 12/17 at 4:54 PM irector stated he had add that prior to the arm that was near bund if the resident and operations Done of the elopement was the elopement of the elevator indicated a utside in the parking diministration to che resident got our ook the elevator to eloor by the ER rought folks in whe evator and the collections of the elopement of the elovator to eloor by the ER rought folks in whe evator and the collections.	riticipated in the search was 2/17 at 2:46 PM. NA #9 said, is hard to keep up on resident is unable to remember the incident.  assigned to the Resident perment, could not be reached erview.  able to identify which nursing great to the resident on the day one of the elopement. He is elopement, there was an interviewed on the elevator that would not was near the elevator. The irrector was not aware at the ent, that the wander guard unde locking the elevator door earing a wander guarded or. The Plant Operations after Resident #103 was found ang lot, he was asked by neck the cameras to see how to first floor and then went out. "He also said, "I immediately to knew the system, both the impany for the wander guard.	F 35	3		
sy wl er Di ou ac th to th br ele sy tra	stem did not include hen a resident we need the elevator indicated autside in the parkid diministration to che resident got our ok the elevator to e door by the ER rought folks in whe evator and the constant of the constan	ade locking the elevator door earing a wander guarded or. The Plant Operations after Resident #103 was found ing lot, he was asked by neck the cameras to see how it of the building. He said, "She in first floor and then went out." He also said, "I immediately o knew the system, both the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345004	B. WING _			09/12/2017
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	elevator." He did no itself was tested to stime of the elopement. The Administrator ar 9/12/17 at 4:16 PM. Resident #103 was ankle bracelet at the was effective in sour exit doors, but that the second floor of the father than the Administrator at elopement in April, a something that woul working with a reside attempted to get on the elopement, the eresidents could no lot that way.  Immediate jeopardy Resident #103, unsuelevator to the first fl was found in the face #103 was located by amount of time outsi injuries.  3. Resident #131 was 9/4/17 upon dischargeresident's medical hid her left hip with surgeresident's hospital D 9/4/17 included specifications.	h a wander guard enters the tknow if the ankle bracelet ee if it was working at the nt.  and DON were interviewed on The Administrator stated wearing a wander guard time of the elopement which adding an alarm and locking all the resident had left the acility by using the elevator.	F3	553		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345004	B. WING		09/12/2017
	NAME OF PROVIDER OR SUPPLIER  PERSON MEMORIAL HOSPITAL  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 353  Continued From page 137  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	6	STREET ADDRESS, CITY, STATE, ZIP CODE 115 RIDGE ROAD ROXBORO, NC 27573	,	
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 353	Continued From pa	ge 137	F 353		
	Resident #131 revents Data Set (MDS) assistance plan were not your assistance for all of (ADLs), with the excassistance of one windependent with ear reported to be continued as a history of a fall at a noderate risk for a history of a fall at and repair. The Fall the resident required move from place to A review of Resident (PT) Plan of Care diassessment of the rabilities. The Plan or required supervision ambulation. This ledefined as needing cues or touching/steresident ambulated, or intermittently.	aled her Admission Minimum lessment and individualized yet due for completion.  Ity's Admission Nursing /17 at 3:15 PM revealed the Her short and long term issed to be intact and inted to be consistent and inted to be consistent and inted to be consistent and issident required extensive her Activities of Daily Living its deption of requiring limited ith dressing and being its desired and bladder.  In the completed on 9/4/17 is 131 was determined to be at falls. She was noted to have thome with a left hip fracture in Risk Assessment indicated did, "hands-on assistance to place."			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
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F 353	revealed an assess current functional a Plan of Care indica supervision or touch The resident was a supervision for trandetermined to be at and falls.  A review of the resident and falls.  A review of the resident and falls.  A review of the resident and falls.  A review of a Nursing Note date of the needs. She are assist of one.  Review of a Nursing AM also revealed Fourther review of a Nursing AM also revealed Fourther review of Resident and an ambulated with a wone.  An observation was AM. Upon entering Resident #131's call above the door to hactivated call bell was closed and she hallway. At that time was made of Resident Housekeeping staff she passed by Resident staff she passed by Resident suppression of the staff she passed by Resident suppression of the passed by Resident staff she passed by Resident suppression of the passed by Resident staff she passed by Resident suppression of the	bilities was conducted. The ted the resident required hing assistance for toileting. Iso assessed as requiring sfer with toileting. She was a moderate risk for balance dent's medical record included ted 9/6/17 at 2:34 PM. The resident was able to verbalize abulated with a walker with the g Note dated 9/7/17 at 8:59 Resident #131 ambulated with r, but required assistance and	F 353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X'		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _		,	09/12/2017	
	ROVIDER OR SUPPLIER	,	•	STREET ADDRESS, CITY, STATE, ZIP COL 615 RIDGE ROAD ROXBORO, NC 27573	STATE, ZIP CODE		
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F 353	At 8:01 AM, Administ observed as she walk The administrative strook into the resident' continued to be lit ab #131's room. At 8:0' Member #2 was obseresident's room. The she did not knock or The call light continuer Resident #131's room Administrative Staff A Resident #131's room member she did not bresident's room. The above the door to the AM, Resident #131's to her room. Within a delivery, the resident' On 9/9/17 at 8:15 AM was observed as she room and closed the conducted with NA #2 interview, the NA was her call light on. The needed assistance to An interview was con with Resident #131. recalled putting on he before breakfast and the bathroom. Resident supposed to go to and needed assistance and reeded assistance and reeded assistance and reeded assistance.	or to Resident #131's room. Trative Staff Member #1 was ked by the resident's room.  aff member did not knock or it's room. The call light ove the door to Resident 7 AM, Administrative Staff erved as she passed by the administrative staff member look into the resident's room.  At 8:08 AM,  Member #3 passed by  In. The administrative staff knock or look into the call light continued to be littered as tray was delivered one minute of the tray  Is call light was turned off.  In, Nursing Assistant (NA) #2  In came out of the resident's door. An interview was 2 at that time. During the 3 asked why the resident had 1 NA reported the resident of get to the bathroom.  Inducted on 9/9/17 at 3:20 PM  Upon inquiry, the resident or call light in the morning stated she needed to use ent #131 reported she was 5 the bathroom by herself oce to do so. She did not	F3	53			
	morning, but reported hour for them to com-	out on the call light that d, "Sometimes it takes a half e." Resident #131 stated ock or watch to see exactly					

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F 353	assist her. The resinight" earlier in the light to request bath #131 reported she was "quite a long time." couldn't wait any lor because, "I just kne if I waited anymore. used the walker in hathroom unassiste unassisted). Residifacility's Administrational told her, "You need A follow-up interview at 9:40 AM with Resinterview, the reside light was not answer assistance to go to stated she had actuate that night and ender and back to bed by no one came to help she knew she should feel she had a choic didn't feel strong en and had been instrushe should not amb.  An interview was con PM with the facility's Upon inquiry as to was responding to call lights and dietary, should dietary, should	elapsed before staff came to ident also described "one week when she put on the call proom assistance. Resident waited for what seemed to be. The resident stated she anger for staff to come in well would wet myself all over." Resident #131 reported she are room to walk to the and and then back to bed (also ent #131 stated she met the cor a couple of days ago and	F 353			

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the call light could nesident, he/she sho could take care of the asked what her explorestaff to answer a "Ideally, less than 5".  An interview was concerned he had been since her admission week ago. Upon incresident continued the ambulation and toile ambulation and toile ambulating to/from the night were discustated he, "would have diagnoses including mellitus, and aftercated he had been stated he, "would have diagnoses including mellitus, and aftercated he had been stated he, "would have diagnoses including mellitus, and aftercated he had been stated he, "would have diagnoses including mellitus, and aftercated he had been stated he, "would have diagnoses including mellitus, and aftercated he had been stated he, "would have diagnoses including mellitus, and aftercated he had been stated he, "would have diagnoses including mellitus, and aftercated he, "the night were discusted he, "would have diagnoses including mellitus, and aftercated he, "the night were discusted he, "would have diagnoses including mellitus, and aftercated he, "the night were discusted he, "the	ot meet the needs of the buld let someone know who he resident's need. When ected response time would be call light, the DON stated, minutes."  Inducted on 9/12/17 at 11:55 herapist (PT) #1. PT #1 en working with Resident #131 to the facility a little over one quiry, the PT reported the orequire assist of one for eting. The resident's report of the bathroom on her own in assed with the PT. The PT ave wanted her to have help."  In a short-term resident with heart failure, diabetes are from surgery.  In a short was a short with the property of the bathroom on her own in a short was a short with the property of the bathroom on her own in a short was a short with the property of the bathroom on her own in a short was a short with the property of the bathroom on her own in a short was a short with the property of the bathroom on her own in a short was a short with the property of the bathroom on her own in a short was a short with the property of the bathroom on her own in a short was a short with the property of the bathroom on her own in a short was a short with the property of the bathroom on her own in a short was a short with the property of the bathroom on her own in a short was a short with the property of the bathroom on her own in a short was a short was a short was a short with the property of the bathroom on her own in a short was a s	F 353		
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL  SUMMARY S (EACH DEFICIEN REGULATORY OF PROCEED OF PROCEED OF PROCEED OF PROCED OF PROC	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 ambulating to/from the bathroom on her own in the night were discussed with days a short-term resident with diagnoses including heart failure, diabetes	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 141  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 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	ROYIDER OR SUPPLIER  MEMORIAL HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION)  Continued From page 141  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 the 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 with diagnoses including heart failure, diabetes mellitus, and aftercare from surgery.  The admission Minimum Data Set (MDS) assessment dated 08/16/17 revealed Resident #36 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 (90/03/17 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

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F 353	him after no one resexplained he felt that him and did not respanded that he did not "mess."  Upon request, there (NA) documentation toileting or incontine Resident #56 during 2017.  In an interview with PM, she stated she during the week of Oproviding incontinen specific date.  During an interview on 9/10/17 at 4:09 Pbowel incontinence of that nursing assistar incontinent care as assigned residents.  On 09/12/17 at 2:16 conducted with Nurse that she always world she stated it would be anyone who needed receive the care with depending on how be time. She added that soiled clothing and solied clothing and solied she stated #56 on during the weeks and the solied she stated #56 on during the weeks and the solied she stated #56 on during the weeks and the solied she stated #56 on during the weeks and the solied she stated #56 on during the weeks and the solied she stated #56 on during the weeks and the solied she stated #56 on during the weeks and the solied she	ould get to the facility to help ponded for so long. He to the staff did not care about ect his need for help. He to like sitting in his own  was no nursing assistant provided to indicate whether note care was provided for the month of September  NA #2 on 09/09/17 at 4:25 worked with Resident #56 9/03/17 but did not recall the care for him on any  with the Director of Nursing M, she agreed that lack of care was a dignity issue and this were expected to provide soon as possible to their  PM an interview was the #4 on 9/12/17. She stated and the rehabilitation hall. The her expectation that incontinence care should	F 35	3		

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F 353	incontinence care on aware of his incontinent that a resident might care when she had 1 her as she often did. have to prioritize who finish up with one rest to the next. She furth to get to each one as agreed that a resider few hours to receive.  In an interview with the 9/12/17 at 3:18 PM himontinence care shossible and that he member to lie in fector even 20 minutes.  4.b. Resident #56 who 08/09/17 from the horesident with multiple aftercare from surgical A review of Resident plan dated 08/09/20 problems, goals, or in management or after there were two physical provide pain relief for 08/09/17 - Dilaudid The or one of the or one of the or of the	any specific date, but was ence issue. NA #6 stated have to wait for incontinence 5 to 20 residents assigned to She explained she would a needed care the most and sident before she could move her explained that she tried a soon as possible and she hat would not want to wait a bowel incontinence care.  The on-call physician on the estated that bowel ould be provided as soon as would not want his family as waiting for care for 2 hours as admitted to the facility on spital as a short-term and diagnoses including all amputation of the left foot.  #56's current nursing care 7 revealed there were no interventions for pain for early from surgery.  Sician's orders in place to residents #56 as follows:  Tablet 2 MG give 1 milligram 4 hours as needed for pain.  The patch 5 %. Apply to one time a day for pain.  The patch 5 %. Apply to one time a day for pain.  The patch 5 %. Apply to one time a day for pain.  The patch 5 %. Apply to one time a day for pain.  The patch 5 %. Apply to one time a day for pain.	F3	553		

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F 353	(MDS) assessment digners, heart failure and same MDS indicated cognitively intact and made it hard for him to his day-to-day activitive recorded on the asse of "1 through 10", with severe pain.  In an interview with Right 10:34 AM, he stated if previous Friday (09/0) least an hour for som him with pain medicar remember exactly whomedication, but he known. Resident #56 of from his recent foot so back due to arthritis. repositioning helped I back pain and surgical strong enough that he patch or his oral pain further stated that his level 7 on a scale of the pain level was at 8. Finot the only time he hereceive pain medicativery long time for any	aion Minimum Data Set ated 08/16/17 revealed gnoses which included, in diabetes mellitus. The	F	353	DEFICIENCY)			
	finally answered the c	-						

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F 353	#56 received Dilauce on 08/30/17 and on 08/30/17 and on A review of the Sep Resident #56 had remouth at 8:20 PM of An interview was concern with the Nurse #09/01/17 when Resident #56 had regularly, was interview was at level 7. She state issues, then she would check to see ordered. Nurse #9 scheduled Lidocaine and Dilaudid ordered address his pain. Since the state would wanter provided in a timely level was at 7 or 8.  Nurse #4, who had regularly, was interview would expect for pawithin 5 to 10 minuters.	ord (MAR) revealed Resident lid 1 mg by mouth at 3:43 AM 08/31/17 at 8:57 PM.  Itember 2017 MAR revealed eceived Dilaudid 1 mg by n 09/01/2017.  Inducted on 09/09/17 at 4:15 #9 who was on duty on ident #56 reported having pain ed if a resident had pain redictions and if pain medications were explained Resident #56 had a e patch to be given once daily, d as needed every 4 hours to the did not specifically recall laining of pain on 09/01/17 or espond to his call, but added to have pain medication way, especially if the pain worked with Resident #56 riewed on 9/12/17 at 2:16 pm. resident did not ask for pain en, but when he did, she in medication to be given	F 353				
	09/12/17 at 2:50 PM Resident #56 had a times, but did not sp answering his call li medication request.	If, she stated she did recall the sked for pain medication at pecifically remember ght on 09/01/17 for his pain.  She stated that anytime a her he had pain, she reported					

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F 353	4:25 PM, she state that he/she needed report it to the nurse explained she had very short time and with the residents a problems. She did Resident #56's call medication on 09/0 During an interview 09/12/17 at 3:18 Pl was to provide pair possible after the resident was the provident was to provide pair possible after the resident was the provident was t	with NA #2 on 09/12/17 at d if a resident reported to her d pain medication she would e as soon as she could. She been working in the facility a l that she was not very familiar and which ones had pain not remember answering light when he requested pain	F 35	3			
	minutes revealed fi and the nursing as me up." The reside NA told him to get to him since she was Another resident st getting me dressed me sometimes but wet." In July 2017, residents stated the on Sunday to go to RC minutes reveal residents about ge The aides tell resid when we need help resident stated "we	of the Resident Council (RC) rom August 2017, "I lay in bed sistants (NAs) are not getting ent also stated that a third shift the NA on the next shift to help getting ready to leave. ated "They don't help with I and my roommate will help sometimes they leave you RC minutes revealed ey were not getting up on time Bible Study. In June of 2017, ed ongoing concerns from ting water in a timely manner. ents "let me get your aide to to go to the bathroom." The eneed more help so we can ments on time." The May 2017					

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F 353	RC minutes revealed residents that attended would be starting tood stay for 3 months and leaving. The resident NAs and nurses." The concerns noted in Apas March, 2017.  An interview with NA revealed today she had up to 18 resident An interview was compmon 9/8/17. NA #1 residents on this day manageable assignment worked the 3:00 pm to reported there were used to do her best to get are ported they need more acred one without ruse. An interview was compmon 9/8/17. Nurse with just two nurses residents and most times stated it was battle to needs and she felt on Nurse #1 continued to pass was nonstop and with the residents and reported the residents and reported they knew the Nurse #1 reported she enough staff in the face of the resident and they was the face of the residents and reported she resid	the DON informed the ed the meeting that 2 NAs ay and agency nurses would d some nurses will be ts stated "We need good ere were also staffing ril, 2017 RC minutes as well #6 on 9/7/17 at 10:22 am ad 14 residents but she has ts on her assignment. Iducted with (NA) #1 at 3:15 reported she had 9 and that it was a nent. NA #1 stated she to 11:00 pm shift and usually 3 to 4 on this shift. It what she could and tried all the care done. NA #1 nore help in order to get the shing.  Inducted with Nurse #1 at 3:30 at 11 revealed she was here more often than not. Nurse if the 7:00 am to 7:00 pm had 25 to 30 residents. She ying to meet the resident's verworked and burnt out. To add that the medication id it was difficult to assist id the aides. Nurse #1 is know we do the best we here was not enough help. The did not feel there was cility and stated everyone had been addressing it.	F3	53				

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F 353	Continued From pag	e 148	F 35	3			
	even had a meeting Executive Officer) in staffing issues, but not a finite staffing issues, but not not not not not not not not not no	August, 2017 to address the othing seems to get done.  Inducted with Nurse #2 at 3:45 at #2 reported typically we reach of the two nurses. The average an extra nurse and then residents, but most often it sheduled. Nurse #2 stated sidents, it can be very difficult the needs of the residents, have to get passed on to the stated we do not have a se so we have to do all our this can be very time ere a lot of treatments. Sometimes there was set times there was not. at the hospital staff very					
	9/8/17 at 3:55 pm. Thave enough staff and the resident's weights heights were not alw stated she had reported. An interview was cor 9/8/17 at 4:00 pm. Now was to have 3 nurses recently they would be not was to they would be not was stated they (the Dind coverage, but if the what we had. Nurse	inducted with the Dietician on the Dietician stated they don't aid it was a struggle to follow as because the weights and ays done. The Dietician ted this concern to the DON.  Inducted with Nurse #3 on lurse #3 revealed the goal as on the shift, but more the scheduled for 3, but only 2 the floor due call outs. Nurse in a staff) would try and they didn't we worked with #3 stated if we had 3 nurses as better. Nurse#3 reported					

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meet the needs of the residents ld and sometimes things got hift.  In the Activities Director/NA #12 on in revealed that there was a idents being ready for activities. added that 10:30 am was the first y. She noted lately that some of people were still in bed when it vities or the NA would say they et up. The AD/NA #12 reported oncerns to the DON about the regready for activities. The red sometimes it depended on a because some aides would a to activities when they were residents were still in bed. In activities when they were residents were still in bed. In the DON on the resident Council she would let tow that new staff was coming. If there were specific complaints, ask for more specific information its or group and if there was an take care of it right away. The he would counsel staff if needed weekly staff meetings. The DON ew there was a concern about to the Sunday church service e was told the staff were getting more often on the weekends. It is conducted with the DON on the revealed at the red had 3 agency nurses one for	F 35	3			
	PARTICL RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)  page 149 meet the needs of the residents Id and sometimes things got hift.  In the Activities Director/NA #12 on in revealed that there was a idents being ready for activities. added that 10:30 am was the first y. She noted lately that some of people were still in bed when it vities or the NA would say they et up. The AD/NA #12 reported oncerns to the DON about the ing ready for activities. The red sometimes it depended on the because some aides would it to activities when they were residents were still in bed. It is conducted with the DON on im. The DON reported every to Resident Council she would let be with the were specific complaints, ask for more specific information its or group and if there was an itake care of it right away. The he would counsel staff if needed weekly staff meetings. The DON is we there was a concern about to the Sunday church service was told the staff were getting more often on the weekends. It is conducted with the DON on im. The DON confirmed that	PREFIX TAGE  TAL  RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)  Page 149  The Activities Director/NA #12 on a revealed that there was a idents being ready for activities. The red added that 10:30 am was the first being ready for activities. The red activities or the NA would say they et up. The AD/NA #12 reported concerns to the DON about the ring ready for activities. The red sometimes it depended on the because some aides would to activities when they were residents were still in bed. The conducted with the DON on a m. The DON reported every to Resident Council she would let bow that new staff was coming. If there were specific complaints, ask for more specific information ts or group and if there was an take care of it right away. The he would counsel staff if needed weekly staff meetings. The DON the word of the Sunday church service ewas told the staff were getting more often on the weekends. The DON confirmed that any concerns. She revealed at the rad 3 agency nurses one for prim one for 7:00 pm to 7:00 am age the Minimum Data Set	STREET ADDRESS, CITY, STATE, ZIPV 615 RIDGE ROAD ROXBORO, NC 27573  RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)  page 149  meet the needs of the residents Id and sometimes things got hift.  In the Activities Director/NA #12 on in revealed that there was a idents being ready for activities. added that 10:30 am was the first your short of the NA would say they et up. The AD INA #12 reported oncerns to the DON about the ing ready for activities. The residents were still in bed when it wities or the NA would say they et up. The AD INA #12 reported oncerns to the DON about the ingready for activities. The residents were still in bed. If the conducted with the DON on im. The DON reported every to Resident Council she would let bow that new staff was coming. If there were specific complaints, ask for more specific information its or group and if there was an take care of it right away. The he would counsel staff if needed levely staff meetings. The DON withere was a concern about to the Sunday church service was told the staff were getting more often on the weekends. It is conducted with the DON on im. The DON confirmed that ing concerns. She revealed at the rhad 3 agency nurses one for prom one for 7:00 pm to 7:00 am ige the Minimum Data Set	A 345004  B. WING  TAL  TAL  TAL  TAL  TAL  TAL  TAL  TA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′				(3) DATE SURVEY COMPLETED	
		345004	B. WING			09/	12/2017	
	ROVIDER OR SUPPLIER		•	61	REET ADDRESS, CITY, STATE, ZIP CODE 5 RIDGE ROAD DXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 353	were normally 2 nurses they have 3 nurses, to do the Rehabilitat other two nurses wo census which usuall residents. She repo had about 12 reside demands were higher reported staff have a staffing needs and shiring 4 NAs and one have been trying to order to prevent burntake a day off and where the need may hours. The DON ad nursing staff from the in the building) if the reported we try to fir have the NAs have a their assignment. The aware the NAs have a their assignment. The aware the NAs had a to 19 residents at time was too many to be quality care.  An interview with NA revealed she had be about a year and he working 16 hours earling. NA #9 reports.	t. The DON reported there ses on the floor but the goal is scheduled and stated if one nurse would be assigned ion (Rehab) Unit and the uld split the remaining of the y was about 20 to 25 inted the Rehab Unit usually into because the acuity and the er for these residents. She approached her regarding the was in the process of the nurse. At this time, they use the staff they have, and in mout, they ask the staff to ork a different shift to fill in the beinstead of increasing ded, at times, they would pull the hospital (which was located the was staff available. She and coverage. Her goal was to no more than 12 residents on the DON reported she was a larger assignment of 15 these. The DON confirmed that on an assignment and deliver the working at the facility for its shift was on the weekend inch day and an 8 hour shift on ted her assignment today.	F	3353				
	times, it has been as reported she does the done and help the re were a number of ca	at was manageable, but at shigh as 15 or 16. NA#9 he best she can to get her job esidents. NA#9 stated there all outs and the staff does try bey cannot, we have to make						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING _	B. WING		09/12/2017		
	ROVIDER OR SUPPLIER			61	TREET ADDRESS, CITY, STATE, ZIP CODE IS RIDGE ROAD OXBORO, NC 27573			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 353	Continued From page	e 151	F3	353				
	assignment was heave the care done and we reported they have be she started.  An interview with the							
	on 9/9/17 at 4:44 pm. was a staff meeting ir reported several staff attended and compla wages and cost of livi	e Operations was conducted The CEO revealed there h August, 2017. The CEO (nursing and NA's) ined about staffing, salaries, ing. The CEO stated the rith the number of staff						
	available. He indicate were recently approve Manager. He further starting Monday and position over the wee NA coverage there sh	ed, in terms of staffing, they ed for 4 aides and a Nurse added that three aides were two aides accepted the kend. The CEO stated for hould be 7 aides on the day ing shift and 4 aides at						
		he Senior Director were As had a workload of up to assignment.						
	revealed there were r meet the desired amo The census varied fro	e census for last 18 months multiple days that did not punt of aides and nurses. The reviewed with the DON.						
	9/10/17 at 11:15 am. review of the daily ce there was not enough DON reported there very the payroll. She ofter off her assignment to	DON was conducted on The DON confirmed, after nsus and staffing sheets, a staff on each shift. The were 13 nurses currently on a had to take the third nurse do other tasks like are and work as a NA. She						

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		345004	B. WING _		(	9/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 353	on days. She stated payroll including full to some who work weeks since March, 2017 th NAs, 3 RNS, and 2 L have since hired 10 NDON confirmed the doto have 7 on day shift night shift. The DON left for better wages, issues and some were disciplinary action. To offer incentive program An interview with Nurrevealed she worked am to 7:00 pm and on hours. She reported nurses on the weeked was hired, she was to third nurse. She state facility since March, 20 nurses scheduled on reported she has had chart and get caught difficult to meet the nuthere were only 2 nur was the nurse assign the high acuity and do she had been asked shift to fill in, but she indicated the staffing shift stating sometime of times we had 2 or down to just one NAC had 3 or 4 aides. She does not help and the	there were 22 NAs on the ime, part time, per diem, and sends only. She reported ey have lost/terminated 12 PNs. The DON added, they NAs, 3 LPNs and 1 RN. The esired staffing for NAs was t, 6 on evening shift and 4 on reported some of the staff some left due to staffing the terminated as a result of a the DON reported we do ms to the NAs and nurses.  The series of the staff some left due to staffing the terminated as a result of a the DON reported we do ms to the NAs and nurses.  The series at 3:28 pm on 9/10/17 the every other weekend 7:00 the day during the week for 8 there was usually only 2 the series of the ed she had been at the 2017, and there were only 2	F3	53			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		LE CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/	12/2017	
	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	1		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 354 SS=F	#5 reported she was reported to the CEO was ready to walk out nurses and aids have being short staffed.  An interview with NA revealed the facility restated it was very streassignment done for reported she had been and worked 7:00 am indicated on day shift aides. She reported and if they did not generated here with the revealed here expects staffed to budget to restated it was up to me the support they need 483.35(b)(1)-(3) WAIDAYS/WK, FULL-TIME (1) Except when waim (f) of this section, the services of a register consecutive hours a (2) Except when waim (f) of this section, the services of the section the services of the services of the section the services of the section the section the services of the section that the section the section the section the section the section the section that the section that the section the section that the section th	ready to quit and she at the August meeting she at. She reported a lot of a left since she started due to a left since started she started a left since she started due to a left since she started she	F 35			10/24/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER.		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD	1 00/12/2011	
PERSON	WIEWORIAL HOSPITAL			ROXBORO, NC 27573		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475	
F 354	Continued From page	e 154	F 354	1		
	nurse only when the occupancy of 60 or for This REQUIREMENT by: Based on review of the schedules and staff in schedule a Registere consecutive hours per out of 28 weekends of 4/8/17, 4/9/17, 4/23/11 and 5/21/17).  Findings included: A record review of the there was no RN covers of Sunday for (3/19/17, 4/23/17, 5/6/17, 5/7/11.  An interview was consumer of the host amount of the host amount of the staff of	the facility's licensed staff interviews the facility failed to di Nurse (RN) for eight and di Alley for 7 days a week for 9 eviewed (3/19/17, 4/1/17, 7, 5/6/17, 5/7/17, 5/20/17, 7, 5/6/17, 5/7/17, 4/9/17, 7, 5/20/17, and 5/21/17).  Iducted with the RN House spital on 9/10/17 at 12:05 ervisor reported she did not ad Care Unit (ECU) staff. The DON confirmed erage on the reviewed DON revealed she did not attes reviewed. The DON e house supervisor from the lie building) acted as the RN		"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 net to fill vacant positions with supplement staffing while pending new hires; must ensure RN on schedule daily 8hours/d.  "The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Nurse staffing schedule shared with HI and CFO to review position needs. Supplemental staffing initiated to fill vacancies to limit DON working staff nurse shifts. Vacant positions posted a will be filled to ensure RN on worked schedule 8hours/day. The hou of other RNs in leadership/manager ro will be captured to aide in meeting the 8hours/day of RN coverage requireme Variance in RN coverage will be report to Administrator promptly.	rk o eed al ay.  R and rs le int. eed	
	I .	DON on 9/17/17, at 2:45 pm tion was to demonstrate a		"The monitoring procedure to ensure that the plan of correction is effective a that specific deficiency cited remains		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345004	B. WING _			09/	09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 354	4 Continued From page 155 Registered Nurse was in the building 7 days a week for 8 consecutive hours.  F 354 Registered Nurse was in the building 7 days a week for 8 consecutive hours.  F 354  F 354  F 354  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 RI 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		o RN tion ed	10/24/17				
SS=C	the following informat  (i) Facility name.  (ii) The current date.  (iii) The total number by the following category.	and the actual hours worked gories of licensed and aff directly responsible for t:						

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		•	6	15 RIDGE ROAD		
SUMMARY STATEMENT OF DEFICIENCIES ( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	,		(X5) COMPLETION DATE
vocational nurses (as  (C) Certified nurse aid  (iv) Resident census.  (2) Posting requirement  (i) The facility must pospecified in paragraph daily basis at the begin dai	defined under State law)  des.  ents.  ents.  est the nurse staffing data in (g)(1) of this section on a inning of each shift.  ded as follows:  de format.  dece readily accessible to  dosted nurse staffing data in oral or written request, lata available to the public of to exceed the community  tion requirements. The the posted daily nurse in mum of 18 months, or as in whichever is greater.  The facility staff posting and acility failed to post accurate and actual staffing totals for responsible for resident of ten days reviewed	F	356	processes that lead to the deficiency cited; Posted nurse staffing with actual worker		
Findings included:	•			licensed staff was not posted accuratel		
	Continued From page vocational nurses (as (C) Certified nurse aid (iv) Resident census.  (2) Posting requiremed (i) The facility must pospecified in paragraph daily basis at the beg (ii) Data must be post (A) Clear and readable (B) In a prominent plaresidents and visitors (3) Public access to pushed the post of the facility must, upo make nurse staffing do for review at a cost not standard.  (4) Facility data retent facility must maintain staffing data for a min required by State law This REQUIREMENT by:  Based on review of the staff interviews, the facility access the factual hours worked a licensed staff directly care per shift for five (9/9/17, 9/8/17, 9/7/17)	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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).	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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).	MEMORIAL HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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).	A BUILDING  345004  345004  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  815 RIDGE ROAD  ROXBORO, No. 27573  SUMMARY STATEMENT OF DESIGNICIES  (EACH DEFOCINCY) WIST DE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 156  vocational nurses (as defined under State law)  (C) Certified nurse aides.  (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).	A BUILDING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,
PERSON I	MEMORIAL HOSPITAL		1	615 RIDGE ROAD ROXBORO, NC 27573	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETION
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			out information required and is updathe unit secretary. The hours posted not match the working schedule for observed dates.  "The procedure for implementing the	I did 5
	the staff posting for am - 7:00 pm and se am. The other form nurses for first shift shift as 3:00 pm - 11 11:00 pm - 7:00 am.	nurses for the first shift 7:00 econd shift as 7:00 pm - 7:00 recorded staff posting for as 7:00 am - 3:00 pm, second :00 pm, and third shift as		acceptable plan of correction for the specific deficiency cited; The form for posting nursing staffing revised on 09/12/17 to include the required information of facility name current date, total number and the a hours worked by licensed and unlice	y was , ctual ensed
	posting dated 9/9/17 Registered Nurses ( pm shift totaling 16 a staffing schedule for no RNs on the 7:00 An interview was co	e staff on 9/12/17 at 1:00 pm 7 revealed there were two RNs) on the 7:00 am to 7:00 actual hours worked. The 9/9/17 revealed there were am - 7:00 pm shift.  nducted with the Director of 1/12/17 at 2:45 pm. The DON		nursing staff directly responsible for resident care per shift, and Residen census. In the event of changes in t schedule that affect actual worked he form will be updated promptly to ensure accurate posting. Posted da nursing staffing data will be maintain electronically for 18 months.	t he lours, ily
	confirmed there wer posting and indicate recorded for the 7:00 actual hours. The I know why they were record the staffing. nurses worked 12 houses worked 12 house dated 9/8/17 on the 7:00 am - 3:00 hours worked and to 11:00 pm shift indicate.	e discrepancies on the staff d there should be no RNs 0 am to 7:00 pm shift and no DON reported she did not e using two separate forms to The DON confirmed the our shifts unless otherwise  //12/17 at 1:00 pm of the staff or revealed there was one RN 0 pm shift totaling 8 actual wo RNs on the 3:00 pm - eating 8 actual hours worked. e for 9/8/17 revealed there		"The monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains correction in compliance with the regular requirements;  The unit secretary will complete form for next day(s) and will ensure posting designated area. Posting of form will reviewed at the beginning of each sensure accuracy. Changes will be most to be reflective of required elements posting and any discrepancies obseduring audit will be corrected prompose.	d that rrected atory  n daily ng in Il be hift to nade of crved tly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	1 03/12/2017		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL P		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 356	confirmed there was am - 3:00 pm shift at total and actual hou Additionally, the DO RN on the 3:00 pm hours worked should the RN began her significant with the RN began her significant with the RN began her significant with the RN began her significant worked at 1:00 pm shift totaling schedule for 9/7/17 on the 7:00 am - 3:00 pm - 11:00.  An interview with the confirmed there was pm shift and the act recorded as 8. Add there were 2 RNs for with the accurate how the RNs on the 7:00 am actual hours worked 11:00 pm shift totaling the staffing schedul was one RN on the RNs on the 3:00 pm shift totaling the staffing schedul was one RN on the RNs on the 3:00 pm shift significant with the RNs on the 3:00 pm shift significant was significant with the RNs on the 3:00 pm shift significant with significant with the RNs on the 3:00 pm shift significant with the RNs on the 3:00 pm shift significant with the RNs on the 3:00 pm shift significant with the RNs on the 3:00 pm shift significa	e DON on 9/12/17 at 2:45 pm is no RN working on the 7:00 and she indicated the staff is worked were inaccurate. N confirmed there was one in 11:00 pm shift and the actual distribution between the actual hours worked should be actual hours worked should be actual hours worked should be actual hours worked there were two actual actual hours worked. In actual hours worked he actual hours worked he actual hours worked he actual hours worked. In actual hours worked he actual hours	F 356	"The title of the person responsible implementing the acceptable plan of correction;  Administrator or Designee			
	confirmed there was 3:00 pm shift and th	s one RN on the 7:00 am - e actual hours worked should he DON further confirmed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		STRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING _		<del></del>	09/	12/2017
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL			615 RII	T ADDRESS, CITY, STATE, ZIP CODE DGE ROAD BORO, NC 27573		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	shift with the accurate DON reported the Unstaff posting each moschedule. The DON recorded it inaccurate Unit Ward Clerk was was unavailable for a An observation on 9/7 posting dated 9/5/17 on the 7:00 am - 3:00 hours worked and 2 Fpm shift totaling 8 act staffing schedule date no RN on the shift an 11:00 pm shift.  An interview with the confirmed there were 3:00 pm shift and the be recorded as 0. The was one RN on the 3 the accurate hours do An interview with the revealed the process posting was done dail shift by the Unit Ward Clerk used to complete the postinidentify why there we stated, in the morning would remove the pre The DON reported he Ward Clerk was to co accurately.	or the 3:00 pm - 11:00 pm e hours documented. The it Ward Clerk completed the it was easy. The DON reported the not in the facility today and in interview.  12/17 at 1:00 pm of the staff revealed there was one RN in pm shift totaling 8 actual RNs on the 3:00 pm - 11:00 in it was a complete in the ed 9/5/17 revealed there was in the ed 9/5/17 revealed there was in the interview i	F	856			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER			61	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 356 F 371	3:50 pm revealed her expectation for completing the staff posting was that it be done accurately and updated as needed.  483.60(i)(1)-(3) FOOD PROCURE,			356 371			10/24/17
SS=F	considered satisfacto authorities.  (i) This may include for	erve - Sanitary  rom sources approved or  ry by federal, state or local  bod items obtained directly  subject to applicable State					
	facilities from using prigardens, subject to consafe growing and food  (iii) This provision does	s not prohibit or prevent roduce grown in facility ompliance with applicable					
	(i)(2) - Store, prepare accordance with profeservice safety.  (i)(3) Have a policy refoods brought to residusitors to ensure safehandling, and consunthis REQUIREMENT by:  Based on observatio facility failed to discar and six of ten air vent	distribute and serve food in essional standards for food egarding use and storage of dents by family and other eand sanitary storage,			" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:	ę	
	•	ed all residents. Findings			Leftover food is stored in accordance o policy and is to be discarded after 3 day		

PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345004	B. WING _	B. WING		09/12/2017		
	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, Z 615 RIDGE ROAD ROXBORO, NC 27573	•			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE ENCY)	(X5) COMPLETION DATE
F 371	inspected. One of the contained salmon stopacks dated 8-26-17 8/28/17, meat balls 8/30/17, beef enchild dated 8/31/17 and a During this observation said this is garbage items from the refrigion on 9/08/2017 at 8:3 date on the leftovers in the refrigerator the you should throw it deftover, it should be there were no obsermore than three day 2. On 9/05/2017 at 2 inspected. The vertices was noted to have be 9/08/2017 at 8:41 At the kitchen appeare on them. Cook #1 sinceptor was shown	10:13 AM, the kitchen was ne walk-in refrigerators eaks in individually sealed 7, carmel sauce dated and pork chops dated adas and mixed vegetables pple crisp dated 9/1/17. ion the Food Service Director and began to remove the erator.  3 AM Cook #2 said, "The sist the date we put the food e first time. Three days later out. Once you reheat the thrown out." At this time, vations of leftovers held for its.  10:13 AM, the kitchen was a tabove a reach-in refrigerator rown mildew-like stains. On M, six of ten ceiling vents in d to have mildew-like staining and Maintenance does the	F3	On 09/05/17, leftover for walk-in refrigerator with greater than 3days of wexpired food was discar Six of ten vents in the kit have brown mildew stain work order was created clean the vents with issue.  "The procedure for impacceptable plan of correspecific deficiency cited Leftover food will be sto and then discarded after department will be educe food by CFO by 10/24/1 walkthrough of all food see completed daily and be noted on a food storate and Lead.  All vents in the kitchen we 09/20/17. All staff were to create work orders for requests on 09/27/17.  "The monitoring procedent the plan of correction is specific deficiency cited and/or in compliance wirequirements; The CFO or designee we weekly observation of for Concerns observed duriwill be addressed and a days will be discarded, a be reported to Dietary te corrections. Results of a reviewed for patterns ar reported at QAPI month	a marked date hen first used. All ded on 09/05/17. itchen appeared to n on 09/08/17. A on 09/20/17 to ues.  lementing the ection for the ; red and dated, r 3 days. Dietary eated on storage of 7. A daily storage areas will discrepancies will age log by Dietary were cleaned on educated on how r maintenance  fure to ensure that effective and that remains corrected th the regulatory will complete bod storage areas. ing walkthrough ny leftover food <3 and variances will eam lead for audits will be nd/or trends and			

Facility ID: 953396

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _	B. WING		09/	12/2017
	ROVIDER OR SUPPLIER			615	EET ADDRESS, CITY, STATE, ZIP CODE RIDGE ROAD XBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371 F 428 SS=D					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 an 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		10/24/17
	reviewed at least onc pharmacist.  (3) A psychotropic drubrain activities associand behavior. These limited to, drugs in the (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.  (4) The pharmacist mato the attending physical contents of the attending physical contents on the attending physical content	of each resident must be e a month by a licensed ag is any drug that affects ated with mental processes drugs include, but are not e following categories:					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	<b>345004</b> B. WING _		B. WING		09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 428	drug that meets the of (d) of this section for (ii) Any irregularities in during this review museparate, written report attending physician a director and director and director and the irregularity the (iii) The attending phyresident's medical recirregularity has been action has been taken be no change in their physician should doct the resident's medical (5) The facility must can procedures for the review that include, but frames for the different steps the pharmacist identifies an irregular to protect the resident This REQUIREMENT by:  Based on record revinterviews with of the	le, but are not limited to, any riteria set forth in paragraph an unnecessary drug.  Inoted by the pharmacist is to be documented on a port that is sent to the individual indiv	F 42	"The plan of correcting the specific deficiency. The plan should address processes that lead to the deficienc cited; Resident #66 had pharmacy	s the	
	reviewed for unneces Findings included:	sary medications.		recommendation on 08/22/17 for GI Zyprexa with goal to discontinue the dose. The pharmacy recommendati	e PRN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/1	2/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (			
				615 RIDGE ROAD			
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	Continued From pag	e 164	F 4	28			
F 428	Resident #66 was or on 7/3/17, with diagrand dementia without. The admission Minin 7/24/17, specified Reimpaired cognition, Indementia. The MDS did not have any behassessment period. The resident was not medications.  Resident #66 was di 7/31/17.  The resident was rehome on 8/2/17 with depression and dem Record review reveal 8/2/17, for Zyprexa 1 (PRN) for agitation of treat the symptoms of as schizophrenia and Review of the August Record (MAR) reveal the PRN Zyprexa the PRN Zyprexa the faugust. A review of electronic medical resident with the symptoms of the August Record (MAR) reveal the PRN Zyprexa the PRN Zyprexa the faugust. A review of electronic medical resident with the symptoms of the August and Review	riginally admitted to the facility noses including depression at behaviors.  Inum Data Set (MDS) dated esident #66 had moderately had depression and also indicated the resident naviors during the The 7/24/17 MDS specified receiving antipsychotic  scharged to the hospital on eadmitted to the nursing diagnoses including entia without behaviors.  Alled a physician's order dated 1.25 mg daily as needed or anxiety. Zyprexa is used to of psychotic conditions such	F 4	was not reviewed by attendand the record did not indicated diagnosis or documented by Order to discontinue Zypre received and noted on 09/3.  "The procedure for implemacceptable plan of correctispecific deficiency cited; All August and September recommendations for GDR reviewed by 10/20/17. Pharecommendations will be resigned by DON and Attend within 30 days of receipt of communication. Pharmacy communicate outstanding during monthly consultation.  "The monitoring procedure the plan of correction is eff specific deficiency cited reand/or in compliance with requirements; Monthly pharmacy recomm GDR will be audited for accreason of declination for the by the Administrator or Des Discrepancies will be addressed at QAPI monthly the months and then quarterly	cate supporting behaviors. exa was 30/17.  menting the on for the pharmacy of for will be armacy eviewed and ding Physician for will items to DON items to DON items to pharmacy eviewed and ding the series of the regulatory in th		
	a Consultation Repo pharmacist dated 8/22/17. The Consu	ent's medical record included rt from the consultant  Itation Report indicated acciving the antipsychotic		" The title of the person resimplementing the acceptate correction;  Administrator or Designee	ble plan of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/1	2/2017
NAME OF PROVIDER OR SUPPLIER  PERSON MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	discontinued. The ph stated that the use of required a qualifying recommendation also antipsychotic orders i were limited to seven documentation for the antipsychotic medical. Review of the Septen Administration Recon#66 received the PRN between 9/1/17 and 9.  During an observation at 1:45 PM, the reside behaviors.  On 9/9/17 at 4:21 PM interviewed about the medication and lack or recommendations. The the resident returned medication orders that to taper the use of the He stated his plan was medication and discommendation and discommendatio	and recommended it be tarmacist recommendation an antipsychotic medication diagnosis. The stated that "as needed" an emergency situation days and required econtinued need of the tion.  The Medication do (MAR) revealed Resident Not Zyprexa five times (Mary) and the medication of Resident #66 on 9/9/17 and the medical Director was a use of the antipsychotic of response to the pharmacy me Medical Director stated from the hospital with at included the Zyprexa and antipsychotic medication. The ewed the pharmacy distated his expectation was inner should have reviewed a pharmacy recommendation also stated he expected administered, there had to the reason it was used.	F 42	В		
	within 3-5 days. He a whenever a PRN was be documentation for An interview was con PM with the Nurse Pr	Iso stated he expected administered, there had to the reason it was used.  ducted on 9/12/17 at 12:16				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345004	B. WING	B. WING		9/12/2017	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP C 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 431 SS=E	off orders, had been of weeks. He stated that pharmacy recomment write orders but since leave, there would be orders, so he had been the NP also stated he pharmacy recomment that he had been bus admissions recently a pharmacy recomment 483.45(b)(2)(3)(g)(h) LABEL/STORE DRUGUMENT The facility must providrugs and biologicals them under an agree \$483.70(g) of this part unlicensed personnel law permits, but only supervision of a licensial service that assure the accuration of the service that assure the accuration of the service consultation of the service con	Secretary, who usually took out on leave for the last few the first few the dations, he would usually the Ward Secretary was on a no one to transcribe the en waiting to review them. The usually reviews the dations within a week but y with some hospital and had not addressed dations at the facility. DRUG RECORDS, GS & BIOLOGICALS de routine and emergency to its residents, or obtain ment described in the transcribed in the facility may permit to administer drugs if State under the general sed nurse.  Collity must provide the ses (including procedures at acquiring, receiving, nistering of all drugs and the needs of each resident.		431		10/24/17	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED			
		345004	B. WING		09/12/2017	
	NAME OF PROVIDER OR SUPPLIER  PERSON MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	1 03/12/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 431	(g) Labeling of Drug Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable.  (h) Storage of Drug (1) In accordance with facility must stored locked compartment controls, and permit have access to the controlled drugs list Comprehensive Drug Control Act of 1976 abuse, except where package drug distrit quantity stored is minimum be readily detected. This REQUIREMENT by:  Based on observative record review, the famedications within the specified by the mare Room; and, failed to minimum identifying (including the reside	and Biologicals. It is and Biologicals. It is used in the facility must be ce with currently accepted les, and include the bry and cautionary expiration date when  It is and Biologicals. It is and Biologicals. It is tate and Federal laws, expiration date when  It is under proper temperature is only authorized personnel to keys.  It provide separately locked, compartments for storage of ead in Schedule II of the leg Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can left is not met as evidenced it is not met as evidenced i	F 43	"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 miss temperature recording on 09/08/17. Or medication was observed unlabeled in medication room refrigerator and two other medications were observed	ing ne	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345004	B. WING _			09	/12/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				61	15 RIDGE ROAD		
PERSON	MEMORIAL HOSPITAL			R	OXBORO, NC 27573		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 431	Continued From page	e 168	F4	431			
	The findings included	l:			unlabeled on medication cart. Medicati	ons	
					stored in refrigerator and unlabeled		
	1) Accompanied by N	lurse #2, an observation was			medications in medication cart were al		
		Medication Room (Med			discarded on 09/09/17. It was determine	ied	
	,	:58 AM. Upon opening the			that the medication storage refrigerator		
		or door, a thermometer in			was malfunctioning and was replaced	on	
	_	ited the temperature was 26			09/09/17.		
	degrees Fahrenheit (				" <del>-</del> "		
	_	by Nurse #2. A temperature			" The procedure for implementing the		
		r indicated the temperature			acceptable plan of correction for the specific deficiency cited;		
	9/7/17 (the time was				Medication storage refrigerator will have	<b>'</b> Δ	
	3/// // (tile tillle was i	not documented).			daily temperature check and recorded		
	The contents of the M	Med Room refrigerator on			temperature log by charge nurse on		
	9/7/17 at 9:58 AM inc				second shift. Variances in fridge temps		
	I .	Lantus insulin dispensed for			will be reported to DON or Designee, a		
	Resident #30. One v	•			the charge nurse will create a work ord		
	dispensed from the p	harmacy on 6/30/17, a			if indicated. Both medication carts will	ре	
	second vial of insulin	was dispensed on 8/8/17,			checked to ensure all medications are		
	and the third vial of in	sulin was dispensed from			labeled by 10/05/17 and weekly by		
	the pharmacy on 8/13				Director of Nursing or Designee.		
		ct information indicated					
	1 -	ntus insulin should be stored			" The monitoring procedure to ensure t		
		Do not freeze. Discard if			the plan of correction is effective and the		
	frozen.				specific deficiency cited remains correction		
		_antus insulin dispensed			and/or in compliance with the regulator	У	
		n 8/18/17 for Resident #41.			requirements;		
		Novolog insulin dispensed n 8/13/17 for Resident #30.			Weekly audits of medication storage refrigerator and temperature logs will be	0	
	A review of the manu				completed by Infection Preventionist of		
	I .	unopened Novolog insulin			Designee. Medication carts will be aud		
		ween 36F to 46FDo not			weekly for 30 days by DON or Designe		
	I .	lo not use Novolog if it has			for unlabeled medications and then	-	
	been frozen.				monthly for 60 days. Results of audits	will	
		Humalog insulin dispensed			be reviewed for patterns and/or trends		
	I	n 9/6/17 for Resident #133.			and reported at QAPI monthly for three	)	
	A review of the manu				months and then quarterly thereafter.		
	information indicated	unopened Humalog insulin					
	should be stored bety	ween 36F to 46F. Do not			" The title of the person responsible for	•	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345004	B. WING			09/	12/2017
	ROVIDER OR SUPPLIER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD COXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	administered rectally) pharmacy on 2/20/17 Resident #71. An aumedication by the pharmacy on 2/20/17 Resident #71. An aumedication by the pharmacy on 2/5 mg prodispensed from the president #85. House stock of 2 boand 32 individual (not acetaminophen suppover-the-counter pain rectally). A review of information indicated stored between 25F transcription indicated stored indicated stored indicated stored indicated from the product of the manufaction indicated prevnar 13 36F to 46F; Do not freeze. House stock of 1-via indicated prevnar 13 36F to 46F; Do not freeze. I-vial of Perforomist treatment of chronic of disease or asthma). manufacturer 's production indicated prevnar 13 36F to 46F; Do not freeze.	ing) promethazine inausea medication to be indispensed from the and labeled for use by exiliary label placed on the armacy read, "Do not inethazine suppositories harmacy on 6/9/17 for exes (12 count in each box) is in a box) 650 mg esitories (an ineliever to be administered the manufacturer's product the suppositories should be in 80F; Do not freeze. In Pneumovax 23 Single idispensed from the in A review of the inuct information indicated did be stored between 36F to al Aplisol (a vaccine) harmacy on 8/31/17 and in opened on 9/1/17. A currer's product information all be stored between 36F to al Prevnar 13 (a vaccine). A currer's product information should be stored between exeze; Discard if frozen. it (a medication used for the obstructive pulmonary	F	431	implementing the acceptable plan of correction.  Infection Preventionist, DON or Design	ee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345004	B. WING _	<del></del>		09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	AM with Nurse #2. Ithe Med Room refrigsupposed to be 36 Fobserved as she turn the Medication Room temperature would in the Medication Room refrigerator was obsine recommended ranger Room refrigerator to be with (noted on the logish medications to be stimanufacturer's recommended ranger and the Don report pharmacy regarding refrigerator of the Medication was temperature in the Medicated the temperature remained an observation was temperature in the Medicated the temperature recommended ranger recommended ranger recommended ranger recommended ranger refrigerator of the Medicated the temperature recommended ranger recommend	anducted on 9/7/17 at 10:00 Upon inquiry, the nurse stated gerator's temperature was to 46 F. The nurse was need the temperature up on morefrigerator. She stated the need to be watched.  AM, an interview was acility's Director of Nursing interview, the DON stated she need to be outside of the need to 46F) and the ored in accordance with the need in accordance with the need in accordance with the need to had called the the medications stored in the need Room. The pharmacy back if the refrigerator	F 4	31		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017
	ROVIDER OR SUPPLIER		6	TREET ADDRESS, CITY, STATE, ZIP CODE  15 RIDGE ROAD  ROXBORO, NC 27573	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION
F 431	medications stored in same as those store the observation made. Accompanied by Nu made of the refrigeral Medication Room on thermometer in their temperature was 300 reading was verified.  2. The temperature did not include documeringerator temperatingerator temperations were the same as the during the observation. An interview was conwith the DON. The laware there was a comperature of the Management of the Management of the Management of the Management of the DON states.	en checked on 9/8/16. The in the refrigerator were the d in the refrigerator during e on 9/7/17.  It is a #2, an observation was ator's temperature in the in 9/8/17 at 2:30 PM. The efrigerator indicated the in F. The thermometer by Nurse #  Ilog sheet on the refrigerator mentation to indicate the cure had been checked on it is stored in the refrigerator in made on 9/7/17.  Inducted on 9/8/17 at 2:55 PM DON reported she was not continuing problem with the index Room refrigerator.  It was conducted on 9/9/17 at ON upon her request. At that it is the Med Room refrigerator and all medications stored in	F 431	DEPIGIENCY)	
	Medication Cart on 9 observation revealed med cart contained tunlabeled vials of ipinhalation (an inhale management of chrodisease); 1 - loose, to	as made of the Short Hall 0/7/17 at 9:30 AM. The difference of the he following: 2 - loose, ratropium solution for difference difference obstructive pulmonary unlabeled vial of 2.5 milligram ml) albuterol solution for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345004	B. WING _	<del></del>		09/12/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 431	Continued From pag	e 172	F 4	31			
	asthma); and, 2 - ind packages of 2.5 mg/s solution.  An interview was corwith Nurse #1. Nurse assigned to the Shorinquiry, the hall nurse need to throw away to medication stored or reported the vials of	d medication used to treat ividually wrapped, unlabeled 3 ml albuterol inhalation adducted on 9/7/17 at 9:35 AM to #1 was the hall nurse to Hall Med Cart. Upon to estated she would probably the unlabeled vials of the med cart. The nurse medication should have been tage that was labeled by the					
	An interview was cor PM with the facility ' Upon inquiry as to w unlabeled vials of inh	<del>-</del>					
	made of the Medicat refrigerator on 9/7/17 of the refrigerator at included one vial of F used for the treatmen	information required,					
	An interview was cor	nducted on 9/7/17 at 12:31					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345004	B. WING			09/	12/2017
	ROVIDER OR SUPPLIER		•	6	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD COXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431 F 441	Upon inquiry as to wh unlabeled vials of inha stated she expected a appropriately.	e 173 Director of Nursing (DON). Lat her expectations were for alation solution, the DON all medications to be labeled  f) INFECTION CONTROL,		431 441			10/24/17
F 441 SS=J	PREVENT SPREAD,  (a) Infection prevention  The facility must esta	con and control program.  blish an infection prevention IPCP) that must include, at	F -	441			10/24/17
	investigating, and cor communicable diseas volunteers, visitors, a providing services un arrangement based u conducted according	der a contractual pon the facility assessment to §483.70(e) and following ndards (facility assessment					
	for the program, whic limited to:  (i) A system of surveil possible communicab before they can sprea facility;  (ii) When and to whor	lance designed to identify ble diseases or infections and to other persons in the m possible incidents of se or infections should be					
	•	smission-based precautions					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345004	B. WING			09/1	12/2017
	ROVIDER OR SUPPLIER			615 RIDGE	DRESS, CITY, STATE, ZIP CODE ROAD O, NC 27573	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	(iv) When and how is resident; including be (A) The type and dure depending upon the involved, and (B) A requirement the least restrictive possicircumstances.  (v) The circumstance must prohibit employed disease or infected secontact with resident contact will transmit (vi) The hand hygier by staff involved in decent of the facility's Iffactions taken by the (e) Linens. Personn process, and transpossicient of infection.  (f) Annual review. The annual review of its program, as necessare This REQUIREMEN by:  Based on observation facility staff: 1) Failed glucometer (device to blood glucose or blood states).	event spread of infections; solation should be used for a ut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the sible for the resident under the sible for the resident under the es under which the facility eyes with a communicable skin lesions from direct ts or their food, if direct the disease; and the procedures to be followed lirect resident contact.  Ording incidents identified PCP and the corrective facility.  The limits handle, store, ort linens so as to prevent the the facility will conduct an IPCP and update their	F	deficie proces cited;	plan of correcting the specific ency. The plan should address t sses that lead to the deficiency Resident #55 continues to rece		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _		0:	9/12/2017	
NAME OF P	ROVIDER OR SUPPLIER	-	'	STREET ADDRESS, CITY, STATE, ZIR			
				615 RIDGE ROAD			
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES  NCY MUST BE PRECEDED BY FULL  DUSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE	(X5) COMPLETION DATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIE			
E 444							
F 441	Continued From page	-	F 4				
		or 1 of 3 residents observed		demonstrated no evidend			
		glucose checked (Resident		related to blood sugar mo	onitoring.		
		aff also failed to wear gloves					
		blood glucose check for 2 of 3		Resident #134 was disch	_		
		to have their blood glucose		spouse on 9/9/2017. Price			
		#55 and Resident #134); and,		the resident did not demo	•		
	1 .	hand hygiene after providing		adverse effects from brea			
		care and before providing		control practice related to	o blood sugar		
	perineal care for 1 of 1 resident reviewed for infection control (Resident #10).  Immediate jeopardy began on 9/8/17 and is			monitoring.	dad appropriate		
				Resident # 10 was providing incontinence care 09/09/			
				deficient practice was ob	•		
	1	ne Nursing Assistant (NA) #10		deficient practice was ob	Serveu.		
		od glucose checks nor the hall		The procedure for impler	menting the		
		ere trained on how to disinfect		acceptable plan of correct			
		er between residents in		specific deficiency cited;	Shorr for the		
	_	e manufacturer's directions for		The unit staff reviewed th	ne policy on		
		A #10 did not perform hand		glucose monitor cleaning			
		esidents when doing the blood		hygiene and validated the			
		I did not wear gloves on two		consistent with the CDC	-		
	T -	when doing the blood		Thereafter, education on	-		
	1	ne of these occasions		glucometers was initiated			
	_	ursing assistant had been		the Director of Nursing fo	_		
		Ill nurse to use gloves.		complete blood glucose			
				Additional training has be	een conducted on		
	Example number 2	is at no actual harm with		glucose monitor disinfect	tion, per the		
	potential for more th	nan minimal harm that is not		manufacturer□s instructi	on, to both		
	immediate jeopardy	and the scope is isolated (D).		licensed nursing staff and	d CNAs. Those		
				trainings were conducted	d by a licensed		
	The findings include	ed:		nurse and/or infection co	ntrol		
				preventionist.			
		acility policy entitled "Blood					
		/Treatment" (Originated June		The ECU protocol regard			
	2015) read, in part:			individuals can complete	•		
	_	ame of a glucometer] with		monitoring was changed			
	1	sinfectant wipes after each		9/27/2017, to only allow			
	resident use."			nurses to complete blood	_		
				monitoring. By limiting th			
	A review of the facil	ity's policy entitled "Hand		performing the blood glue	cose monitoring,		

Facility ID: 953396

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/	12/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 33.	12.2011	
				615 RIDGE ROAD			
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	Continued From page	e 176	F 44	1			
F 441	Hygiene" (Revised July "A. Indications for Ushand rub in all other rebelow, unless hands situations on the list indirect patient contact patient's environment potentially infectious fluids, specimens, etc.  A portion of the facilit (Revised July 2017) and Aspects of Hand Carasection identified siture gloves was indicated "Gloves should be usal. Touching excretifluids, mucous members. It is likely that has with blood, body fluid infectious material"  An interview was con AM with the Infection hospital. The Infection hospital. The Infection duties included the trainfections for the facilishe provided education infection control topic. A continuous observation of the grant of the she did a finger still and the she did a finger still	ally 2017) read, in part: e:2. Use an alcohol-based recommended situations are visibly soiled." The included: Before and after and contact with the it; and, after contact with materials and/or bodily c.  y's policy on Hand Hygiene also addressed "Other e and Protection." This ations when the use of and read, in part: ed when: ions, secretions, blood, body wranes, or non-intact skin fally contaminated items ands will come in contact s, or other potentially  ducted on 9/8/17 at 11:05 Control nurse shared by the on Control nurse reported her acking and trending of ity. The nurse also reported	F 44	there will be improved accounts staff carrying out the procedure maintenance of infection control standards. Training on the poli procedure for completing blood monitoring, including hand hygi initiated on 9/22/2017 and concurrence the organization so Infection Concurrence all licensed nursing staff conducting glucose monitoring. Training we completed by 9/29 for nurses reassigned to conduct blood glucting monitoring.  Key members of the facility lead team will have huddle meetings Monday through Friday to report on the above actions and identity opportunities related to resident spreadsheet is maintained and enhanced the organization of the and strengthened the structure discussion. The leadership team composed of the Administrator, Nursing, Director of Quality, and Human Resources. Adjunct will be provided by the CEO, Claworker, Director of Plant Opera others as may be needed from time.  The Director of Nursing or Desi educate Nurse aides on approprincontinence care technique and interest	e and ol cy and l glucose dene, was ducted by ontrol nurse for cting blood vill be outinely ose  dership s daily, rt progress ify any new t safety. A has ne meeting of the m is , Director of d Director support FO, social tions, and time to		
	#10 was not wearing lancet to do a finger s	gloves when she used the stick and completed the BG observed as she placed the		requirement to change gloves to dirty and clean procedures, by  The monitoring procedure to enough the plan of correction is effective.	10/24/17. nsure that		

Facility ID: 953396

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _		0:	9/12/2017	
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL	,		STREET ADDRESS, CITY, STATE, ZIP ( 615 RIDGE ROAD ROXBORO, NC 27573	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	exited the room.  On 9/8/17 at 4:54 PM she entered Resident glucometer and BG s. The NA did not disinf residents. She did not hand sanitizer, or put test strip into the glucometer strip into the glucometer strip into the glucometer. At that time the procedure and strip the procedure and strip with NA #10. During asked as to how she shared glucometer be hesitated before static wipe." When asked who sany questions regard glucometer. She static nurse.  The NA was observe Nurse #2 on 9/8/17 at the hall nurse assign when NA #10 inquire use to disinfect a shat instructed her to use began to go back into an alcohol wipe to dis glucometer. At that the NA to exit the reswas asked who she was a sked was	lancets, individually es, and BG test strips) and  1, NA #10 was observed as t #55's room with the supplies in the plastic case. ect the glucometer between of wash her hands, use a congloves. NA #10 put a cometer and turned towards orm a finger stick on the equation of the NA was asked to stop ep out into the hallway.  Iducted on 9/8/17 at 4:55 PM the interview, the NA was was supposed to disinfect a etween residents. The NA ng she needed to use "a which wipes she would use, if not know. At that time, the he would go to if she had ing disinfection of the ted she would go to the hall d as she approached the t 4:58 PM. Nurse #2 was ed to care for Resident #55. Ed what wipes she needed to irred glucometer, Nurse #2 an alcohol wipe. The NA of Resident #55's room to use	F 4	specific deficiency cited re and/or in compliance with requirements;  The Infection Preventionis competency observations nurses of disinfecting bloo monitors and use of gloves conducted at least 5 times 30 days, then monthly for Variances will be reported nurse upon observation for remediation. Results of au reviewed for patterns and/reported at QAPI monthly months and then quarterly Director of Nursing or desi observations of 2 nurse aid various shifts to include we incontinence care to ensur care is provided with chan between dirty and clean proposed Results of audits will be repatterns and/or trends and QAPI monthly for three months and the person respinglementing the acceptal correction.  Director of Nursing or Design of the person of the person respinglementing the acceptal correction.	t will complete on licensed d glucose s will be s per week for 60 days. to the licensed or immediate dits will be for trends and for three or thereafter. The signee will make des weekly (on eekends) during re appropriate ging gloves rocedure. eviewed for d reported at onths and then		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345004	B. WING	<del> </del>	,	09/12/2017	
	ROVIDER OR SUPPLIER	,	•	STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 441	the facility 's Director  On 9/8/17 at 4:59 PM accompanied as she and inquired which w glucometer disinfection ruse to use the wipe approved germicidal NA #10 she would nepurple top and use the glucometer. While N germicidal wipes, the needed to be used w Nurse #2 responded, Upon the NA's return the nurse reminded has BG check. After Nacontainer of germicidal fishe had been told has tated she had not the manufacturer directly germicidal wipes and nurse or DON for furt NA #10 read the directly was observed as she in accordance with the disinfect the glucor A follow-up interview on 9/8/17 at 5:05 PM NA was asked why she tween residents ar performing a blood gishe knew she should reason as to why she was asked observation.	se stated she would go to r of Nursing (DON).  1, Nurse #2 was went to the DON's office ipes needed to be used for on. The DON instructed the es "with the purple top" (an wipe). Nurse #2 then told ed to get the wipes with the lose to disinfect the A #10 was retrieving the nurse was asked if gloves hen a BG check was done. "Of course, it's blood." with the germicidal wipes, her to use gloves when doing A #10 opened the new all wipes, the NA was asked now to use these wipes. The ot. The NA was directed to ections on the label of the encouraged to ask the hall ther instructions, as needed. Cotions for disinfection and e used the germicidal wipes he manufacturer instructions meter.  Was conducted with NA #10. During the interview, the he did not wash her hands and use gloves when lucose check. The NA stated and did not verbalize a	F 44	41			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/12/2017
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP COL 615 RIDGE ROAD ROXBORO, NC 27573	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	#10 was observed fifinger stick to compl #134. The NA was the surveyor entered a pair of gloves she them on. She told the stick him again becaused adequate blood sup again observed as a second finger stick of BG check was comproom and went to the container of germicing She then used the glucometer.  An interview was converted with the facility's DC infection control con BG checks were dis she would expect stop between residents, of the check, and disinfect appropriately after each of the glucometer.  On 9/15/17 at 1:07 for Nursing was informed by telephone. The favailable.  2. Review of the fact Hygiene Policy, last the following on page A."1. Indication "Use plair	the facility. At that time, NA from the hallway as she did a lete a BG check on Resident and wearing gloves. When do the room, NA #10 pulled out had in her pocket and put her resident she needed to ause she did not get an apply the first time. The NA was the used a lancet to do a con Resident #134. When the poleted, NA #10 exited the leter nursing station where the dall wipes had been placed. Itermicidal wipes to disinfect when the cursed. The DON reported aff to wash their hands use gloves when doing a BG the blood glucometer ach use.  PM, the facility's Director of led of the Immediate Jeopardy acility's Administrator was not callity's Infection Control, Hand revised on 07/2017 revealed	F4	.41		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 15 RIDGE ROAD COXBORO, NC 27573	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 441	other recommended visibly soiled when contaminated body during patient care."  Under Other Aspect Protection the follow "C. e) Perform I gloves. Gloves do r An observation of a provided for Resider at 11:19 AM. Nursir # 12 washed their horovided the bath us warm water. While NA #7 provided periwith soap and warm times, folding the washcloth after the scompleted the perin washcloth in the bas was turned to her sir was a large bowel mused disposable wip movement, and ther buttocks with the sa the perineal care. Na fresh basin of wate with the same wash residue present and NA # 7 did not remo hand hygiene at tha paste to the buttock, urned to her back, provided to her back, provided with the same wash residue present and the paste to the buttock, turned to her back, provided to her ba	lcohol-based hand rub in all use below, unless hands are moving from a site to a clean body site	F 441			

PERSON MEMORIAL HOSPITAL  (X4) ID PREFIX TAG  F 441  Continued From page 181  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  STREET ADDRESS, CITY, STATE, ZIP CODE  615 RIDGE ROAD  ROXBORO, NC 27573  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CONSTRUCTIVE ACTIO	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
PERSON MEMORIAL HOSPITAL  (X4) ID PREFIX TAG  F 441  Continued From page 181  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  STREET ADDRESS, CITY, STATE, ZIP CODE  615 RIDGE ROAD  ROXBORO, NC 27573  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CONSTRUCTIVE ACTIO			345004	B. WING	······		9/12/2017
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 441  Continued From page 181  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					615 RIDGE ROAD		
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	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
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	F 441	been removed. NA same gloves and us provide the perineal was dried, NA #7 ap perineal area as she pair of gloves worn to NA #7 did not wash based hand rub, or centire bathing, incomprocedure.  In an interview with land, she stated she wash hands or chan bowel movement and remainder of the bat applying a zinc paster added she had not be wash cloth after clear before cleansing the know that using bow or gloves during per resident at risk for U only been trained do gloves only before pand after care was coroom.  On 09/09/17 at 12:00 conducted with NA # year or two since she #10, and that usually She stated she rememble hygiene in-service in was taught to do hat entering a resident's	#7 continued to wear the e the same washcloth to care. After the perineal area plied zinc paste to the front e continued to wear the same to clean the bowel movement. ther hands, use an alcohol change gloves throughout the atinence, or perineal care  NA #7 on 09/09/17 at 11:46 thad not been educated to ge gloves after cleaning a d before continuing the th, cleansing the perineum, or e to the perineal area. She to been instructed to use a clean ning the rectal area and e perineum, and she did not tivel contaminated washcloths ineal care could put the TIs. NA #7 stated she had to hand hygiene and wear troviding care for a resident tompleted before leaving the  4 PM an interview was #12. She stated it had been a the was assigned to Resident to she worked in activities. The state of the sident to she worked in activities. The state of the sident to she worked in activities. The state of the sident to she worked in activities. The state of the sident to she worked in activities. The state of the sident to she worked in activities. The same state of the same sident to she worked in activities. The same state of the same sident to she worked in activities. The same state of the same sident to she worked in activities. The same state of the same sident to she worked in activities. The same state of the same sident to she same same sident to she sam	F 4	41		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345004	B. WING		09/	12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	(DON) on 09/10/17 at would expect for the rehands and change glaincontinence care and or providing perineal would expect the NAs control and perineal cadded that zinc paster applied to the perineut used to clean the bown acknowledged the professor of the perineut used to a UTI.  An interview was consumed that she editinfection control upon small sessions through explained there was a months earlier (May 2 employees. The IP and use, so she did not hygiene education refor patient care, such added that she would collaborate with the Diregarding hand hygiene.	rith the Director of Nursing (4:09 PM, she stated she nursing assistant to wash oves after providing bowel of before continuing the bath care. She also stated she is to follow the infection care policies. The DON should not have been using the same gloves well movement and occdure that was used could ducted with the Infection (29/12/17 at 11:29 AM. The located the employees on orientation and through shout the year. She is a hand hygiene day several (2017) to educate the liso stated she was not a specifically provide hand garding nursing procedures as perineal care. She	F 44			
F 463 SS=J	483.90(g)(2) RESIDE ROOMS/TOILET/BAT	TH .	F 46	3		10/24/17
	(g) Resident Call Sys  The facility must be a	tem dequately equipped to allow				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X:) ND PLAN OF CORRECTION (X:) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X:) A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 463	residents to call for s communication syste directly to a staff mer	e 183 taff assistance through a em which relays the call mber or to a centralized staff	F 46:	3	
	by: Based on observation interview, staff interview, staff interview, all the proviet had a light working of audible component a bathrooms to allow reassistance. The call bathrooms for 5 of 18 (Private bathrooms for 6	on, resident interview, family iew and record review, the de functioning call bells that utside of the room and an at the nurses' station in the esidents to call for bell was not working in the B bathrooms checked 201, 262, 265, 270 and room 240 and 241).  Degan on 9/7/17 and is 66 could not find staff to tt, she transferred the commode. She did not for help after toileting and the pattern to include a high likelihood for falling the injury associated with her inputation and continued all therapy for transferring, in the lower body. Three hand bells were distributed thad non-functioning call		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 26 was initially provided a hand bell to use the bathroom. The Resident was ther moved to room 263 with a functioning bell. Parts were ordered and the call in room 262 was repaired on 9/15/17. The resident is content in room 263 at has remained there.  Resident #38 (who resided in room 26 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 26 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 residence and bathrooms were checked functional call bells. The check was conducted by the CEO, CFO, HR,	dent

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OIV	<u>/IB NO. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
		345004	B. WING				09/12/2017
NAME OF P	ROVIDER OR SUPPLIER			S	FREET ADDRESS, CITY, STATE, ZIP CODE		
DEDCON	MEMODIAL LICEDITAL			61	5 RIDGE ROAD		
PERSON	MEMORIAL HOSPITAL			R	OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 463	Continued From page work.  Findings included:  1. Resident #66 was home on 7/17/17. He Assessment indicate including hypertension disease, septicemia, non-Alzheimer's dem generalized muscle widney failure, acquirk knee, surgical afterca amputation and gastre disease.  Her Minimum Data S 7/24/17 indicated she cognition, required experson for transfer, dwas not steady with rand only able to stab She had no fall histor occupational and phy assessment period.  A Fall Event report in assisted fall on Sund Interview with the the	admitted to the nursing er admission Minimum Data d she had diagnoses on, peripheral vascular diabetes mellitus, tentia, depression, veakness, abdominal pain, ed abscess of left leg below are for below knee to-esophageal reflux  et (MDS) assessment dated et was moderately impaired in ktensive assistance from one ressing and toilet use. She moving on and off the toilet ilize with staff assistance. The part of the process of the process of the process of left leg below are for below knee to esophageal reflux.  et (MDS) assessment dated et was moderately impaired in ktensive assistance from one ressing and toilet use. She moving on and off the toilet ilize with staff assistance. The process of the process		463	Director of Emergency Services, of Imaging and other staff. If a beidentified as not functioning, a har was provided to the resident or the resident was temporarily moved in resident room with a functional be additional 100% audit was compley 9/18/2017 and there were no calls identified as malfunctioning.  b. Call bell functionality checks completed daily by various depart representatives from the organizar The Director of Imaging is coording these checks and has developed schedule of assigned personnel to complete the tests. The Director Imaging is analyzing the complete and initiating follow-up as needed c. Each occupied resident room adjacent bathroom will be checke at a minimum. Variances are bein immediately acted upon by either providing the resident with a hand moving him or her temporarily to a with a functional call system, or rethe non-functional call bell with or functions. Work orders are being	Director cell was and bell ento a cell. An ceted on set bells are being a coof ced tests. In and discounting a coof ced tests. In and cell, aroom ceplacing a cell, aroom ceplacing and that given to	<b>y</b>
	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.				Plant Operations for additional fol and vendor engagement.  d. The administrator and/or des re-educate staff on how to initiate orders when a call bell is found to non-functional. The staff will also re-educated on the storage location hand bells. This training was initiate beginning 9/26/2017.	ignee wi work be be on for	ill

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/SUPPL			(X3) DATE SURVEY COMPLETED		
		345004	B. WING		05	9/12/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		712/2011
				615 RIDGE ROAD		
PERSON I	MEMORIAL HOSPITAL			ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 463	Continued From page	e 185	F 46	3		
	for toilet use every sh According to the Occi therapy notes dated §			e. A supply of hand bells will b maintained at the nursing station storage location is identified with (hand bells) and staff are aware location of extra bells.	n. The n a sign	
	dressing and had imp to being able to safely	essistance with lower body broved in toileting - transfers of transfer to the toilet with a serior minimum assistance for		f. The call bell vendor was con 9/8/2017 and has responded wit visits for repair on 9/8/2017 and 9/12/2017. The call bell vendor called again on 9/19/2017 and re	h on-site was	
	at 10:22 AM about ho provide residents. Sh	was interviewed on 9/07/2017 by she knows what care to ne said, "After a day or two, I ne Sometimes, she		the vendor to do a more compre assessment of the current system 9/27/2017.		
	likes to use the comm	ee in a diaper. Now, she node. She wears a diaper press call bell for help"		g. Key members of the facility team will have huddle meetings Monday through Friday, to repor on the above actions and any ne	daily, t progress	
	observed in her private She was attempting to wheelchair. She appreciable gripping the graph back herself into her should be s			opportunities related to resident spreadsheet is maintained and he served to enhance the organizat meeting and strengthen the structhe discussion. The leadership to composed of the Administrator, leading the structure of the st	safety. A nas tion of the cture of eam is Director of	
	had to take vital signs said Resident #66 go own if she feels like it	me time NA #15 was #66's room. She said she s and blood sugars. She es to the bathroom on her . At 4:30 PM Resident #66 oom and said in a loud and		Nursing, Director of Quality, and of Human Resources. Adjunct s will be provided by the CEO, CF Worker, and Director of Plant Op	support O, Social	
		O FELL AND NEED MY #15 went in the room to		The monitoring procedure to ens the plan of correction is effective specific deficiency cited remains and/or in compliance with the re	and that corrected	
	asked if she had put of	AM Resident #66 was on the call bell yesterday to needed help. She said the		requirements; The Social Worker will conduct vinterviews with Residents #66 ar	weekly	

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		L IDENTIFICATION NITIMBED:		E CONSTRUCTION	l\ /	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/	12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 463	surveyor tested the coutside the door or ri On 9/08/2017 at 7:58 the Unit Secretary th #66's bathroom was the first time she had On 9/08/2017 at 8:13 Person #1 and #2 an up, but not working." the bathroom - one a side of the commode height on the other s neither worked. The Person #1 said, "I've works."  Surveyors initiated ca at 10:00 AM. Four m not working. These w and shared bathroom  On 9/08/2017 at 10:5 she calls maintenance the bathroom that do  On 9/08/2017 at 11:1 interviewed about ca aware of a call bell re get in contact with th would call his pager of Nurse #3 was asked resident to use to call have bells and would	king in the bathroom. The call bell and it did not lighting at the nurses' station.  B AM the surveyor informed at the call bell in Resident not working. She said it was I heard about it.  B AM Contract Maintenance rived. One said, "It's hooked There were two call bells in about waist height on one and another about knee ide of the commode and Contract Maintenance tried both and neither  all bell checks on 9/08/2017 ore calls in bathrooms were were in rooms 201, 265, 270 in 240 and 241.  BB AM, the Administrator said be when there is a call bell in lesn't work.  B AM Nurse #3 was Il bells. She said, "I am eported not working. I would be Maintenance Director. I or leave a message. When about other means for the Il for help, she said, "We I have to find them".	F 46:	the social worker and/or designed weeks beginning 9/20/2017, to that their call bells are function staff are responding to requess assistance with toileting in an amanner and time, and then more thereafter. Call bell functionalisare being completed daily by departmental representatives organization. The Director of It analyzing the completed tests initiating follow-up as needed. audits will be reviewed for patt trends and reported at QAPI methods and then quarter thereafter.  The title of the person responsimplementing the acceptable procorrection;  Administrator or Designee	o ensure nal and that ts for appropriate onthly ity checks various from the maging is and Results of terns and/or nonthly for rly		
	have bells and would Immediately following distributing hand bell						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION		ATE SURVEY MPLETED	
		345004	B. WING _			09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	÷	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 463	bells.  On 9/08/2017 at 11:2 Operations was interreport about a proble call. We would not can as needed basis. bell in Resident #66' work.  On 9/09/2017 at 11:0 observed in Resident On 9/08/2017 at 3:1' Therapist was interved with Resident to toilet. She said, "person assistance. assist and cues for some She needed contact done safety training She added, "Typicall her. She is good ab I would not recomme She can self-propel compliant. The safe been an issue (i.e., huge thing."  Resident #66 was in at 4:20 PM. She sai yesterday and could dangerous."  On 9/09/2017 at 10: was interviewed. She fequired assistant needed supervision.	25 AM, the Director of Plant rviewed. He said, "If we get a em, then we get a service check other call bells. It is on He confirmed that the call s bathroom room did not	F 4	63		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345004	B. WING	·····		09/12/2017	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CO 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 463	times. Resident #66 confusion. She had the assisted fall with staff of wheelchair and she Director of Rehab procession on 9/8/17 at 12:30, the informed of the immed 2. Resident #38's bathon 9/08/2017 during the resident said she used Her quarterly Minimulassessment reference her cognition was seed dressing, transfer and independent. A care of 10//17 included ap ADLs and for falls incresident to use bell to "The resident needs afloors free from spills light; a working and repersonal items within Her care plan dated able to toilet independent. Surveyors initiated cat 10:00 AM. The cat bathroom did not wor On 9/08/2017 at 10:55.	a. She can be forgetful at had some episodes of tried to get up. She had one f. She was trying to get out e did not wait for assist. The ovided education to the CNA.  The administrator was ediate jeopardy.  Throom call bell was tested rounds at 10:00 AM. The ed the bathroom.  The data of 7/11/17 indicated everely impaired. Her did toileting ability was plan with a review start date proaches for problems with dicated, "Encourage the call for assistance" and a safe environment with and/or clutter; adequate eachable call light and reach."  Total checks on 9/08/2017 Indicated she was dently.  The data of the data of the call bell in Resident #38's the when tested.  The data of the call bell in esn't work.	F 46	53			

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345004	B. WING	·····		09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 463	contact the Maintena problem was noted. leave a message." V about other means for help, she said, "W to find them". Immed she was seen distributing the was seen distribution to see distribution to was seen distribution to see distribution to was seen distribution to see distribution to was seen distribution to was seen distribution to was seen distribution to was seen distribution to see distribution to was seen distribution to see distribution to was seen distribution to see distribut	Il bells. She said she would noce Director if a call bell "I would call his pager or When Nurse #3 was asked or the resident to use to call We have bells and would have liately following the interview uting hand bells to Resident residents who did not have 5 AM, the Director of Plant wiewed. He said, "If we get a m, then we get a service heck other call bells. It is on He confirmed that the call is bathroom room did not	F 46				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345004	B. WING		09/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 463	11:25 AM, the Direct interviewed. He sail problem, then we go not check other call basis.  Surveyors initiated of at 10:00 AM. Four interviewed at 10:00 AM. Four interviewers not working. To 265, 270 and share resident in 201 said resident in room 26 five cents here. A said the light is out,	tor of Plant Operations was d, "If we get a report about a set a service call. We would bells. It is on an as needed call bell checks on 9/08/2017 more calls bells in bathrooms. These were in rooms 201, d bathroom 240 and 241. The she used the toilet. The 5 said the "call ball isn't worth family member in room 270 but will ring at desk.	F 463		
	interviewed about commerce of a call bell of get in contact with the would call his pager. Nurse #3 was asked resident to use to call have bells and would limmediately following distributing hand be other residents who bells.  On 9/08/2017 at 11: Operations was interport about a problicall. We would not an as needed basis observation with the	all bells. She said, "I am reported not working. I would ne Maintenance Director. I or or leave a message. When d about other means for the all for help, she said, "We d have to find them".  In the interview she was seen alls to Resident #66 and to the did not have functioning call arriviewed. He said, "If we get a em, then we get a service check other call bells. It is on the confirmed, by a surveyor that bathroom call 265, and 270 and 240/241, in			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I' '		E SURVEY PLETED
		345004	B. WING	<del> </del>	09	/12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 463	member of the resided did not work. The Dirsaid two of the five be component not workinurses' station for room on 9/09/2017 at 11:00 observed in each of the Component of the Co	did not work. The family ent in room 270 said the light rector of Plant Operations athrooms only had the visual ng. A signal was sent to the om 270 and 240/241.  1 AM a hand bell was he identified bathrooms.  2 PM, the Director of Plant call bell in room 201 was  m was provided. It indicated the from 9/08/2017 at 2:54 PM, "Room 201 repaired. ing. Rooms 262 & 265 has	F 46	53		
F 490 SS=J		diate jeopardy. RESIDENT WELL-BEING	F 49	90		10/24/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345004	B. WING		09/12/2017
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 490	enables it to use its re efficiently to attain or practicable physical, well-being of each re	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial	F 49	00	
	by: Based on record rev resident, staff, Pharm Practitioner and Med facility administration leadership and mana residents' needs were Immediate jeopardy to Resident #103, unsu elevator to the first flo	iew, observation and nacy Consultant, Nurse ical Director interview, the failed to provide the gement necessary to ensure e met.  Degan on 4/16/17 when pervised by staff, took the por, exited the building and		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 nursi unit effective 9/19/2017. The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	
	#103 was located by amount of time outsic injuries. Resident #10 community on 4/22/1 Immediate jeopardy be ongoing for Resident	pegan on 9/8/17 and is		a. Recruitment for the permanent administrator has been approved for placement on corporate internal job boards, electronic recruitment sites su as Indeed, Career Builders, and NCH. [North Carolina Hospital Association]. applicants will be reviewed and there be follow up for screening and interviewing of appropriate candidates timely manner. There is a mutual agreement between the interim	A All will
	This tag is cross-refe F224 J Based on observation pharmacist, nurse pro Director and record re to answer call bells ti timely manner and pre the bathrooms so if a	n, interviews with the staff, actitioner, and Medical eview, the facility neglected mely, provide assistance in a rovide functioning call bells in resident needed to summon hey could get help and		administrator and the organization for 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 permanent administrator is hired. This overlap will ensure continuity in unit administration as the new permanent administrator assumes this management position.	the S

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
				615 RIDGE ROAD	
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 490	Continued From pag	ge 193	F 490		
	prevent an accident	from occurring, follow up on			
	lab specimens to de	termine the course of		b. On 9/25/2017, the unit engaged	the
	treatment for signs a	and symptoms of urinary tract		services of a registered nurse certified	l in
		dent and provide psychiatric		gerontology with extensive experience	
		or monitoring necessary to		a Director of Nursing in a skilled nursi	_
		t's needs and treatment.		facility and is also a Licensed Nursing	
		sampled residents (#10,		Home Administrator. This individual v	vill
	#24, #66, #130 and	#131).		serve as a mentor and coach to the	
	L P. C	0/7/47		current Director of Nursing Services.	This
		began on 9/7/17 and is		will be initiated immediately upon	
	• •	t #66. This resident could not		completion of required screening and	
		er to the toilet, she transferred		on-boarding.	
		the commode. She did not I for help after toileting and		c. On 9/25/2017, an additional contr	ract
		pack into her wheelchair		registered nurse was engaged to prov	
		I was not functioning. She		quality assurance and staff developme	
	expressed anger and			support. This individual began her	
		d a high likelihood for falling		on-boarding on 9/26/2017 and will rep	ort
		ous injury associated with her		to the Director of Nursing. This individ	
	_	elow the knee amputation,		will remain in place until the licensed	
	T -	that day and a continued		nurse staffing level is more consistent	
	need for occupationa	al therapy for transferring,		_	
	toileting and dressin	g the lower body. On 9/7/17,		d. Beginning 9/23/2017, and continu	ing
	•	before hand bells were		until substantial compliance is confirm	
	distributed to the bat			and ECU has consistent leadership, the	
	non-functioning call	bells.		organization will have a manager on o	-
				each Saturday and Sunday. This pers	
	F241 J			will come into the unit for a minimum of	
		on, record, review and staff		four hours; make rounds and meet wit	:n
		ws, the facility failed to		residents, families, and staff to offer	
		66 a functioning call bell in		additional support; and address any a	
		e could call for assistance		of identified concern. This responsibil	
		lent #56 incontinence care		will be shared by key leadership roles may include: CEO, CFO, CNO,	ıııal
	-	sident #10 a bath and a manner to maintain the		Administrator, DON, Director of Qualit	V
		31 timely call bell response		Director of Human Resources, Director	•
		ce. This affected 4 of 40		of Imaging, Director of Surgery, and	/' y
	_	viewed for dignity (Resident		Director of Emergency Services. Any	
	#10, #56, #66 and #			unresolved concerns from the weeker	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345004	B. WING		09/12/2017
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PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 490	ongoing for Resider find staff to assist he independently onto have a means to ca prior to transferring because the call bel expressed anger and dangerous.  F279 J Based on observation review, the facility facomprehensive care needs of the resider the delivery of care (Resident #8, #56, #Immediate jeopardy ongoing for Resider find staff to assist he independently onto have a means to ca prior to transferring because the call bel expressed anger and dangerous. She ha and receiving a serie post-surgical knee a on that day and a contraction of the call below that day and a contraction of the call below that day and a contraction of the call below that day and a contraction of the call below that day and a contraction of the call below that day and a contraction of the call below that day and a contraction of the call below that day and a contraction of the call below that day and a contraction of the call below that day and a contraction of the call below that the call below that the call below that day and a contraction of the call below that the call below the call below the call below the call below the call	began on 9/7/17 and is at #66. This resident could not be to the toilet, she transferred the commode. She did not all for help after toileting and back into her wheelchair all was not functioning. She did stated that it was a stated that it was a sampled residents and to form the basis for a for 4 of 18 sampled residents and #128).  began on 9/7/17 and is at #66. This resident could not be to the toilet, she transferred the commode. She did not all for help after toileting and back into her wheelchair all was not functioning. She did stated that it was a high likelihood for falling ous injury associated with her amputation, high blood sugar ontinued need for	F 490	will be discussed at the Monday hudo 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 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 conducti rounds on the nursing facility unit two per shift on the 12-hour evening shift. The role of nursing supervisor during rounding is to provide additional supervision and oversight to the ECU team as needed. As the nursing supervisor makes rounds on the unit, will discuss any immediate needs with licensed nursing staff. The nursing supervisor is also available to the ECI respond to any emergency that may occur.  f. The parent company for the hosp and its nursing unit is providing and we continue to provide on-site visits or conference calls at least twice per more for a minimum of 3 months to be conducted by representative of the pacempany with long term care operations.	secuing ee this she in the U to sital will with arent
	dressing the lower before hand bells we bathrooms that had	y for transferring, toileting and hody. Three hours passed ere distributed to the non-functioning call bells.		experience. The visits will include evaluation of on-going or new complia and quality improvement initiatives. addition, the corporate representative explore use of data analytics to assist defining processes and systems of cli and operational focus. An analysis	n s will in

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
		345004	B. WING _		0	9/12/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	0.12/2011	
				615 RIDGE ROAD			
PERSON	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 490	Continued From pag	ge 195	F 4	90			
	interview and record provide functioning bathrooms so that if summon staff for as and prevent an acci bell was not working sampled residents witheir rooms (Reside facility also failed to elopement of a cogrish known to have wand 1 of 2 sampled residents. Immediate jeopardy Resident #103, unstelevator to the first fit was found in the fact #103 was located by amount of time outs injuries.  Immediate jeopardy ongoing for Resider find staff to assist he independently onto have a means to caprior to transferring because the call belexpressed anger and dangerous. She ha and receiving a serie post-surgical knee a on that day and a coccupational therap dressing the lower before hand bells with the summediate in the same and the sa	d review, the facility failed to call bells in resident a resident needed to sistance, they could get help dent from occurring. The call in the bathroom for 2 of 2 who used the private bath in the #66 & Resident #38). The supervise and prevent the nitively impaired resident, dering behavior. This affected dents reviewed for supervision is.  began on 4/16/17 for supervised by staff, took the loor, exited the building and sility parking lot. Resident by staff after an undetermined ide of the facility and had no set to the toilet, she transferred the commode. She did not lift for help after toileting and back into her wheelchair I was not functioning. She did stated that it was did a high likelihood for falling ous injury associated with her imputation, high blood sugar		summary of these visits or or conference calls will be submadditional review through the developed by corporate and collaboratively through the fateam and the Person Memor Council.  g. A care plan policy was a 9/26/17 that ensures developmaintenance of person-centromprehensive care plans the measurable objectives and the meet the residents medical mental and psychosocial newextent practicable, the reside representative will be provide opportunities to participate in consultant.  h. Key members of the fact team will have huddle meeting Monday through Friday, to reson the above actions and to new opportunities related to safety. A spreadsheet is man has served to enhance the of the meeting and strengthen of the discussion. The leader composed of the Administrat Nursing, Director of Quality, of Human Resources. Adjur will be provided by the CEO, Worker, Director of Plant Op others who may be called up to time.  "The monitoring procedure to the plan of correction is effective."	nitted for a Action Plan carried out acility-based rial Quality approved on oment and ered at include imetables to I, nursing, eds. To the ent / resident ed with a the care illity leadership and adjusted and interest ed with a the care illity leadership and and interest entitled		

Facility ID: 953396

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/	12/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 615 RIDGE ROAD ROXBORO, NC 27573	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE
F 490	Continued From page Immediate jeopardy be ongoing for Resident independently and hawork.  F353 J Based on resident intreview of the staffing provide staffing in suffineeds of residents for (#66, #103, #131, and were at the immediate - 5 were at no actual than minimal harm the and the scope is a part Immediate jeopardy be Resident #103, unsupelevator to the first flowas found in the facility.	e 196 Degan on 9/8/17 and is #38 who toilets Ind a call bell that did not  derviews, staff interviews and records, the facility failed to ficient numbers to meet the r x of x sampled residents of #56). Examples 1 and 2 be jeopardy level. Examples 3 harm with potential for more at is not immediate jeopardy letern (E).  Degan on 4/16/17 for pervised by staff, took the por, exited the building and lity parking lot. Resident	F 4	DEFICIE	remains correct the regulatory of the f-assessment of the to Alliant. The to work and the ECU has a laboratively with the QAPI procest of focused in the town of the will complete a comple	ated y on e n ss	JAL
	amount of time outsice injuries.  Immediate jeopardy to ongoing for Resident find staff to assist her independently onto the have a means to call prior to transferring because the call bell expressed anger and dangerous. She had and receiving a serior post-surgical knee and on that day and a coroccupational therapy	a high likelihood for falling us injury associated with her nputation, high blood sugar		CEO or other assigned A	Administrative		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
F 490	F441 J Based on observation facility staff: 1) Failer glucometer (device us blood glucose or bloomesidents and failed to between residents for to have their blood glucose of the tween residents observed to the tween completing a bound of the tween residents observed to the tweet (Resident #2) Failed to perform bowel incontinence of perineal care for 1 of infection control (Resident #2) we ashared glucometer accordance with the the disinfectant. NA hygiene between resiglucose checks and separate occasions of glucose checks. On occurred after the number of the tweet instructed by the half passed on record reveral pharmacy, and staff Quality Assessment.	and staff interviews, the d to disinfect a shared used to measure a resident's and sugar level) between to perform hand hygiene or 1 of 3 residents observed fucose checked (Resident used falso failed to wear gloves lood glucose check for 2 of 3 to have their blood glucose 55 and Resident #134); and, thand hygiene after providing that are and before providing that are and before providing that are and before providing that are trained on how to disinfect the between residents in manufacturer's directions for #10 did not perform hand didents when doing the blood when doing the blood when doing the blood when doing the blood	F 49			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		3) DATE SURVEY COMPLETED	
		345004	B. WING		0	9/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 490	committee put into place recertification survey current immediate jet recertification survey on the prior recertification survey on the prior recertification control (Comprehensive Carred 11 (Infection Control Assurance). The conduring 2 or more feder pattern of the facility's effective Quality Asserting Program.  Immediate jeopardy to Resident #103, unsurelevator to the first flowas found in the facility amount of time outsic injuries.  Immediate jeopardy to ongoing for Resident find staff to assist her independently onto the have a means to call prior to transferring because the call bell expressed anger and dangerous. She had and receiving a serior post-surgical knee aron that day and a coroccupational therapy dressing the lower before hand bells we	tor the interventions that the ace following the on 10/6/16. Four of the nine opardy citations during the on 9/12/17, were also cited ation survey including F279 to Plan), F353 (Staffing), ol), and 520 (Quality tinued failure of the facility trail surveys of record show a sinability to sustain an essment and Assurance opegan on 4/16/17 for opervised by staff, took the toor, exited the building and ity parking lot. Resident staff after an undetermined de of the facility and had no opegan on 9/7/17 and is #66. This resident could not to the toilet, she transferred the commode. She did not for help after toileting and tack into her wheelchair was not functioning. She stated that it was a high likelihood for falling us injury associated with her inputation, high blood sugar intinued need for for transferring, toileting and add. Three hours passed	F 49				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _		09	/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 514 SS=D	Director of Nursing (Diregarding the administ the needs of residents and the DON express and call bell response education had been diassistants (NAs) but it better understanding. The Administrator state NAs to find out if they a resident was not be stated she felt that resplanning, as well as conursing assistants we by the facility. The Administrator said, "Vinave needed to be." 483.70(i)(1)(5) RES RECORDS-COMPLE LE  (i) Medical records. (1) In accordance with standards and practices.	M, the Administrator and DON) were interviewed stration of resources to meet in the Administrator is a specific concern about neglect in the DON stated some lone with the nursing indicated there had to be a cofficient of the definition for neglect. It is a specific concern about neglect is a specific concern about neglect in the definition for neglect. It is a specific concern and the specific concern and care communication with the concern and care in the specific concern and care in the s	F			10/24/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE ROAD ROXBORO, NC 27573	03/12/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION	
F 514	Continued From page (5) The medical record (ii) Sufficient information (iii) A record of the record of the record of the record (iii) The comprehens provided;  (iv) The results of an and resident review determinations condition (v) Physician's, nursiprofessional's programmer (vi) Laboratory, radisservices reports as This REQUIREMENT by:  Based on observation interviews the facility document the meal sampled for nutrition	ge 200  ord must contain-  tion to identify the resident; esident's assessments; sive plan of care and services  my preadmission screening evaluations and ducted by the State; se's, and other licensed ess notes; and  ology and other diagnostic required under §483.50.  IT is not met as evidenced  on, record review and staff y failed to accurately intake for 1 of 3 residents	F 51			
	admission diagnose mellitus and hyperte minimum data set d Resident #24 was s and required limited had no swallowing pweight on 08/02/17  A review of the mos 05/01/17 revealed F problem related to swas to maintain ade evidenced by maintain	s of malnutrition, diabetes ension. The most recent ated 08/10/17 revealed everely cognitively impaired assistance with eating and problems. Her most current		Resident #24 did not consume any of lunch meal on 09/07/17 during mealt observation. Documentation after lun Nurse Aide #3 noted Resident #24 consumed 25%-65%; documentation meal intake was inaccurate. Education ADL care and documentation was provided to Nurse Aide #3 on 09/27/7 Resident #24 was discharged on 09/09/17.  "The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	ime ich by of on on	

AND BLAN OF CORRECTION INDESTRUCTION NUMBER		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345004	B. WING		09/12/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE S15 RIDGE ROAD ROXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		TION
F 520 SS=J	and consuming greate meals daily. The interprovide and serve her monitor, document arrefused to eat.  A continuous observa Resident #24 on 09/0 1:50 PM, and Resident lunch. During an interconfirmed Resident # her lunch.  A review of the nutritic Care (POC) for Resid 1:00PM revealed 25-lunch meal.  On 09/09/2017 at 2:5 interviewed via teleph documented the lunch On 09/09/2017 at 3:2 Nursing (DON) stated POC on 09/07/17 that was consumed by ReDuring an interview owith the Dietitian, she underweight and malistated it was very imp documentation of the accurate to determine During an interview on DON indicated the exoffer a resident a meanintake accurately on F483.75(g)(1)(i)-(iii)(2)(a)	er than 50% of at least 3 ventions were, in part, to redict as ordered and to a report if the resident tion was conducted of 7/17 from 12:20 PM thru at #24 had not eaten any view at 2:00 pm, Aide #3 24 had not eaten any of 24 had not eaten any of 25 on documentation in Point of 25 on documentation in Point of 26 on documentation in Point of 27 PM, Aide #3 was 28 one and stated she had not 28 none and stated she had not 25 of 18 Aide #3 had documented in 25 of 18 Aide Resident #24 was 25 nourished. The Dietician 26 ortant for the 27 pm, the 28 pm, the 29 of 18 and to document the 29 of 18 and to document the 20 of 18 and	F 514	Nurse aides will be re-educated on AD care and documentation requirements 10/24/17 by Director or Nursing or designee.  The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains corresponding in compliance with the regulator requirements;  The MDS coordinator or designee will make observations during one mealting and review of meal intake documentation 5 residents weekly. Variances will be reviewed with DON and the Nurse Aidwill be re-educated. Weekly audits will continue for 30 days and then monthly 60 days. Results of audits will be reviewed and reported QAPI monthly for three months and the quarterly thereafter.  "The title of the person responsible for implementing the acceptable plan of correction;  MDS Coordinator or designee	at nat cted y  ne on ee e for wed lat en	7

AND DUAN OF CORDECTION IDENTIFICATION NUMBER		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345004	B. WING			09/	12/2017
	ROVIDER OR SUPPLIER		•	615	EET ADDRESS, CITY, STATE, ZIP CODE RIDGE ROAD XBORO, NC 27573	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	and assurance commminimum of:  (i) The director of nurse (ii) The Medical Direct (iii) At least three others staff, at least one of wadministrator, owner, individual in a leaders (g)(2) The quality assemittee must:  (i) Meet at least quart coordinate and evaluate identifying issues with assessment and assurancessary; and  (ii) Develop and implemation to correct identification in the correct identification is related to the communication of such communication is related to the correct identification in the correct identification is related to the correct identification in the correct identification is related to the correct identification in the correct identification is related to the correct identification in the correct identification is related to the correct identification in the correct identification is related to the correct identification in the correct identification is related to the correct identification in the correct identification in the correct identification is related to the correct identification in the correct identification is related to the correct identification in the correct identification in the correct identification is related to the correct identification in the correct identification i	nt and assurance.  ntain a quality assessment ittee consisting at a  sing services;  tor or his/her designee;  er members of the facility's who must be the a board member or other ship role; and  essment and assurance  erly and as needed to ate activities such as a respect to which quality irance activities are  ement appropriate plans of iffied quality deficiencies;  mation. A State or the quire disclosure of the nittee except in so far as a sted to the compliance of the requirements of this  with attempts by the and correct quality	F	520			

PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION  LDING		(X3) DATE SURVEY COMPLETED	
		345004	B. WING _			09/12/2017	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP (	•		
				615 RIDGE ROAD			
PERSON I	MEMORIAL HOSPITAL			ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From page	e 203	F 5	20			
	This REQUIREMENT	is not met as evidenced					
	by: Based on record rev pharmacy, and staff i Quality Assessment a Committee failed to n procedures and moni committee put into pla recertification survey current immediate jec recertification survey on the prior recertifica (Comprehensive Care F441 (Infection Contr Assurance). The cont during 2 federal surve of the facility's inabilit	iew, observations, physician, interviews, the facility's and Assurance (QAA) maintain implemented tor the interventions that the face following the on 10/6/16. Four of the nine opardy citations during the on 9/12/17, were also cited ation survey including F279 e Plan), F353 (Staffing),		" The plan of correcting the deficiency. The plan should processes that lead to the cited; The findings from the recediscussed with the Medical 9/9/2017. The facility held a QAPI meg/25/2017 to discuss and a allegation of compliance for classified as immediate jet of the procedure for impler acceptable plan of correcting specific deficiency cited; a. The facility will hold meetings for the next 6 meetings for 10 meetings for	d address the deficiency ent survey were all Director on eeting on approve the or the areas opardy.  menting the ion for the monthly QAPI onths to monitor orts toward		
	record review, the fac comprehensive care needs of the resident	plans to address the current s and to form the basis for or 4 of 18 sampled residents		maintaining compliance wi for the stated deficiencies recommend any additional changes or changes in mo monthly QAPI meeting will minimum the CEO or design	and to I systemic onitoring. The I include at a		
	ongoing for Resident find staff to assist her	began on 9/7/17 and is #66. This resident could not to the toilet, she transferred he commode. She did not		administrator, Medical Director of Nurse Quality and/or designee, a Human Resources.	ing, Director of		
	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.			b. Additional ad hoc mee QAPI Committee or subco held as new opportunities Action plans for response	mmittee will be are identified.		
	recertification survey	cited at F279 during the on 10/6/16 when the facility imprehensive plan of care ent #38) for Urinary		will be monitored by the Ad Director of Quality.	dministrator and		

Facility ID: 953396

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345004		345004	B. WING			09/12/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C			
PERSON MEMORIAL HOSPITAL				615 RIDGE ROAD ROXBORO, NC 27573			
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE COMPLETION HE APPROPRIATE DATE		
F 520	Continued From page 204		F 5	20			
	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			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			
	dangerous. She had and receiving a serio post-surgical knee be high blood sugar on to need for occupational toileting and dressing three hours passed be distributed to the batton-functioning call be administrator was infigeopardy.  The facility was also recertification survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactivities of daily living the post-survey failed to ensure adequactive failed to ensure adequactiv	a high likelihood for falling us injury associated with her elow the knee amputation, that day and a continued all therapy for transferring, go the lower body. On 9/7/17, pefore hand bells were hrooms that had bells. On 9/8/17 at 12:30, the formed of the immediate  cited at F353 during the on 10/6/16 when the facility quate staff to provide go care for 2 of 6 dependent 59 and #19) and apply pled resident with		Director. Minutes from the be maintained and concerr opportunities will be followed appropriate team member. These meetings, including recommendations from the corrective and/or responsive the staff, will be reported to QAPI Committee.  e. The parent company for and its nursing unit is provice continue to provide on-site conference calls at least two for a minimum of 3 months conducted by representative company with long term can experience.	meetings will as and ed up by the A summary of e residents and we actions by the monthly  or the hospital ding and will visits or vice per month to be we of the parent are operational		

Facility ID: 953396

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345004	B. WING _			09/	12/2017
NAME OF P	ROVIDER OR SUPPLIER	L	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2017
					15 RIDGE ROAD		
PERSON	MEMORIAL HOSPITAL				OXBORO, NC 27573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	3. F441 Based on obinterviews, the facility a shared glucometer resident's blood glucobetween residents are hygiene between resident #55). The wear gloves when cocheck for 2 of 3 resides blood glucose checker (Resident #134); and, hygiene after providing and before providing resident reviewed for #10).  Immediate jeopardy the ongoing. Neither the observed to do blood nurse (Nurse #2) were to disinfect a shared residents. NA #10 dispetween residents which checks and did not we occasions when doin.  The facility was also recertification survey failed to wear gloves room with Contact Providents (Resident #1 Isolation Precautions 4. F520 During the residents residents residents and the contact Providents (Resident #1 Isolation Precautions 4. F520 During the residents residents residents residents residents residents and the contact Providents (Resident #1 Isolation Precautions 4. F520 During the residents r	servations and staff (staff: 1) Failed to disinfect (device used to measure a use or blood sugar level) and failed to perform hand idents for 1 of 3 residents ir blood glucose checked facility staff also failed to impleting a blood glucose ents observed to have their ed (Resident #55 and 2) Failed to perform hand and bowel incontinence care perineal care for 1 of 1 infection control (Resident  Degan on 9/8/17 and is Nursing Assistant (NA) #10 glucose checks nor the hall re adequately trained on how glucometer between d not perform hand hygiene men doing the blood glucose rear gloves on two separate g the blood glucose checks.  Cited at F441 during the on 10/6/16 when the facility and gowns when entering a recautions for one of two exacts of the staff of the contact exacts of the contacts of the contact exacts of the contacts of the contacts exacts of the contacts of the contact	F	520	long-term care consulting group to ass with quality systems and process development and/or refinement. The tresponding consultants primarily assigned to the project maintain the designation of Certified QAPI Professionals. Collective the consulting group consists of members whom have extensive experience as long-term care registered nurses, administrators, operators and hold othe certifications such as MDS nurse executives, etc. The organization had entered a contract with the consulting company in January 2017 for services be provided upon request. On 9/9/2011 contact was made with the organization for additional support and assistance to respond to the survey findings, assist it education and re-establishing systems sustained compliance. Continued support will be provided in collaboration with on-going support from the corporation offices.  "The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correcting and/or in compliance with the regulator requirements; A summary of the Resid group meetings, including recommendations from the residents a corrective and/or responsive actions by the staff, will be reported to the monthle QAPI Committee.  The corporate representatives will expective and to the corporate representatives will expective and the summer of the monthle QAPI Committee.	ely, ers er to 7, n o n for n tee that that teted ry ent nd y	
	facility Quality Assess Committee failed to n	sment and Assurance naintain implemented			use of data analytics to assist in definit processes and systems of clinical and	ng	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
		345004	B. WING _		09	/12/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI			
PERSON MEMORIAL HOSPITAL				615 RIDGE ROAD			
				ROXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE			(X5) COMPLETION DATE	
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		F 52	DEFICIENCY)		DATE	
	new employees in pla Nursing stated they h documentation" and h the state agency about indicated a comprehe expected to capture the	ad sought guidance from ut a month ago. The DON					