PRINTED: 06/14/2018 FORM APPROVED OMB NO. 0938-0391

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		TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
Establishment of the CFR(s): 483.73	Emergency Program (EP)	E 00	01	5/31/18
comply with all applic emergency preparedr [facility] must establis comprehensive emerge program that meets the section.* The emerge	able Federal, State and local ness requirements. The h and maintain a gency preparedness ne requirements of this ncy preparedness program			
comply with all applic local emergency prephospital must develop comprehensive emergency and that meets the section, utilizing an all *[For CAHs at §485.6] with all applicable Fedemergency prepared CAH must develop ar comprehensive emergency and this REQUIREMENT	able Federal, State, and haredness requirements. The or and maintain a gency preparedness he requirements of this l-hazards approach. 25:] The CAH must comply deral, State, and local hess requirements. The hid maintain a gency preparedness hall-hazards approach.			
facility failed to have of preparedness (EP) ploating include community bate facility risk assessme strategies, the emerging did not include missing program. The EP plantesident population. Tinclude policy and program and	comprehensive emergency an. The EP manual failed to ased risk assessment, nt and associated ency plans and procedures ag resident in their EP a failed to identify its The EP manual did not accedures for sheltered		This Plan of Correction is prepare necessary requirement for continuous participation in the Medicare and program. It does not in any mann constitute an admission to the value alleged deficient practice. E001 Based on record reviews and statinterviews the facility failed to have	ued Medicaid er lidity of
	comply with all applic emergency preparedr [facility] must establis comprehensive emerger program that meets the section.* The emerger must include, but not elements: *[For hospitals at §48 comply with all applical local emergency preparedromprehensive emerger program that meets the section, utilizing an all emergency preparedromprehensive emergency preparedromprehensive emergency preparedromprehensive emergency preparedromprehensive emerger program, utilizing an all this REQUIREMENT by: Based on record revifacility failed to have of preparedness (EP) planticude community based facility risk assessments assessments as the emergency program. The EP planter program. The EP planter program. The EP planter program. The EP planter program and	*[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced	comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to have comprehensive emergency preparedness (EP) plan. The EP manual failed to include community based risk assessment, facility risk assessment and associated strategies, the emergency plans and procedures did not include missing resident in their EP program. The EP plan failed to identify its resident population. The EP manual did not include policy and procedures for sheltered	comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to have comprehensive emergency preparedness (EP) plan. The EP manual failed to include community based risk assessment, facility risk assessment and associated strategies, the emergency plans and procedures did not include missing resident in their EP program. The EP plan failed to identify its resident population. The EP manual did not include policy and procedures for sheltered be a program and that meets the requirements of this section, and the plant and associated strategies, the emergency preparedness (EP) plan failed to identify its resident population. The EP manual did not include policy and procedures for sheltered

05/23/2018 **Electronically Signed**

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

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED
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345311	B. WING _			05/03/2018
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AB CENTER		ROXBORO, NC 27573		
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es to track residents and staff other facilities and policy and esidents and others who ity during an emergency. de policy and procedures to formation and protect ity, secure and maintain int's medical records. The EP failed to include contact resident's physician and contact information of the Certification Agency. EP failed to include procedure in and medical resident with other health accilities that would be of care and method of regarding facility needs and assistance for its occupancy jurisdiction during an communication plan failed to be of sharing information and its from its emergency plan to imbers or resident eEP communication plan training dates done before	EC	comprehensive emergency pre (EP) plan. The EP manual faile include community based risk assessments, facility risk asse and associated strategies, the plans and procedures did not i missing resident in their EP pro EP plan failed to identify its respopulation. The EP manual did policy and procedures for shell residents and staff who remain facility, policy and procedures residents and staff who were nother facilities and policy procestaff, and resident and others or remained in the facility for an emergency. The Manual did no policy and procedures to preseresident information and protect confidentiality, secure and mai availability of resident medical. The EP communication plan facinclude contact information of the State and Certification Agency. EP communication plan failed to in procedures of sharing informat medical documentation of its reother healthcare providers and that would be providing continuand method of sharing informat regarding the facility needs and to provide assistance for its oc authority having jurisdiction duemergency. The EP communication duemergency.	ssments, emergen- nclude ogram. The sident of the totrack of the t	cy he ude ith re cy to n
TO THE TO THE TENER OF THE CONTRACT OF THE CON	IDENTIFICATION NUMBER:	A BUILDIN 345311 B. WING	A BUILDING 345311 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573 PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE, TAG E 001 Sto to track residents and staff oesidents and others who tity during an emergency, de policy and procedures to formation and protect tity, secure and maintain th's medical records. The EP failed to include contact resident's physician and ontact information of the Cartification Agency. EP I failed to include procedure on and medical recisities that would be of care and method of regarding facility needs and assistance for its occupancy jurisdiction during an communication plan failed to e of sharing information and s from its emergency plan to mbers or resident the EP communication plan training dates done before Tocations in an emergency the decidence of the contact regarding the facilities and health would be providing continuity who are sheltered by other relocations in an emergency information and providing docu	AB CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION) JOER 1 JOER 1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	` ′	ATE SURVEY MPLETED	
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		345311	B. WING _			05	5/03/2018	
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E 001	Continued From page	e 2	E 0	001				
E 001	b. Review of the EP facility revealed the Enot include process of facility would commu of its occupancy/ resiability to provide assijurisdiction during an c. Review of the Commanual provided by the documentation as to emergency plan wou residents, family men representatives. d. Review of the EP refacility revealed the facility revealed the facility did not include staff, residents and of facility in an event whe executed. e. Review of the EP residency of the E	manual provided by the EP communication plan did or procedure as to how the nicate and share information dents needs and facilities stance to authority having emergency situation. Immunication Plan in the EP he facility revealed no how the facility 's ld be shared with its inbers and/ or resident in manual provided by the acility did not establish a ts or staff who will be the procedure for sheltering thers who remained in the men evacuation could not be in manual provided by the	EO	01	members or resident representatives. EP communication plan failed to provious the training dates done before November 2017. As of 05/31/18 the EP policy and procedures has been updated to show that the facility will share information wother facility through a contractual agreement that will maintain confident to the professional standards and practices to uphold the continuity of cafor the Residents in the happenings of disaster or emergency should occur. As of 05/31/2018 the EP policy and procedures has been updated to show that the facility has a contractual agreement with surrounding facilities take in, admit and assist through the sharing of information of its occupancy/residents needs with surrounding facilities; this same plan we ensure that residents and family members information surrounding the facilities emergency plan in the admission.	de per vith sality are a vill pers		
	on how residents cor maintained, how residents	of policies and procedures Ifidentiality would be dent 's medical information nd how residents medical			packet, and have sheltering guideline residents, family member, and staff who must remain in the facility in an event evacuation could not be executed.	10		
	records will be availa when residents were other facilities during f. Review of the EP n	ble for continuity of care evacuated or transferred to			The facilities EP was updated to include all resident physicians, staff working in facility, names and contact numbers, a contact information of other facilities including but not limited to surrounding	the Ind		
	include names and co	ontact information of all staff			facilities that would be offering assista in case of an emergency or disaster. T update includes information of the Nor	nce This		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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E 001	Continued From page and contact information		E	001	Carolina Nursing home Licensure and			
	including but not limit would be providing so residents during an eg. Review of the EP rfacility revealed the coinclude contact inform Nursing Home Licens and contact informatic Ombudsman.	ed to its sister facilities that ervices and care to the mergency. nanual provided by the ommunication plan did not nation of the North Carolina sure and Certification Agency on of Long Term Care			Certification Agency and contact information of Long Term Care Ombudsman; and to include information of residents needs to ensure that the Command Center established by the facility can provide the appropriate assistance in the event of an emergency or disaster.			
	facility revealed the E not include process o how resident informat would be shared with care providers who w of care for residents w	nanual provided by the P communication plan did r procedure that indicated tion and medical documents other facilities and health ould be providing continuity who are sheltered by other locations in an emergency						
	revealed the EP cominclude process or prefacility would communion its occupancy/ resinability to provide assignated in the line during an emergency j. Review of the Communication as to be emergency plan would include the EP communication in the E	munication Plan in the EP ne facility revealed no now the facility ' s						
	manual provided by t	munication Plan and the EP ne facility revealed there n of the dates when the						

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E 001	During an interview of Administrator indicated facility a few weeks a facility Maintenance the EP plan as he was had had all the docu and consultant revea Director and the previous for the EP manual was a During an interview of Maintenance Director and elopement drills. The Maintenance Director and elopement drills and believe to the tracking of reconducted during an Maintenance Director access to resident and the maintenance Director indicated the information of facility from facility Human I Maintenance Director unaware that all continuous the facility electror was the facility Admindecide as to how it with the source of	mprehensive or table appleted. on 5/3/18 at 2:10 PM, the ed that he had joined the ago. He further stated the Director was more aware of as involved in the process mentation. The Administrator aled the facility Maintenance vious administrator were mergency preparedness. dicated he was unsure why not completed. on 5/3/18 at 2:10 PM, the or, revealed the fire, tornado were completed on 3/28/18. The comprehensive or the emergency plan was ance Director was unsure esidents and staff would be emergency situation. Or indicated that he had no as electronic records and it at decision on how these eat the names and contact a staff were easily assessable.	E 00			

	NT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED		
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E 001	family members or re	ould share with residents, sident representatives	E 0	01	
F 565 SS=C	related to emergency F 565 Resident/Family Gro CFR(s): 483.10(f)(5)	up and Response	F 5	65	5/31/18
	and participate in res (i) The facility must p group, if one exists, v reasonable steps, wit to make residents an upcoming meetings in (ii) Staff, visitors, or or resident group or family providing assistance requests that result from (iv) The facility must person who is approviding assistance requests that result from (iv) The facility must resident or family groups concerning is in the facility. (A) The facility must response and rational (B) This should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must impleme request of the resident should not be facility must implement should not be facility must i	other guests may attend hilly group meetings only at a invitation. provide a designated staff or yed by the resident or family and who is responsible for and responding to written from group meetings. Consider the views of a supplied and act promptly upon the ecommendations of such sues of resident care and life to be able to demonstrate their such for such response. The construed to mean that the such as recommended every that or family group. Sident has a right to have			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUC		\ , ,	(X3) DATE SURVEY COMPLETED		
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F 565	Continued From pag	e 6	F 56	5		
	families or resident residents in the facili This REQUIREMEN by:	epresentative(s) of other ty. Γ is not met as evidenced				
	Based on record rev			This Plan of Correction is pre necessary requirement for co participation in the Medicare a program. It does not in any m constitute an admission to the the alleged deficient practice.	ntinued and Medicaid anner	
	was conducted on 5/revealed an issue wi grievances. The residents in the grievances were acted and there were no expression some grievar residents in the meeter each meeting only contracted the prior month were Director (AD). The reaction of the prior month were Director (AD). The reaction of the prior month were possible to the prior month were not resolved from president Council predocumented their issues discussed the ongoin meeting. Several of the AD explained during were passed along to ensure resolution of the Resident Council Meeting and the prior the property of the prior the property of the prior th	meeting reported not all ed on promptly by the facility eplanations given as to the loces were not resolved. The ting explained that during concerns with resolution from discussed by the Activities esidents also indicated the latter resolution to concerns evious meeting. The esident reported the AD loues/ concerns, and long concerns during each the members indicated the latter meetings that the issues of the appropriate staff to the issues.		Based on record review and seresident interviews, the facility resolve grievances that were the resident council meetings consecutive months. All managers were in-serviced importance and the necessity grievance process and their regrievance process. Through the staff were in-serviced on what our grievance officer or Admir all concerns should be followed and reported in a timely manager were in-serviced as to when the events and how to forward counted the grievance officer, and whote grievance officer and grievance located. The Social Worker, a Director were in-serviced as the importance of resident counciling and how such grievances should be facilities.	d failed to reported in for 5 of 5 d as to the of the ole in the his process to report to histrator, that ed through her. Staff or report incerns to ere ce forms are and Activities of the I grievances,	
		ent Council minutes dated indicated the concerns		Grievance Counselor will repo		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 565	of Nursing (ADON). In the concerns were don't he concerns were don't he concerns were don't he concerns were don't he previous me addressed. Minutes a voiced during the me sent to Director of Nu details regarding the in the minutes. Review of the Reside January 2, 2018 indicated to nursing we minutes reported the nursing were sent to regarding the concerns documented. Review of the Reside February 6, 2018 indicated to nursing issuminutes. Review of the Reside February 6, 2018 indicated to nursing issuminutes. Review of the Reside March 5, 2018 indicated to ADON. No furnursing issues were concerned to Administrator indicated and the previous admitted the previous admitte	re sent to Assistant Director No further details regarding ocumented in the minutes. Int Council minutes dated revealed nursing a concern eting had not been also indicated new concerns eting related to nursing were ursing (DON). No further concerns were documented attended the residents reported to previous month's meeting re not addressed. The new concerns related to ADON. No further details are forwarded to ADON were and Council minutes dated icated old and new nursing to ADON. No further details uses were documented in the and Council minutes dated icated nursing concerns were ther details related to documented in the minutes.	F	299	new or outstanding grievances that remain incomplete. The grievance office will manage this process, and follow up with families and residents within 48 hours. The Activities Director will report the following day all grievances that arise from the resident council meetings. The will be passed along to the grievance officer who will then record and investigate. Any grievances that arise is the resident council meeting will be followed up in the next resident council meeting to ensure compliance and resolve. The Administrator will review the grievance log for accurate completion, twice per month for two months, and of a month thereafter. This information will be presented at our quarterly QAPI meeting for quality assurance by our Grievance Officer.	t ise ese n	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		I ·		(X3) DATE SURVEY COMPLETED	
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F 565	Continued From page	e 8	F t	565				
	He further stated a pl grievance process we the grievance folder v	as started on 3/24/18 when						
	process dated 3/24/1 and Social Worker (S grievances in a timely residents and family	f correction for the grievance 8 revealed the Administrator (W) would respond to y manner and follow up members. The plan of ated that SW would maintain						
	Review of the Grieva revealed no grievand resident council nurs							
	2018 revealed conclu	ual grievance forms for April usion of the grievance was ents were not provided with ummary.						
	indicated the concernmeeting were forward department and nurs forwarded to the Adm further stated, she producil a general resident she was were handled, how the recorded and docum resolutions. She state previous administrate issue. AD indicated did not contain the deconcern, just a gener council had concerns further indicated the	ing concerns were ninistrator and DON. AD ovided to the resident olution in the next meeting. as unsure if all the concerns ne previous administrator ented the concerns and their						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	COM		DATE SURVEY COMPLETED
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F 565	copy of the concerns concerns were not retained the administrator was During an interview of SW indicated she wo concerns on a concerns on a concerns and log prior to the name of the concern. She acknowled and she was unsure how documentation was administrator or other of the concern. She acknowled and interview of the concern of the concern. She acknowled and interview of the concern of the concern of the concern of the concern. She acknowled and interview of the concern of the co	stated she did not keep a stated she did not keep a stated and she assumed shandling their concerns. In 5/2/18 at 11:00 AM, the build record the resident's start form and forwarded it to department heads based on knowledge she had not kept sew Administrator. She stated the follow up or done by the previous or departments. In 05/03/18 a 06:50 PM, the wild department he was unable ce logs or any resolutions to the previous administration. Expectation the residents, resident council members wance without any issue or too stated the expectation toold be investigated when ons of the investigations be orted to ensure resolution. Expectation that appropriate eled and log maintained so indicated a system would ddress resident council	F5	665		
F 585 SS=C	would be done with t members. Grievances CFR(s): 483.10(j)(1)- §483.10(j) Grievance	- (4)	F 5	585		5/31/18

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F 585	that hears grievance reprisal and without reprisal. Such grievarespect to care and furnished as well as furnished, the behavesidents, and other facility stay. §483.10(j)(2) The refacility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(4) The facility must grievance policy to of all grievance policy to of all grievances regcontained in this papprovider must give a to the resident. The include: (i) Notifying resident postings in promine facility of the right to (meaning spoken) of grievances anonym of the grievance offican be filed, that is, address (mailing an number; a reasonal completing the reviet to obtain a written displayed.	cility or other agency or entity es without discrimination or fear of discrimination or ances include those with treatment which has been that which has not been vior of staff and of other concerns regarding their LTC esident has the right to and the rompt efforts by the facility to the resident may have, in	F 58	5			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		345311	B. WING			1	C 03/2018	
	ROVIDER OR SUPPLIER D HEALTHCARE & REH	AB CENTER		90	REET ADDRESS, CITY, STATE, ZIP CODE 1 RIDGE ROAD DXBORO, NC 27573	1 001	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 585	be filed, that is, the particle of the particl	with whom grievances may bertinent State agency, to Organization, State Survey ong-Term Care Ombudsman in and advocacy system; wance Official who is seeing the grievance process, ag grievances through to their any necessary investigations aining the confidentiality of all led with grievances, for of the resident for those dianonymously, issuing cisions to the resident; and the and federal agencies as specific allegations; king immediate action to intial violations of any resident and violation is being season of the resident property, by the civices on behalf of the inistrator of the provider; and	F	585				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345311	B. WING		C 05/03/2018	
	NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573	03/03/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 585	of the residents' rights or if an outside entity the State Survey Age Organization, or local confirms a violation for rights within its area of (vii) Maintaining evide result of all grievance 3 years from the issue decision. This REQUIREMENT by: Based on record revi interview the facility for grievance summary for #23, Resident # 26, For #49). Findings included: During an interview of Administrator indicate and the previous admitted facility grievance with the facility grievance of any grievance and the further stated a pli grievance process was the grievance folder of the Plan of process dated 3/24/12 and Social Worker (Signievances in a timely residents and family in residents and family in residents and family in the state of the process dated and family in residents and family in residents and family in residents and family in the state of the process dated and family in residents and family in the state of the process dated and family in the state of the process dated and family in the state of the process dated and family in the state of the process dated and family in the state of the process dated and family in the state of the process dated and family in the process dated and family	e law if the alleged violation is is confirmed by the facility having jurisdiction, such as ncy, Quality Improvement law enforcement agency or any of these residents' of responsibility; and ence demonstrating the is for a period of no less than ence of the grievance. The is not met as evidenced ew, resident and staff ailed to provide a written or 4 of 4 residents (Resident Resident #40, and Resident Resident #40, and Resident ence folder. He stated he was ous administrator kept track what the resolutions were. The is started on 3/24/18 when was not locatable. The correction for the grievance is revealed the Administrator.	F 588	This Plan of Correction is prepared as necessary requirement for continued participation in the Medicare and Medicare and It does not in any manner constitute an admission to the validity of the alleged deficient practice. F585: Based on record review and staff and resident interviews, the facility failed to provide a written grievance summary for 4 residents (Resident #23, Resident #26, Resident #40 and Resident #49). As of 05/31/2018 Resident #23, #40, # and #49 and/or the Representative all received closure and written follow-ups their grievances. Resident #23 receive written response on 05/25/18 and the items that were part of the grievances were replaced. Resident #40 received written response on 05/25/18 and close to the grievances, the CNA that was accused was suspended pending investigation and was terminated as a	caid of or 4 26, s to d a	

CENTER	3 FOR WEDICARE 8	INICUICAID SERVICES				OIVID INC	<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		SURVEY PLETED
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		345311	B. WING_			05/	/03/2018
NAME OF P	ROVIDER OR SUPPLIER			S1	FREET ADDRESS, CITY, STATE, ZIP CODE		
DOVDOD	OUEALTHOADE A DEL	AD OFNITED		90	11 RIDGE ROAD		
ROXBORG	O HEALTHCARE & REH	IAB CENTER		R	OXBORO, NC 27573		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 585	Continued From pag	ge 13	F 5	585			
	Review of the facility	complaints/ Grievances			result of our findings. Resident #26		
		e revised 02/23/17 revealed			received a written response 05/25/18 a	ınd	
	1	ds have up to 48 hours to			the items that were missing were		
	1	es/complaint, make written			replaced. Resident #49 received a writ	ten	
	_	nd return the grievance form			response 05/25/18 and her missing ite		
		Policy also indicate the			were replaced as well.		
	administrator has no			Word replaced do Well			
		ulated plan after receiving it			The grievance officer will manage the		
		ads. Policy also states once			Grievance process, and follow up with		
		n was decided the grievance			families and residents within 48 hours	via	
		a written decision to the			written response. A copy of the written	, i.u	
	resident/family mem			response will be stapled and kept with	the		
	summary of the state			grievance form for record keeping.	uic		
		mary of the pertinent findings			grievance form for record keeping.		
	_	ctive action taken by the			All staff members were in-serviced as f	·O	
	I .	written decision was issues			the importance and the necessity of the		
	by the end of next be				grievance process and their role in the	,	
	by the end of flext be	usiness day,			grievance process. Through this proce	00	
					staff were in-serviced on what to report		
	Poviow of the individ	dual grievance forms for April			our grievance officer or Administrator,		
					_		
		18 revealed conclusion of the grievances were omplete and residents were not provided with			all concerns should be followed throug	· I	
	· ·				and reported in a timely manner. Staff were in-serviced as to when to report		
	a written grievance s	Buillinary.			events and how to forward concerns to		
					the grievance officer, and where		
	1 Davious of the Min	imum Data Cat (MDC) datad				ara	
		nimum Data Set (MDS) dated			grievance officer and grievance forms	яe	
		sident # 23 was admitted to			located.		
	_	with diagnoses of chronic			The Administration will not invested		
		ry disease (COPD), Irritable			The Administrator will review the]]
	_	d Morbid Obesity. Resident #			grievance log for accurate completion,		
		ntact, and needed limited to			twice per month for two months, and or		
		e for all activities of daily living			a month thereafter. This information wi	ii .	
	(ADLs).				be presented at our quarterly QAPI]]
					meeting for quality assurance by our		
		ince form dated 4/25/18			Grievance Officer.		
		23's socks were missing.					
	_	ievance was incomplete and					
	I .	resident was provided with a					
	written grievance su	mmary.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 '	PLE CONSTRUCTION G	(X3	COMPLETED			
		345311	B. WING			C 05/03/2018		
	ROVIDER OR SUPPLIER D HEALTHCARE & REH	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573	<u> </u>			
(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 585	During an interview Resident # 23 indica grievance related to and the staff had info would be replaced if further stated she had for her grievance or summary. 2. Review of the Min 3/09/18 revealed Rethe facility on 5/15/1 kidney disease, hemore cerebrovascular accular	on 5/3/18 at 4:00 PM, ted that she had filed a her missing socks on 4/25/18 ormed her that the socks not found. Resident # 23 ad not received any resolution any written grievance imum Data Set (MDS) dated sident # 40 was admitted to 4 with diagnoses of chronic hiplegia following ident, heart failure. Resident intact, and needed limited to be for all activities of daily living nnce form dated 4/16/18 40 self-reported the led, the resident did not like lage used by nurse aide re. Grievance form also	F 5					
	suspended. Conclus incomplete and did r provided with a written	tion taken was staff member ion of the grievance was not indicate the resident was en grievance summary.						
	Resident # 40 indica grievance as the nur assisting her with dra someone had told he suspended. Resider not received any wri 3. Review of the Min	on 5/3/18 at 4:10 PM, ted that she had filed a ree aide was too rude while essing. Resident # 40 stated er the nurse aide was at # 40 further stated she did tten grievance summary. imum Data Set (MDS) dated sident # 26 was admitted to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED C		
	345311		B. WING					
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573		05/03/2018		
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 585	muscular dystrophy. cognitively intact, an assistance for all acceptable and assistance for action taken was good the grievance was in indicate the resident grievance summary. During an interview Resident # 26 indicated grievance and the faction and written grievance and the faction also stated, no written provided to her for each acceptable and also stated. Acceptable and also stated are grievances. 4. Review of the Mir 3/16/18 revealed Resident # 26 was cognitively extensive assistance (ADLs). Review of the grievance and the grievance for acceptable and acceptable acceptable and acceptable acceptable and acceptable acceptable and acceptable acceptable and acceptable acce	6 with diagnosis of ure, diverticulosis, and Resident # 26 was and needed limited to extensive tivities of daily living (ADLs). Ince form dated 4/25/18 a 26 had reported a missing rm also indicated that the ewn replaced. Conclusion of incomplete and did not a was provided with a written a was provided with a written are stated she did not receive the summary. Resident # 26 ten grievance summary was earlier grievances. Resident # aborate on her previous thin and the sident # 49 was admitted to 4 with diagnosis of heart and intended a provided to a contract, and needed limited to the for all activities of daily living the state of the provided and reported a missing rm also indicated that the	F 5	85				
	the grievance was ir	wn replaced. Conclusion of ncomplete and did not was provided with a written						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	345311 B. WING			1	C (03/2018				
	ROVIDER OR SUPPLIER D HEALTHCARE & REHA	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573			05/03/2018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ICH CORRECTIVE ACTION SHOULD E SS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 585	Continued From page	e 16	F 5	85					
	grievance and the fac	ed that she had filed a sility replaced her gown. stated she did not receive							
	SW indicated she wo concerns on a grieva the administrator or of the concern. She ack any log prior to the neindicated grievances or family member we not provided a writter the grievance to the remember. She stated follow up or documents.	n 5/2/18 at 11:00 AM, the uld record the resident's nee form and forwarded it to repartment heads based on nowledge she had not kept ew Administrator. She received from the residents are resolved verbally and had a resolution and summary for residents or their family she was unsure how the station was done by the or or other departments.							
	Administrator acknown to locate the grievance any grievances from He stated it was his efamily members and were able to file griev fear. The Administration was all grievances were ported and the action documented and reported to the stated it was his effective to the grievance of the stated it was his effective to the grievance of the stated it was his effective to the grievance of the stated it was his effective to the grievance of the grievan	n 05/03/18 a 06:50 PM, the pledged that he was unable to logs or any resolutions to the previous administration. Expectation the residents, resident council members rance without any issue or for stated the expectation build be investigated when cons of the investigations be corted to ensure resolution. Expectation that appropriate sted and log was maintained							
F 761 SS=E	Label/Store Drugs an		F 7	61			5/31/18		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345311		B. WING		C 05/03/2018		
NAME OF PROVIDER OR SUPPLIER ROXBORO HEALTHCARE & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 901 RIDGE ROAD ROXBORO, NC 27573	1 00/00/2010		
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F 761	Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the capplicable. §483.45(h) Storage of §483.45(h)(1) In accordance federal laws, the facibiologicals in locked of temperature controls, personnel to have accessor for the comprehensive of the Comp	of Drugs and Biologicals aused in the facility must be a with currently accepted s, and include the y and cautionary expiration date when If Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. It was provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the imal and a missing dose can is not met as evidenced and staff interviews, the 205 tablets and capsules in identify the medication xpiration date in four of four	F 76	This Plan of Correction is prepared as necessary requirement for continued participation in the Medicare and Med program. It does not in any manner constitute an admission to the validity the alleged deficient practice. F761: Based on observation and staff intervi the facility failed to store 205 tablets a capsules in labeled packaging to identify the stage of the	ews,		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345311	B. WING _				C 5/ 03/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	70072010	
			901 RIDGE ROAD		01 RIDGE ROAD			
ROXBORO HEALTHCARE & REHAB CENTER				R	OXBORO, 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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 761	Continued From pag	ge 18	F7	761				
F 701	tablets, 14 white table capsules were found drawer on the left-hatablets and 4 white the bottom of the third of tablets and 10 man interview on 00 medications. She ad labeled or stored comedication in the shimedication cart. 2. During an inspect medication cart on 00 loose white tablet we second drawer on the linear interview on 00 medication Technicistablet or where it hat medication during the loose white tablet we second drawer on the linear interview on 00 medication during the loose white tablet or where it hat medication during the loose white labels or where it hat medication during the loose white labels or where it hat medication were formed where the labels of the labe	elets, 7 partial tablets and 3 d in the bottom of the second and side; and 8 colored ablets were found in the trawer on the left-hand side. 5/01/18 at 9:02 a.m., Nurse the unpackaged eknowledged they were not rectly. Nurse #2 wasted the arps container affixed to the arps container affixed to the disconding the bottom of the ne left-hand side. 5/01/18 at 9:26 a.m., one as found in the bottom of the ne left-hand side. 5/01/18 at 9:26 a.m., an #1 could not identify the d come from. She wasted the ne interview.		761	the medication name, strength and expiration date in four or four mobile medication carts inspected. As of 05/31/2018 any extra medication that could has caused crowding and/or unnecessary clutter of the medication carts were removed and stored safely with best practices in the medication storage room. All loose medications the were discovered were immediately wasted. As of 05/01/2018 all Med Techs, LPNII and RNII sthat could have the potential work the medication cart were in-service as to proper procedures and protocol if the storage and deliverance of medications to residents. 05/05/18 the facility purchased extra storage bins for each medication carts and all multiple cards of medication were removed from medication carts. These medications were removed in storage bins in the medication rooms to eliminate clutter and waste or said medications. These bins were	and at at at at at at ar ar ar ar		
	tablet in the top draw white tablets, 27 col tablets, 3 capsules a second drawer on the white tablets, 7 colo	ing is a summary: 1 white wer on the left-hand side; 44 ored tablets, 10 partial and 1 gel capsule in the ne left-hand side; and 19 red tablets, 3 partial tablets e third drawer on the left-hand			securely placed and kept up to best standards and practice. All medications carts will be inspected our RN Supervisors weekly for one month, and once monthly thereafter, a should be reviewed and reevaluated a	nd		
	In an interview on 09 Medication Technicis found the loose med	5/01/18 at 9:41 a.m., an #2 stated that if she had			the quarterly QAPI meetings. This information will be monitored by our RI supervisors and will be brought to our quarterly QAPI meeting by our Directo Nursing (DON). This inspection will be logged and reviewed to ensure no loos	N r of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345311 B. WING			05/			
NAME OF BROVI	DED OD SUDDUED	040011	1 2:	CT	IDEET ADDRESS CITY STATE ZID CODE	05/	03/2018	
NAME OF PROVI	DER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
ROXBORO HE	ALTHCARE & REHA	B CENTER			1 RIDGE ROAD			
			ROXBORO, NC 27573		OXBORO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / 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 761 Co	ntinued From page	19	F 7	761				
	e charge nurse. She ntainer affixed to the	e wasted them in the sharps e medication cart.			meds, name, strength and expiration dates are all accounted for and up to dates	ate.		
me of i who	edication cart on 05/20 loose medication the second drawer the second drawer at the second drawer at the second drawer an interview on 05/0 acknowledged that beled or stored prope had seen the tables she would have the wasted the medican interview on 05/0 rector of Nursing (Dedications discoveredication carts were dicated that the pills a pharmacy blister poved against each an on the second and the second against each each each each each each each each	on of Hall 100 and 300 's /01/18 at 9:45 a.m., a total his were found in the bottom on the left-hand side: 10 d tablets, and 3 capsules. O1/18 at 9:45 a.m., Nurse is the medications were not herly. She indicated that if eets during her medication wasted them on discovery. Cations during the interview. O1/18 at 10:12 a.m., the ON) acknowledged that the end on inspection of the end on inspection of the may have broken free from backs when they were another in the drawer. The extation that medications be y labeled packaging.						