PRINTED: 03/29/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ROANOKE LANDING NURSING AND REHABILITATION CENTER 1084 US 64 EAST PLYMOUTH, NC 27962	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ROANOKE LANDING NURSING AND REHABILITATION CENTER 1084 US 64 EAST PLYMOUTH, NC 27962		03/01/2018
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Notice Requirements Before Transfer/Discharge PREFIX TAG REGULATORY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 3/22		·
	PREFIX (EACH DEFICIENCY	IOULD BE COMPLETION
\$483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. \$483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	SS=B CFR(s): 483.15(c)(3)-(§483.15(c)(3) Notice be Before a facility transferesident, the facility must in the reasons for the molanguage and manner facility must send a corepresentative of the County-Term Care Ombordial Record the reasons discharge in the reside accordance with paragraph (c)(5) of this section, the discharge required und made by the facility at resident is transferred (ii) Notice must be made before transfer or disclard (A) The safety of indivible endangered, under this section; (B) The health of indivible endangered, under this section; (C) The resident's hea allow a more immediate under paragraph (c)(1) (D) An immediate transfer endicity and more immediate transfer or disclard the resident's hea allow a more immediate under paragraph (c)(1) (D) An immediate transfer t	3/22/18
under paragraph (c)(1)(i)(A) of this section; or ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) D.		(X6) DATE

Electronically Signed 03/22/2018

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G	\ , ,	TE SURVEY MPLETED
		345266	B. WING		0	3/01/2018
	ROVIDER OR SUPPLIER E LANDING NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1084 US 64 EAST PLYMOUTH, NC 27962		
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F 623	§483.15(c)(5) Conternotice specified in parmust include the follo (i) The reason for tra (ii) The effective date (iii) The location to w transferred or discha (iv) A statement of th including the name, a and telephone numbreceives such request o obtain an appeal for completing the form a hearing request; (v) The name, addrestelephone number of Long-Term Care Om (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and accepto developmental disabilities of the Developmental disabilities of the Developmental disabilities and telephone rumber of the protection and accepto developmental disabilities of the Developmental disabilitie	ats of the notice. The written iragraph (c)(3) of this section owing: ansfer or discharge; of transfer or discharge; hich the resident is rged; e resident's appeal rights, address (mailing and email), er of the entity which sts; and information on how form and assistance in and submitting the appeal ses (mailing and email) and the Office of the State budsman; by residents with intellectual isabilities or related and and email address and the agency responsible for dvocacy of individuals with intellectual isabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental sabilities, the mailing and elephone number of the or the protection and als with a mental disorder errotection and Advocacy duals Act.	F 6.	23		

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL [*] IDENTIFICATION NUMBER: A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345266	B. WING _			03/01/2018		
	ROVIDER OR SUPPLIER E LANDING NURSING A	ND REHABILITATION CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 084 US 64 EAST LYMOUTH, NC 27962			
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F 623	Continued From page	e 2	F 6	523				
	effecting the transfer must update the recip as practicable once to becomes available.	ne notice changes prior to or discharge, the facility pients of the notice as soon the updated information in advance of facility closure						
	In the case of facility the administrator of the written notification proto the State Survey A State Long-Term Car the facility, and the rewell as the plan for the relocation of the residus. 170(I).	closure, the individual who is the facility must provide for to the impending closure agency, the Office of the gency, the Office of the e Ombudsman, residents of esident representatives, as the transfer and adequate dents, as required at §						
	facility failed to provious representative a writt for transfer to the host copy of the notice to	iew and staff interview, the de the resident and resident en notification for the reason spital and did not send a the ombudsman for 1 of 1 or hospitalization. (Resident			F 623 □ The process that led to this deficiency was the facility failed to provide the resident and/or resident representative written notification for the reason for transfer to the hospital and did not sen copy of the notice to the Ombudsman 1 of 1 residents reviewed.	d a		
	5/18/15. His active di	enic bladder, diabetes			On 2/28/2018 100% audit of resident discharges x 30 days to include reside #2 was completed by the Administrator ensure resident and/or resident representative received written notifical indicating the reason for transfer/discharge from the facility and	r to tion		
	data set assessment was assessed as seven Review of Resident #	t2's most recent minimum dated 11/21/17 revealed he verely cognitively impaired. t2's chart revealed on sferred to the hospital for			that a copy of the written notification w provided to the Office of the State Long-Term Care Ombudsman. All area of concern were immediately addresse by the Administrator. On 2/28/18 written notifications for all	as as		

Facility ID: 923414

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345266	B. WING _			03/	/01/2018	
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
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F 623	Continued From page	F 6	623					
F 023	bleeding noted by the surgical incision. No documented to have resident or resident or social Worker stated notices to residents a She further stated sh #2 or his representat the reason for his hoshad not sent any sucombudsman. She fur aware it was required when a resident had the hospital and wou notices. During an interview of Administrator stated who had an unplanned should receive a writt notice as soon as pratte ombudsman. She in the regulations it will discharge notification.	e nurse from a recent written notice of transfer was been provided to the epresentative. on 2/28/18 at 1:50 PM the she provided transfer and resident representatives. The did not provide Resident representatives are did not provide Resident representative a written notification of spitalization on 11/29/17 and the notification to the spitalization to the ther stated she had not been do to provide a transfer notice an unplanned discharged to lid begin performing those on 2/28/18 at 2:00 PM the she was not aware residents and discharged to the hospital ten transfer and discharge acticable and a copy sent to be further stated since it was was her expectation a to be given to Resident #2 the as well as a copy sent to	F		resident transfers/discharges from the facility x 30 days to include resident #2 were mailed to the resident and/or Resident Representative and a copy forwarded to the Office of the State Long-Term Care Ombudsman by the Administrator. On 3/1/2018 an in-service on Notification of Ombudsman and Resident Representative for Discharges/Transfewas completed by the Facility Nurse Consultant with the Administrator, Director of Nursing (DON), Admissions Coordinator and Social Worker to including Facility must notify resident or resident representative of discharge/transfer at least 30 days before the resident is transferred or discharge. Facility must notify resident or resident representative of discharge/transfer as soon as possible when a. The safety of individuals in the fact would be endangered by the residents health improves sufficiently to allow a more immediate transfer or discharge do. An immediate transfer or discharge do. An immediate transfer or discharge do. A resident has not resided in the facility greater than 30 days 3. Written notification must include: a. The reason for transfer or discharge co. The location to which the resident or discharge co. The location to which the resident	on ers side: fore ed sility bility e is eal		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER E LANDING NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1084 US 64 EAST PLYMOUTH, NC 27962				
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F 623	Continued From pag	e 4	F 6	transferred or discharg d. A statement of the rights including the nar telephone number to si e. The name, addres number to the Office of Long-Term Care Ombu f. Copy of written no sent to the Office of the Care Ombudsman All newly hired Adminis Nursing (DON), Admiss and Social Worker will the Staff Facilitator dur Notification of Ombuds Representative for Disc to include: 1. Facility must notify resident representative discharge/transfer at le the resident is transfer 2. Facility must notify resident representative discharge/transfer as s when a. The safety of indiv would be endangered b. The health of indiv would be endangered c. The residents hea sufficiently to allow a m transfer or discharge d. An immediate tran required by the resider needs e. A resident has not facility greater than 30 3. Written notification a. The reason for trai	e residents appeal me, address and ubmit appeal ss and telephone if the State udsman etification must be e State Long-Term etrator, Director of sions Coordinator be in-serviced by ring orientation on sman and Resident charges/Transfers y resident or e of east 30 days before red or discharged y resident or e of soon as possible viduals in the facility widuals in the facility widuals in the facility widuals in the facility etratory in the facility of the facility for the facilit			

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F 623	Continued From page	e 5	F	b. The effective date discharge c. The location to w transferred or discharge d. A statement of the rights including the nat telephone number to se. The name, addre number to the Office of Long-Term Care Omb f. Copy of written not sent to the Office of the Care Ombudsman Monitoring 25% audit of all reside be completed by the Sweekly x 4 weeks, ever weeks then monthly x Nursing Home Notice Tool to ensure the respresentative receives notification indicating transfer/discharge from that a copy of the writt provided to the Office Long-Term Care Ombothe The DON will review the Notice of Transfer Audweeks, then every 2 with the monthly x 1 monitaries of concern were The Quality Improvem forward the results of Notice of Transfer Audweeks and The Executive QI Committed Tool to determine trenders.	hich the resident is ged e residents appeal ime, address and submit appeal ss and telephone of the State indisman otification must be the State Long-Term ent discharges will Social Worker ery 2 weeks x 4 1 month utilizing the of Transfer Audit ident and/or resident the reason for m the facility and then notification was of the State indisman. The Nursing Home dit Tool weekly x 4 weeks x 4 weeks th to ensure all the addressed. The state will the Nursing Home dit Tool to the the monthly x 3 the QI Committee will the and review the of Transfer Audit		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 623	Continued From pag	e 6	F 623	that may need further interventions into place and to determine the nee further and / or frequency of monito The Administrator and Director of N will be responsible for the implemer of corrective actions to include all 1 audits, in services, and monitoring to the plan of correction.	ed for rring. lursing ntation 00%			
F 644 SS=D	CFR(s): 483.20(e)(1) §483.20(e) Coordina A facility must coordi pre-admission screen (PASARR) program to of this part to the material displayed to the material displayed to the material displayed to the passion of the PASARR level passion assessment, care played.		F 644		3/22/18			
	all residents with new serious mental disord related condition for la significant change. This REQUIREMENT by: Based on record rev facility failed to make after a change in me residents (Resident #	vly evident or possible der, intellectual disability, or a level II resident review upon in status assessment. Γ is not met as evidenced riew and staff interview, the a referral for re-evaluation intal health status for 1 of 2		F 644 □ The process that led to this deficier was the facility failed to make a refere-evaluation after a change in merhealth status for 1 of 2 residents refer Preadmission Screening and Reference.	erral for htal viewed			

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F 644	Continued From page	ge 7	F 64	4		
F 644	Resident #8 was ad 1/26/12 with diagno depressive disorder cerebrovascular acc. The quarterly Minim tool (MDS) dated 12 was moderately cogverbal behaviors too of daily living (ADLs assistance for compincluded diabetes maccident (CVA), and A record review revenegative Level I Pre Resident Review (Padmission to the facenegative PASRR so During an annual as anxiety disorder was for Resident #8. On major depressive diher diagnoses in the system and indicate "during stay". Resident recorder was additional to the facenegative page 1.	Imitted to the facility on ses which included major received, single episode, epilepsy, and cident (CVA). Important Data Set-an assessment 2/7/17 revealed Resident #8 gnitively impaired, displayed wards others, and all activities is), except eating, required total pletion. Active diagnoses hellitus (DM), cerebrovascular didepression. The depression of the december of the decemb	F 64	Review (PASRR) On 3/13/18 100% audit of new mental health diagnosis since to the facility x 12 months to it resident #8 was completed by of Nursing to ensure any resinew mental health diagnosis assessed for need to re-evaluate or Psych referral for mental health diagnosis assessed for need to re-evaluate or Psych referral for mental health management initiated. All are concern related to PASRR rewere immediately addressed Medical Records Director. All concern related to psych refeimmediately addressed by the Care Coordinator. On 3/2/18 resident #8 was rere-evaluation of PASRR. New level received on 3/5/18 at a change in PASRR status was On 3/13/18 100% audit of all Observed documentation x 3 include resident #8 was compadministrator to ensure all be assessed and Psych referral management initiated as indicareas of concern were immediated as of concern were immedia	e admission include y the Director dent with a was uate PASRR ealth as of evaluation by the areas of rrals were e Resident ferred for y PASRR Level 1. No inoted. Behaviors 0 days to oleted by the shaviors were for behavior cated. All diately are	
	physician. An interview was corecords director on stated when a psyciahe was notified, resystem. If a diagnossignified the diagnos	onducted with the medical 2/28/18 at 1:45 PM. She hiatric diagnosis was added viewed it and put it in the sis was marked "during stay" it sis was made after admission agnosis changed a resident's		notes for behaviors or change health status x 30 days to inc #8 was completed by the Dire Nursing. All areas of concern immediately addressed by the Care Coordinator. On 3/13/18 an in-service on F completed by the Administrat Medical Records, Minimum D	e in mental lude resident ector of were e Resident PASRRs was or with the	

Facility ID: 923414

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345266	B. WING _			03/01/2018	
	ROVIDER OR SUPPLIER E LANDING NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CIT 1084 US 64 EAST PLYMOUTH, NC 27			
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F 644	needed to be reques change of condition f An interview was corn Nursing (DON) on 2/3 a Level II PASSR or a have been requested November when she health status. She state Records Director) mile of the new regulation	a change in condition ted. She was unsure of a or (Resident #8). ducted with the Director of 28/18 at 3:00 PM. She stated a change of condition should	F6	Nurse (MDS), I Resident Care referral for re-e changes in me include: 1. The DON/ progress notes address any co behaviors or ch ensure appropi 2. Resident of Director of Nur psych referral f evident or poss disorders, intel related condition 3. Medical Ri MDS nurse all mental health f 4. MDS nurse residents and a evident or poss disorders, intel related condition upon a significal assessment ar PASRR. 5. The Medical then submit up for any resident possible serious intellectual disa for a level II resident change in statu re-evaluation of 6. MDS nurse any PASRR lev All newly hired	ecords will forward to the newly added diagnoses for review. e will assess all level II all residents with newly sible serious mental lectual disability or a period for a level II resident ant change in status and request re-evaluation at with newly evident or as mental disorders, ability or a related conditional sident upon a significant us assessment for	of all to ent or the control of the	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345266	B. WING _	B. WING			1/2018
	ROVIDER OR SUPPLIER E LANDING NURSING AI	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 1084 US 64 EAST PLYMOUTH, NC 27962	CODE		
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F 644	Continued From page	9	F6	Nursing, Assistant Director Resident Care Coordinated in regards to referral for refollowing changes in ment to include: 1. The DON/Administrating progress notes during clining address any concerns relabehaviors or change in ment ensure appropriate referrations. Resident Care Coord Director of Nursing (ADON psych referral for all reside evident or possible serious disorders, intellectual disarelated condition. 3. Medical Records will MDS nurse all newly added mental health for review. 4. MDS nurse will assess residents and all residents evident or possible serious disorders, intellectual disarelated condition for a leve upon a significant change assessment and request resident with newly evider serious mental disorders, disability or a related condition for a leve upon a significant change assessment and request resident with newly evider serious mental disorders, disability or a related condition for a leve upon a significant change assessment for resident upon a significant resident with newly evider serious mental disorders, disability or a related condition for a leve upon a significant upon a significant status assessment for resident upon a significant status assessment for resident upon a significant status assessment for resident upon a significant changes assessment for resident upon a significant status assessment for resident upon a significant changes assessment for resident upon a significant change as	or will be tion on PASRI e-evaluation tal health status tor will review place in tental status to als are initiated inator/Assistan in the entry with newly seen tall ability or a see all level II is with newly seen tall ability or a see all level II is with newly seen tall ability or a see all level II is with newly seen tall in status re-evaluation of see and change in tellectual dition for a level and change in evaluation of the care plan for the early and the care plan for the early and the care plan for the evaluation of the evaluation of the care plan for the evaluation of the	Rs us all o nt o d. nt ly efor	

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F 644	Continued From page	e 10	F6	Monitoring 25% audit health diag be comple Coordinate then mont Mental He ensure any health diag to re-evalut for mental The Direct Mental He x 8 weeks ensure all addressed 25% audit documents be comple Coordinate then mont Behaviors all behavior referral for as indicate review the weekly x 8 to ensure addressed 100% aud behaviors status to ir completed Coordinate weeks, the monthly x Note Audit change in	of all newly added mental gnosis to include resident #8 sted by the Resident Care or/ADON weekly x 8 weeks, hly x 1 month utilizing the salth Diagnosis Audit Tool to y resident with a new mental gnosis was assessed for need at the PASRR or Psych referrate health management initiated for of Nursing will review the salth Diagnosis Audit Tool were the monthly x 1 month to areas of concern were detected by the Resident Care for/ADON weekly x 8 weeks, hly x 1 month utilizing the Observed Audit Tool to ensure the salth Director of Nursing were assessed and Psych behavior management initial and. The Director of Nursing were assessed Audit Tool to ensure the salth Director of Nursing were assessed and Psych behaviors Observed Audit Tool to ensure the salth Director of Nursing were assessed and Psych behaviors Observed Audit Tool to ensure the salth Director of Nursing were assessed and Psych behaviors Observed Audit Tool to ensure the process of	ed al d. ekly vill Fool onth		

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F 644	CFR(s): 483.25(g)(1) §483.25(g) Assisted of (Includes naso-gastric both percutaneous endoscenteral fluids). Based comprehensive assessmensure that a resident partitional status, s	tatus Maintenance -(3) nutrition and hydration. c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and d on a resident's esment, the facility must	F	manager Director of Progress weeks, the all areas The Quater forward to Diagnosi Audit Tool to the monthly of Committee and review Audit Tool and the Federmin need furth and to defermin need furth and to deferm the need furth and the need f	ment initiated as indicated. The of Nursing will review the sonote Audit Tool weekly x 8 men monthly x 1 month to ensor of concern were addressed. Ility Improvement (QI) Nurse where sults of the Mental Health is Audit Tool, Behaviors Observed and the Progress Note Audit in Executive QI Committee at 3 months. The Executive QI ee will meet monthly x 3 months with the Mental Health Diagnos of the Interventions put into place the Interventions put into place the Interventions put into place the Intervention of the Interventions of the Intervention of Nursesponsible for the Implemental tive actions to include all 100° as services, and monitoring relation of correction.	ure vill th rved it ths sis Tool may ce and sing tion %	3/22/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345266	B. WING _			03/01/2018
	ROVIDER OR SUPPLIER E LANDING NURSING A	ND REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 1084 US 64 EAST PLYMOUTH, NC 27962	•	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 692	Continued From pag		F 6	692		
		resident's clinical condition is is not possible or resident otherwise;				
	§483.25(g)(2) Is offer maintain proper hydrony	red sufficient fluid intake to ration and health;				
	there is a nutritional provider orders a the This REQUIREMEN by:	red a therapeutic diet when problem and the health care erapeutic diet. T is not met as evidenced view, staff and physician		F 692		
	interview, and observations, the facility failed to provide enteral feeding (tube feeding) as ordered for 1 of 5 residents (Resident #8) reviewed for nutrition.			The process that led to this d was the facility failed to provid feeding (tube feeding) as order to residents. On 3/15/18 100% audit of physical controls.	de enteral ered for 1 of	
	Active diagnoses inc (DM), cerebrovascul	s of one side of the body), order of magnesium		orders x 30 days was comple ensure all physician s orders diet orders/recommendations followed as prescribed. All are concern were immediately ad the Director of Nursing (DON On 2/28/18 the diet order for was clarified to specify Isosoo calorie 250ml brick pack via e	s including s are being eas of ddressed by). resident # 8 urce 1.5	
	assessment tool (MI Resident #8 was mo was totally depender activities of daily living which required 1 per had an impairment of lower limb, had a Pe			feeding tube bolus three time am, 2pm and 7pm if resident 50% of breakfast, lunch and on 2/28/18 an in-service was the Staff Facilitator on Observenting Acute Changes wit assistants (NA) in regards to: 1. Vulnerability of Nursing Facilitation of Staff Resident 2. Examples of resident chainclude decreased po intake/iii. 3. Reporting of a change in	es a day at 10 consumes < dinner. s initiated by vation and th all nursing Home anges to meal refusals	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X-		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345266	B. WING _			03/0	01/2018	
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F 692	part, "State of nourist (PEG) in place, resid (water) flushes. One will not experience si thru next review. Inte ordered; GT (PEG) for provide assistance where the condition of the provide assistance where the condition of the provide assistance where the condition of the provide assistance where the prov	an dated 12/10/17 read, in ment related to (r/t) g-tube ent receives scheduled H2O stated goal read the resident gnificant weight loss/gain rventions included diet as eedings as ordered; and ith meals as indicated." 2/18 for Resident #8 read, in unner in which resident acts propriate behavior. t/care related or due to snacks on chips/cookies ts.(weights). Interventions ent choices, preferences and e and services; if resident sident and return 5-10 In form dated 2/27/18 at 3:50 PO (by mouth) intake since orning). MD (physician) FO PM and ordered bolus 250 ml (milliliters) of (Brand rmula) with less than (<) 50	F	promptly to the unit nurse and/o Supervisor to include decrease or meal refusals. No NAs will be allowed to work in-service has been completed. completed on 3/21/2018. All newly hired NAs will be in-set the Staff Facilitator during orient Observation and Reporting Acur Changes to include: 1. Vulnerability of Nursing Hot Resident 2. Examples of resident changinclude decreased po intake/me 3. Reporting of a change in copromptly to the unit nurse and/o Supervisor to include decrease or meal refusals. On 2/28/18 an in-service was in the Staff Facilitator on Observat Reporting Acute Changes with a nurses, Minimum Data Set Nurs Treatment Nurse, Assistant Dire Nursing (ADON), Resident Care Coordinator, and Quality Improv Nurse (QI) in regards to: 1. Vulnerability of Nursing Hot Resident 2. Examples of Atypical Prese Signs/Symptoms of acute changinclude decreased po intake/me 3. All changes in a resident coshould be taken seriously 4. Assessment of Acute Chanany acute or subtle changes are 5. Interventions for Change in Condition 6. Notification of Physician/RF Changes in Resident Sconditi	until In-serviced betation on the ges to eal refusation and all licensise (MDS) ector of evernent me entation or ges to eal refusation or ges where exported in Resider R for	ce y als e y ed),		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345266	B. WING		03/01/2018	
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2010	
				1084 US 64 EAST		
ROANOKI	E LANDING NURSING AI	ND REHABILITATION CENTER	1	PLYMOUTH, NC 27962		
(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)	DATE	
F 692	692 Continued From page 14		F 692			
F 692	An interview was con 2/27/18 at 2:20 PM. Seaten none of her bre lunch. She stated it wawake after she recethe resident was able hands, but not with utaresident had not earliernative or asked thelp eating. An interview was con 2/27/18 at 2:30 PM. Seaten for any haven't heard anythir behaving differently clike to sleep and she medications." An interview was con Nursing (DON) on 2/2 if a resident refuses a supposed to tell the nurse after a resident The nurse should assechecking bowel and pappropriately by calling the resident refuses and pappropriately by calling a seaten and pappropriately by calling the resident refuses and pappropriately by calling and pappropriately at 2:30 PM. Seaten and pappropriately by calling and pappropriately at 2:30 PM. Seaten and pappropriately at 2:30 P	ducted with NA #3 on She stated Resident #8 had eakfast and none of her vas hard to keep Resident #8 ived pain medication, and to feed herself with her tensils. The NA also stated if ten the staff offered an the resident if they needed ducted with Nurse #4 on She stated, "I usually care for A's should tell me anything v resident, like not eating. I tag about (Resident #8) or not eating today. She does sleeps more with pain ducted with the Director of 27/18 at 2:50 PM. She stated anything the NA was turse. The NA should tell the trefused to eat one meal. tess the resident, including toain status, and treat tog the doctor (MD), or finding	F 692	No licensed nurses, Minimum Data Se Nurse (MDS), Treatment Nurse, Assist Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) will be allowe work until in-service has been complet In-service was completed on 3/21/2013 All newly hired licensed nurses, Minim Data Set Nurse (MDS), Treatment Nur Assistant Director of Nursing (ADON), Resident Care Coordinator, and Qualit Improvement Nurse (QI) will be in-serviced by the Staff Facilitator durin orientation on Observation and Report Acute Changes to include: 1. Vulnerability of Nursing Home Resident 2. Examples of Atypical Presentation Signs/Symptoms of acute changes to include decreased po intake/meal refu 3. All changes in a resident condition should be taken seriously 4. Assessment of Acute Changes whany acute or subtle changes are report 5. Interventions for Change in Reside Condition 6. Notification of Physician/RR for Changes in Resident Staff Facilitator on 24 Hour Nurse	d to ed. 3. um se, y ng ing ing en ted ents	
	been told. My expects MD orders to be follow communication betwee any changes or anyth resident."	eaten the nurse should have ation is for all care plans and wed and there should be een the nurses and NA's for		Shift Report with all licensed nurses, Minimum Data Set Nurse (MDS), Treatment Nurse, Assistant Director of Nursing (ADON), Resident Care Coordinator, and Quality Improvement Nurse (QI) in regards to communicatio resident changes to include: 1. Documentation of: a. Acute change charting to include		

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	ROVIDER OR SUPPLIER E LANDING NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1084 US 64 EAST PLYMOUTH, NC 27962			
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F 692	expectation that if a rethemselves doesn't exthemselves, the staff She also stated she physician and there eating with tube feed consumed at least 50 the NA's were expectif a resident had not family frequently brought in. An interview was cor PM with Resident 8's Resident #8 was 'a bonly seen her 3 times had a feeding tube a always in place for a to get a supplement of meals was consist. An observation was Resident #8 was sittitray set up on the ovideen consumed. An observation was Resident #8 was sittitray set up on the ovideen consumed. An interview was cor AM with Nurse #5. S was the 300 Hall and Hall. Resident #8 was She stated the NA's	rator. She stated it was her resident who usually feeds at or doesn't feed should offer to feed them. That spoken with Resident 8's was an order to supplement ings if Resident #8 had not 10% of her meal. She stated ted to inform the care nurse eaten. She also stated the 100% of what was 100% of what was 100% of what was 100% of what was 100% of a quandary' as he had 100% of a quandary' as he had 100% of what was 100% of what was 100% of what was 100% of a quandary' as he had 100% of what was 100% of a quandary' as he had 100% of a quandary' as he had 100% of a quandary' as he had 100% of what was 100% of a quandary' as he had 10	F 69	decreased po intake/meal refusals b. New orders (medications, ther diet) c. Medical appointments d. Admissions e. Antibiotic therapy monitoring f. Accidents/incidents (new safet interventions/neuro checks) g. Labs drawn, pending lab repor new lab reports h. Discharges i. Abnormal vitals/vital sign moni 2. Nurses must review 24hr repor during change of shift 3. All nurses are responsible for reviewing at least the past 72hrs of reports to ensure assigned nurse is of any changes in relation to reside care/new orders. No licensed nurses, Minimum Data Nurse (MDS), Treatment Nurse, As Director of Nursing (ADON), Reside Care Coordinator, and Quality Improvement Nurse (QI) will be allowork until in-service has been com In-service was completed on 3/21/2 All newly hired licensed nurses, Min Data Set Nurse (MDS), Treatment Assistant Director of Nursing (ADO Resident Care Coordinator, and Quality Improvement Nurse (QI) will be in-serviced by the Staff Facilitator or orientation 24 Hour Nurse Shift Re regards to communication of reside changes to include: 1. Documentation of: a. Acute change charting to includ decreased po intake/meal refusals b. New orders (medications, ther	ts or toring rt shift saware int Set sistant ent owed to pleted. 2018. nimum Nurse, N), uality luring oort in ent de		

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F 692	it was less than their was caring for (Reside know how much breat because, "Her NA did stated (Resident #8) 8:30 AM today. She sereceive a bolus feeding consumed less than a should be given as someal was refused/or She had not given (Reyet. An interview was con AM with NA #4. She seaten none (0%) of his stated there was a shof any changes in resident was supposed to nurse. She stated she was supposed to nurse. She stated she (Resident #8) had not had not told Resident An interview was con 2/28/18 at 11:05 AM. change in therapy or the book. The expect meal refusal was immined refusal was immined refusal, just like assigned NA who told about anything that his resident. She also stated the sident was supposed to nurse. She stated she (Resident #8) had not had not told Resident was immined refusal was immined refusal, just like assigned NA who told about anything that his resident. She also stated she also stated she was supposed to nurse. She stated she was supposed to nurse she was supposed to nurse. She stated she was supposed to nurse. She stated she was supposed to nurse.	usual intake. She stated she ent #8) today and did not kfast she had eaten in't tell me yet." She also was given breakfast about stated the resident was to ng through her PEG if she 50% of any meal. The bolus on as possible after the less than 50% was eaten. esident #8) a bolus feeding ducted on 2/28/18 at 10:45 stated (Resident #8) had er breakfast. She also hift report where she was told sident status or care, or the deginning of the shift. She dehavior or intake changed tell the assigned care estold the 500 Hall nurse to eaten any breakfast, but the #8's assigned care nurse. ducted with the DON on She stated if there was a resident status it was put in ation for bolus feeds after nediately or within 1 hour of a medication, and it was the did the resident's care nurse.	F6	diet) c. Medical appred. Admissions e. Antibiotic the f. Accidents/ininterventions/neug. Labs drawn, new lab reports h. Discharges i. Abnormal vit 2. Nurses must during change of 3. All nurses ar reviewing at leas reports to ensure of any changes ii care/new orders. On 2/28/18 an inthe Staff Facilitat nurses, Minimum Treatment Nurse Nursing (ADON), Coordinator, and Nurse (QI) on Fo Orders to include 1. Processing rorders 2. 24hr chart cl 3. Checking pir medications rece on MAR/TAR appressions.	erapy monitoring scidents (new safety uro checks), pending lab reports of tals/vital sign monitoring treview 24hr report if shift re responsible for set the past 72hrs of shift erassigned nurse is awn relation to resident erapsions and in Data Set Nurse (MDS erapsions), Assistant Director of Resident Care if Quality Improvement collowing Physician set in the control of the contr	ft are		
	tube feed formula any consumed at least 50 "This bolus should be			5. Completing a prescribed to incl	all diet orders as lude PEG feedings of any order that does	not		

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	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (1084 US 64 EAST PLYMOUTH, NC 27962	CODE			
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F 692	feed was missed thi and she's just gettin trying to work on so given it won't interfe today, it's almost lur	ge 17 Already aware that the bolus is morning for (Resident #8) g it now at 11:00 AM. We're mething so if her bolus is re with the next meal. Like nich time and she probably e her bolus feed didn't start	F 6	parameters for use. 7. Notification of DON for discrepancies No licensed nurses, Minim Nurse (MDS), Treatment Notification of Nursing (ADON Care Coordinator, and Qual Improvement Nurse (QI) work until in-service has confined the provided All newly hired licensed nurses (QI) with work until in-service of Nursing Resident Care Coordinator Improvement Nurse (QI) with in-serviced by the Staff Farorientation on Following Plorders to include: 1. Processing new order orders 2. 24hr chart checks 3. Checking pink slips to medications received, order on MAR/TAR appropriately 4. Acceptable time frame administering medications. 5. Completing all diet orders of the prescribed to include PEG (Clarification of any orders to include orders to include orders for use. 7. Notification of DON for discrepancies	num Data Set Nurse, Assistal N), Resident ality vill be allowed ompleted. on 3/21/2018. urses, Minimur eatment Nurse ing (ADON), or, and Quality vill be acilitator during rhysician s rs to include di o ensure er documented y e for uffeedings der that does re time or or all order hysician s or resident #8	to m e,		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 692	Continued From page	± 18	F 6	Coordinator/ADON weekly x 8 weeks, then monthly x 1 month utilizing the Physician sorder Audit Tool to ensure physician sorders including diet orders are being followed as prescribed. The Director of Nursing will review the Physician sorder Audit Tool weekly x weeks, then monthly x 1 month to ensuall areas of concern were addressed. 25% audit of meal intake to include meaintake for resident #8 will be completed the Resident Care Coordinator/ADON stimes a week x 4 weeks, then weekly x weeks then monthly x 1 month utilizing Meal Intake Audit Tool to ensure any marefusals are reported to nursing, resider assessment completed and MD/RR notification. The Quality Improvement (QI) Nurse wiforward the results of the Physician sorder Audit Tool and Meal Intake Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 month and review the Physician sorder Audit Tool and Meal Intake Audit Tool to determine trends and / or issues that mand review the Physician sorder Audit Tool to determine trends and prictor of Nursiand to determine the need for further are for frequency of monitoring. The Administrator and Director of Nursiand Will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring relation to the plan of correction.	8 re al by 5 4 the eal nt ill as e nd ng on	
SS=D	CFR(s): 483.25(n)(1)-	-(4)				

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F 700	alternatives prior to a bed or side rail is correct installation, rails, including but relements. §483.25(n)(1) Asse entrapment from be §483.25(n)(2) Revie bed rails with the reresentative and to installation. §483.25(n)(3) Ensurare appropriate for side appropriate for side rails with the reresentative and to installation. §483.25(n)(4) Follower appropriate for side appropriate for side rails or a laternatives prior to residents reviewed. Findings included: Resident #66 was a 2/20/17. His active of hypertension, Alzher muscle weakness. Review of Resident	Is. empt to use appropriate installing a side or bed rail. If used, the facility must ensure use, and maintenance of bed not limited to the following ss the resident for risk of d rails prior to installation. where the risks and benefits of sident or resident obtain informed consent prior re that the bed's dimensions the resident's size and weight. where the manufacturers' and specifications for installing d rails. It is not met as evidenced ions, staff interviews, and acility failed to assess for the attempt appropriate installing bed rails for 1 of 1 for accidents (Resident #66).	F7	F 700 The process that led to this d was the facility failed to asses of side rails or attempt approalternatives prior to installing 1 of 1 residents reviewed. On 2/28/18 100% audit of all utilizing bedrails to include re was initiated by the Quality Ir Nurse (QI) to ensure resident properly assessed for the use and that appropriate alternati attempted prior to installing b Audit was completed on 3/21 of concern were immediately	ss for the use priate bed rails for residents sident #66 approvement thas been e of bed rails ves had been ed rails. /18. All areas		

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DOANOK	T ANDING NUBGING	AND DELIABILITATION CENTED		1084 US 64 EAST		
ROANOKI	E LANDING NURSING	AND REHABILITATION CENTER		PLYMOUTH, NC 27962		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
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F 700	Continued From pa	ge 20	F 700			
	assessed to be orie	nted to person only and to		by the QI Nurse.		
	_	eness deficit with impaired		On 2/28/18 resident #66 was re-evalu	ated	
		The resident was assessed		for use of bed rails. Appropriate		
		lent on staff for bed mobility.		alternatives were initiated and bed rail		
		ventions were documented to		were removed due to risk of entrapme		
		ed or assessed prior to		On 3/21/18 100% audit of all residents		
		ed rails. The assessment		utilizing bedrails to include resident #6		
	recommended nair	rails were to be used.		was completed by the Director of Nurs		
	Paview of Pasident	#66's significant change		(DON) to ensure resident is care planfor use of bed rails. All areas of conce		
		assessment dated 1/30/18		were immediately addressed by the	111	
				Minimum Data Set Nurse (MDS).		
	revealed the resident was assessed as severely cognitively impaired. He required extensive			On 3/21/18 an in-service on Bed Rails		
	assistance with bed			was completed by the Quality	, l	
				Improvement Nurse (QI) with all licens	sed	
	Review of the media	cal record revealed there was		nurses, MDS, Treatment Nurse, Staff		
	no care plan in plac	e for the use of bed rails.		Facilitator, Resident Care Coordinator	ſ ,	
				Maintenance Director and DON in reg	ards	
	_	on 2/27/18 at 2:33 PM the half		to use of bed rails to include:		
		66's bed were observed to be		4. Assessing the resident for the risk	k of	
	I	ght side of the resident. The		entrapment from bed rails prior to		
		ng in bed and a fall mat was		installation under the Bed Rail Evalua	tion	
	placed next to the b	ed.		in Point Click Care (PCC)		
	During chast ation	on 2/20/10 at 0:20 AM the half		a. Entrapment: an event in which a	ad in	
		on 2/28/18 at 8:30 AM the half 66's bed were observed to be		resident is caught, trapped or entangle the space in or about the bed rail	au III	
		ght side of the resident. The		5. The facility must attempt to use		
		yed to be speaking incoherent		appropriate alternatives prior to install	lina	
		ividual who was not there and		a side or bed rail (trapeze bar, low bed	-	
		ght arm, brushing the right bed		frequent monitoring, activities)		
		. There were no observed		6. Review the risks and benefits of the	ped	
	injuries to the reside			rails with the resident or resident		
	-			representative and obtain informed		
	During an interview on 2/28/18 at 9:52 AM Nurse Aide (NA) #1 stated Resident #66 was not alert and oriented and was very combative with staff.			consent		
				7. Ensure the rail is installed per the	;	
				manufactures recommendations and		
	She further stated he would hallucinate when no			specifications		
		n and swing his arms at his		8. Ensure the bed rail is compatible		
	hallucinations. She	stated Resident #66 did not		the mattress and bed frame and that t	he	

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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	7070172010	
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ROANOKE	E LANDING NURSING A	AND REHABILITATION CENTER		PLYMOUTH, NC 27962			
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F 700	Continued From pag	ge 21	F 70	0			
	of daily living. She shad bed side rails to his arms did hit the line swung his arms be sustained any injuried. During an interview Nurse #1 stated Resto himself and was we further stated he wowhen he had hallucinurse stated Reside she started work for 2017. She stated she	on 2/28/18 at 10:15 AM sident #66 was only oriented very combative with staff. She uld swing his arms or legs nations and also at staff. The nt #66 had side rails since the facility in September of e was not aware of any ails usage being attempted or		dimensions are appropriate for residents size and weight 9. Inspect regularly the math bed rail for the possibility of et 10. Maintenance monitors be regularly to ensure they are incorrectly and/or have no shifted over time. 11. Appropriate documentation with use of bed rails (see attangled Restraint/Enabler Progress 12. Resident is care planned bed rails No licensed nurses, QI nurse, Data Set Nurse (MDS), Treating Staff Facilitator, Resident Car Coordinator, Maintenance Dir	tress and ntrapment ed rails nstalled ed or loosen on in PCC ched) under s Note for use of , Minimum ment Nurse, re		
	During an interview on 2/28/18 at 11:15 AM the Staff Development Coordinator stated she helped with bed rail assessments in November when the new regulations were put in place. She said she completed Resident #66's bed rail evaluation. She stated the facility had not attempted or assessed for alternative interventions to bed side rails before placing the bed side rails on Resident #66's bed. The Staff Development Coordinator continued to state Resident #66 had the bed side rails in place during his entire stay in the facility from 2/20/17 to now. She further stated no assessment for alternative approaches was completed before the installation of the bed rails and she was not aware of this being required in the new regulations. She stated she assessed the rails to see if they fit properly and the continued use of the bed side rails was based on the fact he had always had bed side rails.			Director of Nursing (DON) will to work until in-service on Bed been completed. In-service w completed on 3/21/2018. All newly hired licensed nurse Minimum Data Set Nurse (ME Treatment Nurse, Staff Facilit Resident Care Coordinator, M Director and Director of Nursi will be trained by the Staff Facilit Bed Rails during orientation to 1. Assessing the resident for entrapment from bed rails pricinstallation under the Bed Rail in Point Click Care (PCC) a. Entrapment: an event in resident is caught, trapped or the space in or about the bed 2. The facility must attempt appropriate alternatives prior	d Rails has as as es, QI nurse, OS), ator, flaintenance ng (DON) cilitator on o include: or the risk of or to el Evaluation which a entangled in rail to use		
	During an interview	on 2/28/18 at 11:33 AM the		a side or bed rail (trapeze bar	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345266	B. WING _	B. WING		03/01/2018	
	ROVIDER OR SUPPLIER E LANDING NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STAT 1084 US 64 EAST PLYMOUTH, NC 27962	E, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		IVE ACTION SHOULD BE ED TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 700	should have alternative beds. She further statement alternatives to bed sussessed in the bed installing bed rails or was not done. She a Director of Nursing a speak to what guidal side rail assessment	DON) stated residents ives attempted or assessed a put in place on resident ated it was her expectation ide rails be attempted or rail assessments prior to a Resident #66's bed and it also stated she was not the at that time and was unable to nace was given about the bed in November. She further and about the new regulations	F7	frequent monitoring, 3. Review the risks rails with the resident representative and of consent 4. Ensure the rail is manufactures recomplications 5. Ensure the bed of the mattress and bed dimensions are appropriesidents size and well.	s and benefits of bed to resident btain informed sinstalled per the mendations and rail is compatible with different frame and that the opriate for the eight of the mattress and bility of entrapment onitors bed rails ney are installed eno shifted or looser umentation in PCC (see attached) unde Progress Note e planned for use of the with the end of the with the end of the ent #66 will be the Nurse weekly x 8 ax 1 month utilizing the old to ensure: In a sassessed for the ent is completed the ent with the ent is completed the ent with the ent is completed the ent is completed the ent with the ent is completed the ent with the ent is completed the ent with the ent is completed	th n	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER E LANDING NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1084 US 64 EAST PLYMOUTH, NC 27962	ODE	
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F 700	Continued From page		F 7	benefits of bed rails with the resident representative and informed consent 5. The rail is installed per manufactures recommendate specifications and is comparattress and bed frame and dimensions are appropriated size and weight 6. Appropriate documents with use of bed rails under Restraint/Enabler Progress 7. Resident is care planning bed rails The DON will review the Bed Tool weekly x 8 weeks, the month to ensure all areas of addressed. The Quality Improvement (forward the results of the Bed Tool to the Executive QI Commonthly x 3 months. The Edministrator and 7 or is need further interventions pand to determine the need for frequency of monitoring. The Administrator and Direwill be responsible for the information of corrective actions to including in services, and monto the plan of correction.	the ations and atible with the dithat the for resident ation in PCC QI Note ed for use of ed Rail Audit in monthly x of concern we will all a month ation to be sues that made at the put into place for further and cout of Nursimplementation and all 100%	ere I S ay d
SS=D	CFR(s): 483.70(o)(1) §483.70(o) Hospice s §483.70(o)(1) A long					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY OMPLETED
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NAME OF PROVIDER OR SUPPLIER ROANOKE LANDING NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, 1084 US 64 EAST PLYMOUTH, NC 27962	ZIP CODE	
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F 849	through an agreement Medicare-certified ho (ii) Not arrange for the services at the facility a Medicare-certified ho resident in transferrin arrange for the provise when a resident requivers to a paragraph (o)(1)(i) of the LTC facility through a paragraph (o)(1)(i) of the LTC facility must requirements: (i) Ensure that the hoprofessional standard to individuals providing to the timeliness of the (ii) Have a written agrithat is signed by an atthe LTC facility before any resident. The wrat least the following: (A) The services the least the following: (B) The hospice's residual the provide based on each (D) A communication communication will be LTC facility and the het that the needs of the met 24 hours per day	ring: rivision of hospice services at with one or more spices. re provision of hospice at through an agreement with rospice and assist the right to a facility that will right of hospice services rests a transfer. Indee care is furnished in an an agreement as specified in resting the following respice services meet rest and principles that apply respice services in the facility, and reservices in the facility and reservices in	F	349		

1, 7		IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345266	B. WING		03/01/2018		
NAME OF PROVIDER OR SUPPLIER ROANOKE LANDING NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1084 US 64 EAST PLYMOUTH, NC 27962	1 33/61/2010		
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F 849	(1) A significant chamental, social, or el (2) Clinical complica alter the plan of car (3) A need to transfor any condition. (4) The resident's diagram (F) A provision statist responsibility for decourse of hospice determination to chaprovided. (G) An agreement the resident's needs in corresponsibility to funcare, meet the resident's needs. (H) A delineation of including but not lindiffection and mana counseling (including bereavement); socistion supplies, durable manacounseling (including bereavement); socistion and manacounseling (including bereavement); social delineated with the conditions; and all conditions are conditions.	about the following: ange in the resident's physical, motional status. ations that suggest a need to e. er the resident from the facility eath. ing that the hospice assumes termining the appropriate are, including the ange the level of services that it is the LTC facility's hish 24-hour room and board dent's personal care and ordination with the hospice ensure that the level of care iately based on the individual of the hospice's responsibilities, hited to, providing medical gement of the patient; nursing; ng spiritual, dietary, and al work; providing medical edical equipment, and drugs alliation of pain and symptoms terminal illness and related other hospice services that are are of the resident's terminal	F 849				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER ROANOKE LANDING NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 1084 US 64 EAST PLYMOUTH, NC 27962		
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F 849	report all alleged v mistreatment, negliand physical abuse source, and misap by hospice personadministrator immediate becomes aware of (K) A delineation of hospice and the LT bereavement serviological services and the LT bereavement serviological provision of hospica agreement must defacility's interdiscip for working with hocoordinate care to LTC facility staff ar interdisciplinary teachinical background scope of practice assess the resident that has the skills are sident. The designated intresponsible for the (i) Collaborating wand coordinating LT the hospice care presidents receiving (ii) Communicating and other healthca provision of care for conditions, and other of care for the paties.	ting that the LTC facility must iolations involving ect, or verbal, mental, sexual, e, including injuries of unknown propriation of patient property nel, to the hospice ediately when the LTC facility the alleged violation. In the responsibilities of the resignate a member of the linary team who is responsible representatives to the resident provided by the resident provided	F	849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER ROANOKE LANDING NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP (1084 US 64 EAST PLYMOUTH, NC 27962	CODE	
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F 849	attending physician, participating in the property as needed to coording medical care provided (iv) Obtaining the followspice: (A) The most recent to each patient. (B) Hospice elections (C) Physician certification the terminal illness son the terminal illness son (D) Names and control personnel involved in patient. (E) Instructions on the 24-hour on-call system (F) Hospice medicate each patient. (G) Hospice physician and record keeping of the terminal illness son (P) Hospice medicate each patient. (G) Hospice medicate each patient. (G) Hospice physician and record keeping of the serior to LTC (V) Ensuring that the orientation in the polification of the serior the most recent hospices description of the serior the most recent hospices in the most recent hospices in the physical, well-being, as required the most required the most recent hospices in the serior that in the polification of the serior that the most recent hospices in the physical, well-being, as required the physical, well-being, as required the physical in the polification of the serior that the polification of the serior that the physical in the polification of the serior that the physical in the province of th	dical director, the patient's and other practitioners rovision of care to the patient thate the hospice care with the ed by other physicians. owing information from the hospice plan of care specific form. Cation and recertification of pecific to each patient. Cat information for hospice in hospice care of each how to access the hospice's em. Cation information specific to each patient. LTC facility staff provides icies and procedures of the ent rights, appropriate forms, requirements, to hospice staff ic residents. LTC facility providing hospice agreement must ensure that en plan of care includes both once plan of care and a rovices furnished by the LTC faintain the resident's highest mental, and psychosocial ed at §483.24. T is not met as evidenced form, staff interviews and	F 8	F849	s deficiency	
	by: Based on observation			F849 The process that led to this	s deficiency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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ROANOKI	E LANDING NURSING	S AND REHABILITATION CENTER		1084 US 64 EAST PLYMOUTH, NC 27962			
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F 849	Continued From p	age 28	F8	was the facility failed to main	tain		
	provided by Hosp	ice and facility personnel for 1 of hts (Resident #44).		communication and coordina services provided by Hospice personnel.	tion of		
	The findings inclu			On 2/19/18 100% audit of all receiving Hospice Services in	ncluding		
	05/12/16 with a cu	admitted to the facility on imulative diagnosis including: emorrhage, protein malnutrition, lementia, and malignant		resident #44 was completed Administrator to ensure appr documentation in medical red include: 1. Hospice Plan of Care	opriate		
	indicated that resi impairments. The	/8/18 Minimum Data Set (MDS) dent had severe cognitive resident needed total ilet use, bathing, and personal		 Hospice Election Form Physician Certification/R of Terminal Illness Hospice Medication Info specific to each resident Hospice Physicians Ord Treatments 	rmation		
	A care plan, revised 01/8/18 identified Resident #44 had a progressive decline, and Hospice care was provided due to progressive decline.			7. Progress Notes 8. Evaluations. There were 5 areas of conce On 2/19/18 the Facility Admir			
	02/1/18 for Reside	inistration Record (MAR) dated ent #44's listed a Do Not) order with a begin date of		Director of Nursing (DON), N Set (MDS) Coordinator, Resi Coordinator, and Social Worl Hospice Agency Clinical Ser Hospice Liaison, Office Coor	dent Care ker met with vice Director,		
	A physician note dated 01/15/18 for Resident #44 revealed the resident's long-term prognosis is fair to poor. She was stable for the moment, to watch for signs of skin breakdown, to watch for signs of decompensation, and to watch for aspiration. Physician interventions revealed no change in her regimen. Her pain was well controlled and she was in no distress.			Hospice Case Manager to di facilities expectations in rega hospice communication and facility with appropriate docu include: 1. Hospice Plan of Care 2. Hospice Election Form 3. Physician Certification/Rof Terminal Illness	scuss irds to providing mentation to		
	Home Communic	nent titled "Interdisciplinary ation Record" dated 01/26/18 - ewed from a notebook located		4. Hospice Medication Info specific to each resident5. Hospice Physicians Ord			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ROANOKI	E LANDING NURSING A	ND REHABILITATION CENTER		1084 US 64 EAST			
NOANON	LANDING NONGING AI	TO REHABILITATION SENTER		PLYMOUTH, NC 27962			
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F 849	Continued From page	e 29	F 84	19			
F 849	on Resident #44's be document was the on documentation in Reselectronic or physical nurse visit on 02/26/1 (blood pressure, hear temperature), with a sin chair at nursing state An interview on 02/27 Hospice Director of Cacility Administrator of expectation that the fishould have community providing the facility records, physician or progress notes, and of An interview on 02/28 (Hospice Nurse) reversex expectation that Resillospice medical records though a facility and Hospice search facility and Hospice search facility, and was not the resident's orders It was her expectation print off resident #44' and care plans and phospice tab in the resident's physical chocated in the patient's located in the patient's physical chocated in the patient's physical chocated in the patient's process.	dside table. The one page ally Hospice medical sident #44's complete chart. This form listed one 8, which included vital signs at rate, respirations and significant finding of "patient ation, no pain". 7/18 at 12:36 with the operations (HDO) and the revealed that it was their acility's Hospice nurse dicated to the facility better ty all communication ders, medication listings and did not. 8/18 at 10:50 AM Nurse #3 alled that it was her dent #44's complete ords be available to staff on a preek, per facility agreement, ospice nurse agreed that a ation structure should have and written form) between taff, and be present at the She said she kept most of and notes in her computer. In, from now on, she would so visit notes, updated orders lace them behind the sident's main facility chart. Also document after each in writing and place it in the lart behind the hospice tab so physical chart, which she	F 84	 Treatments Progress Notes Evaluations. On 2/27/18 Hospice Agency provided facility the required documentation for residents receiving Hospice services to include resident #44 for the past 30 dato include: Hospice Plan of Care Hospice Election Form Physician Certification/Recertification Terminal Illness Hospice Medication Information specific to each resident Hospice Physicians Orders Treatments Progress Notes Evaluations. On 2/27/18 the MDS Coordinator was designated as Facility Hospice Liaison On 2/27/18 the MDS Nurse was in-serviced by the Administrator on the expectations of the Facility Hospice Liaison to include:	o ays ation		
		s physical chart, which she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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				1084 US 64 EAST			
ROANOKE	E LANDING NURSING	AND REHABILITATION CENTER		PLYMOUTH, NC 27962			
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F 849	facility Administrator expectation that the Hospice Agreement provide information include: Hospice morders, and did not that the facility and provider failed to compare the facility and hour basis per Hospice of Nursing her expectation that communicated more as provided hospice the facility, and did per their revised Hospice personnel services 24 hours hospice Resident to the facility, which information, nursing orders. The DON services and the services and the services are the services and the facility of the facility of the facility of the facility of the facility.	/28/18 at 11:30 AM with the or revealed that it was her the Hospice Nurse follow the at provision dated 2016 to a from Hospice to the Facility to dedical information, Hospice of their contracted Hos	F 84		rator with any ntation rin regards to: Recertification ormation ders ceiving resident #44 os nurse monthly times ce Quality Chart Audit nave to include:		
	An interview on 03 #2 revealed it was Hospice nurse pro- hospice care plant and coordination n	was not. /1/18 at 11:10 AM with Nurse her expectation that the vide to the facility on site, the with orders, plan of treatment otes report provided to the acility visit, and did not.		 4. Hospice Medication Information Specific to each resident 5. Hospice Physicians Ordinal Specific Treatments 7. Progress Notes 8. Evaluations. All areas of concern will be inaddressed by the DON. DON will review all Quality In (QI) Hospice Chart Audit Too. 	ders mmediately mprovement		

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 849	07/13/16 was review The facility policy on 02/2007 was review	ervices agreement dated ved on 03/1/18. n Advance Directives dated ed on 03/1/18. directives manual dated	F 84	weeks then monthly x one in ensure all areas of concern addressed. The Quality Improvement (Offorward the results of the Quality Improvement (QI) Hospice (Tool to the Executive QI Comonthly x 3 months. The Execommittee will meet monthly and review the Quality Improvement (QI) Improvement (QI) Hospice Chart Audit Tool to trends and / or issues that infurther interventions put into determine the need for furth frequency of monitoring. The Administrator and Direct will be responsible for the inforcement of corrective actions to inclusive audits, in services, and monito the plan of correction.	were QI) Nurse will uality Chart Audit mmittee kecutive QI ly x 3 months rovement (QI) determine may need o place and to her and / or ctor of Nursin mplementatio ude all 100%	o o ng	