PRINTED: 04/10/2019 FORM APPROVED OMB NO. 0938-0391

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	(X3) DATE SURVEY COMPLETED	I' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IT OF DEFICIENCIES OF CORRECTION	
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-ROCKINGHAM (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) (X5) ID PROVIDER'S PLAN OF CORRECTION (CACHE COMPLETED TO THE APPROPRIATE DEFICIENCY) (X6) ID PROVIDER'S PLAN OF CORRECTION (CACHE COMPLETED TO THE APPROPRIATE DEFICIENCY)			B. WING	345378		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY	CITY, STATE, ZIP CODE DRIVE	804 SOUTH LONG DRIVE	8			
F 000 INITIAL COMMENTS F 000	CORRECTIVE ACTION SHOULD BE COMPLETION DATE	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC	PREFIX
			F 000	3	00 INITIAL COMMENTS	F 000
A complaint investigation survey was conducted on 2/5/19 through 2/8/19. Immediate Jeopardy was identified at:					on 2/5/19 through 2/8	
CFR 483.12 at tag F 600 at a scope and severity J CFR 483.12 at tag F 607 at a scope and severity					J	
Tags F 600 and F607 constituted Substandard					J Tags F 600 and F607	
Quality of Care Immediate Jeopardy began on 1/9/19 and was				began on 1/9/19 and was	Immediate Jeopardy	
removed on 2/8/19. An extended survey was conducted.				was conducted.		
An amended Statement of Deficiencies was provided to the facility on 04/08/19 because the results of the facility's Informal Dispute Resolution (IDR) deleted two examples from tag F-835 which resulted in the tag's scope and severity being lowered from a "J" level to an "E" level. The information in tag F-0000 was also changed to reflect the results of the facility's IDR. Event ID #2RY011. F 561 Self-Determination F 561 SS=E CFR(s): 483.10(f)(1)-(3)(8)	3/14/19	1	F 561	y on 04/08/19 because the Informal Dispute Resolution amples from tag F-835 which scope and severity being yel to an "E" level. The 1000 was also changed to he facility's IDR. Event ID	provided to the facility results of the facility's (IDR) deleted two exaresulted in the tag's s lowered from a "J" levinformation in tag F-0 reflect the results of the #2RY011.	
§483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section.				right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f) s section.	The resident has the promote and facilitate through support of renot limited to the right (1) through (11) of this	
\$483.10(f)(1) The resident has a right to choose ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE (X6) DATE	TITLE (X6) DATE	TITLE				ADODATORY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

03/03/2019 **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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345378	B. WING		02/08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	1 02/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 561	waking times), health care services consist assessments, and plapplicable provisions §483.10(f)(2) The reschoices about aspect facility that are signiff §483.10(f)(3) The reswith members of the community activities facility. §483.10(f)(8) The resparticipate in other arreligious, and communiterfere with the right facility. This REQUIREMENT by: Based on observation interviews and record provide showers as sof 3 sampled resident The findings included Resident #4 was addreumulative diagnose Depression. The quadated 9/26/18 indicating impairment and she behaviors. Resident #4 Review of Review of Resident #4 Review of Review of Review of Review of Review	(including sleeping and a care and providers of health tent with his or her interests, an of care and other of this part. Sident has a right to make the soft his or her life in the deant to the resident. Sident has a right to interact community and participate in both inside and outside the sident has a right to citivities, including social, unity activities that do not that of other residents in the or is not met as evidenced on, staff and resident to excheduled for 1 (Resident #4) that review, the facility failed to excheduled for 1 (Resident #4) that reviewed for preferences. It is not met as evidenced the soft picked severe cognitive was coded for physical #4 was coded for total	F 5	This plan of correction constitutes a written Allegation of Compliance wit federal and state requirements. Preparation and submission of this Allegation of Compliance does not constitute an admission or agreeme the provider of truth of the facts alle the corrections of the conclusions s forth on the statement of deficiencie plan of correction is prepared and submitted solely because of require under state and federal law. 1)Processes that lead to the deficie cited were lack of oversight in require preferred bathing method of alert a oriented residents. Corrective Actio	ent by ged or et es. The ements ency esting

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY PLETED
		345378	B. WING		0.5	C 2/08/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		./00/2019
	(0.115 E.K. 0.11 00. 1 E.E.K			804 SOUTH LONG DRIVE		
PRUITTHE	EALTH-ROCKINGHAM			ROCKINGHAM, NC 28379		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 561	Continued From page	e 2	F 5	61		
		al limitations related the left imited range of motion due		accomplished for affected resic the deficient practice by: Occup Therapy evaluation was condu 2/7/19 by the Therapy Outcome Coordinator (TOC). TOC perfo	pational cted on es	
		d D Hall Bath List indicated eceive a shower on Tuesday, ay on second shift.		shower evaluation with 3 Certif Assistants present and provide showering techniques to 3 Cer Nursing Assistants on positioni (#4). Proof of evaluation and fir	ied Nursing d tified ng resident	
	Review of the electro 12/21/18 to 2/6/19 re received a shower at	vealed Resident #4 had not		submitted to Surveyors on 2/7/ Therapy Outcomes Coordinato above process corrected the di it relates to Resident #4 as evid resident #4 has received show	19 by the or. The eficiency as denced by	
	in the dining room wa	ng in a high back wheelchair aiting for lunch. She was odors. Resident #4 was ative. Her legs were		Therapy evaluation on 2/7/19. 2)The procedure for implement acceptable Plan of correction in identification of other potential affected for the deficiency and those residents from similar sit	ting an ncluding residents to protect uations	
	Assistant (NA) #3 sta any shower refusals did not fit properly in was uncomfortable d contractures. NA #3 s she informed anyone chair and Resident #	s/19 at 1:30 PM, Nursing ted she was not aware of for Resident #4 but that she the shower chair because it ue her bilateral leg stated she could not recall if of issues with the shower 4 and stated he had not a shower on second shift.		related to the choice of shower preferences are as follows: The Director of Health Services (DHS)/Assistant Director of He Services (ADHS)/Clinical Comportion (CCC) interviewed Oriented residents on shower/by preferences starting 3/1 and with by 3/11/19. Family interviews we conducted by the DHS on thos deemed not able to be interviewed.	alth petency I Alert and path ill conclude were e residents wed for	
	room on Daisy Lane padded shower chair	n with the Director of 6/19 at 2:10 PM, the shower Hall housed a bariatric and a regular padded DN stated she was aware		shower/bath preferences starting will conclude by 3/11/19. The fix be entered into Smart Charting DHS to ensure communication Department with a completion 3/11/19. A reclining shower chartens.	indings will by the to Nursing date set for	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		
		345378	B. WING		02/08/2019
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	, 52.00.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 561	as scheduled but was stated this was probe of motion in her legs uncomfortable for her DON stated she was showers, but that Rewhat she wanted and staff had not reported positioning issues to assumed that was with showers. In an interview on 2/Rehabilitation Managwas last seen in Aprie eating issues. She streceived no physical since 2015 and she referrals for positioniuse of her wheelchar chair. The RM stated DON to determine Richair. The RM stated DON to determine Richair to receive the had not attained as shower since he had not attained the had n	s not receiving her showers is receiving bed baths. She ably due to her limited range and that it would likely be ar in the shower chair. The showare of any refusals of asident #4 could tell the staffed did not want. She stated did any shower chair her and that she just hy they weren't giving her 6/19 at 2:45 PM, the ger (RM) stated Resident #4 il 2018 but that was due to tated Resident #4 had or occupational therapy had not received any ing concerns related to the irr or the use of the shower if she would follow up with the esident #4's safety in the ive her showers. 6/19 at 5:20 PM, NA #4 tempted to give Resident #4 and been working on second he stated Resident #4 to one side when she was elchair. He stated he had not ins related to Resident #4's ar chair positioning. NA #4	F 56	obtained by Central Supply on 2/1 residents unable to maintain an upposition. 3)The procedure for implementing acceptable Plan of correction incluidentification of other potential residentification of the deficiency cited is follows: Nursing Staff (Full Time, It time, and as needed staff) receive education on F561 on 2/18/19 by and Administrator. This education also provided to staff on 2/19/19 by Clinical Competency Coordinator of FT/PT/ and as needed Nursing stanot be allowed to work until receive education. New hires to the facility receive education on F561 by the during orientation. 4)To ensure solutions are sustained facility will implement the following procedures to monitor performance admissions to facility will be interviby the Admitting Nurse for bath/sh preferences. Family input will be oby the Admitting Nurse for those redeemed not able to be interviewed Preferences will be noted on admit observation form and entered into charting by the DHS/ADHS/CCC whours to ensure communication. DHS/ADHS/CCC will audit 10 resivia Smart Charting daily for 7 days weekly for 3 weeks, then monthly	an ading idents as Part ad the DHS was by the (CCC). aff will ing this a will CCC ad the less New interest of the less of the
	Resident #4 a shower another person on se	ewo staff members to give er and that there was not econd shift available so that aly receiving bed baths.		showers/baths are documented per resident preference. Results of the will be reviewed during facility Quarkssurance Performance Improven	e audits ality

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345378	B. WING			l	C
NAME OF D	ROVIDER OR SUPPLIER	343376	B: Wiite		TREET ADDRESS, CITY, STATE, ZIP CODE	02/	08/2019
NAIVIE OF PI	ROVIDER OR SUPPLIER				04 SOUTH LONG DRIVE		
PRUITTHE	ALTH-ROCKINGHAM				ROCKINGHAM, NC 28379		
	OLUMBA DV OT	ATEMENT OF REFINITIONS		. '	<u>, </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	Resident #4 was sittir was not observed lea up in her high back w bent and there was no lower extremity contra	vation on 2/7/19 at 9:41 AM, and up in her wheelchair. She ning and was sitting straight heelchair. Her knees were to observed evidence of actures. Resident #4 was the legs on request stating	F	561	Committee monthly to ensure compliar with above plan of correction. The DHS/ADHS will present finding in Qual Assurance. 5) Compliance Date 3/14/2019		
	stated she performed 2/7/19 and there was issues with Resident stated she loved getti for Resident #4 to sit aides.	/19 at 11:45 AM, the RM an evaluation early on no safety or positioning #4 in the shower chair. She ng a shower and it was safe in the shower chair for the					
F 584 SS=E	DON stated it was he #4 receive her showe	ble/Homelike Environment	F	584			3/14/19
	but not limited to rece supports for daily livin The facility must prov	ght to a safe, clean, elike environment, including eliving treatment and eg safely. ide-					
	homelike environmen	clean, comfortable, and t, allowing the resident to all belongings to the extent					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345378	B. WING		02/08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	02/06/2019
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 584	receive care and semphysical layout of the independence and do (ii) The facility shall ethe protection of the or theft. §483.10(i)(2) Housek services necessary to and comfortable interested in good condition; §483.10(i)(3) Clean to in good condition; §483.10(i)(4) Private resident room, as spot services in all areas; §483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comfor levels. Facilities initiated and services and services. This REQUIREMENT by: Based on observation interviews and record maintain the roof in grant multiple leaks in the sobserved in 1 resider multipurpose room afacility also failed to recurtains clean and of	uring that the resident can vices safely and that the a facility maximizes resident ones not pose a safety risk. Exercise reasonable care for resident's property from loss deeping and maintenance on maintain a sanitary, orderly,	F 5	1)A. Processes that lead to the decited were flat top roof on facility is need of replacement. Facility roof approved for replacement on 2/22 and scheduled for replacement to 3/14/2019. (1) a. Hallway ceiling to B hall outside of rooms 125 and 12 have roof sealed to prevent future moisture damage and repair of cu	s in /2019 start on vents on 26 will

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG _		Ι,	c
		345378	B. WING				08/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	00.2010
				80	04 SOUTH LONG DRIVE		
PRUITTHE	EALTH-ROCKINGHAM			R	OCKINGHAM, NC 28379		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 584	Continued From page	e 6	F	584			
	The findings included				moisture damage the facility Maintenar	ıce	
		•			Director by 3/8/2019. (b) Hallway ceilin		
	1. Observations of the	e facility's environment			on A Hall outside of room 104 will have	-	
	revealed the following	g ceiling areas had water or			roof sealed and current water damage		
	moisture damage:				repaired by facility Maintenance Director	or	
		AM the hallway ceiling			by 3/8/2019. (c) Facility Maintenance	ĺ	
		de rooms 125 and 126 had			Director will seal the roof and repair		
	moisture damage.	. A B A 4 la a la a lluvia vi a a 3 llua a a a a			ceiling outside of room 114 by 3/8/2019		
		AM the hallway ceiling on m 104 revealed it was			(d) Ceiling on D hallway around the fire detector near the nurses station will be		
	bulging from apparer				repaired by the facility Maintenance		
		' AM the hallway ceiling			Director and the Maintenance Director	will	
	outside room 114, rev				seal the roof above this area by 3/8/20		
	appeared wet and cra				(e) Facility Maintenance Director close		
	· ·	AM the fire detector on the			the hole in the ceiling outside of room		
	D hallway ceiling nea	r the nurses' station had			on 2/8/2019 and support beam is no		
	moisture damage arc				longer visible. (f) Facility Maintenance		
		AM the hallway ceiling			Director will seal roof above area outside		
		d a hole where the support			of room 141 and repair cracks in ceiling		
	board was visible.	A A A A 4 la a la a llusca de a citica de a con C			outside of room 141 by 3/12/2019. (g)		
		AM the hallway ceiling on C			roof above the hallway ceiling outside o		
	evidence of moisture	1 had multiple cracks and			room 143 will have the roof sealed and ceiling repaired by facility Maintenance		
		? AM the hallway ceiling			Director by 3/12/2019. (h) The roof abo		
	outside room 143 had				the hallway ceiling outside of room 149		
		ce of moisture damage.			will have the roof sealed and ceiling	ĺ	
		AM of the hallway ceiling			repaired by facility Maintenance Direct	or	
	outside room 149 had	d evidence of moisture			by 3/12/2019. (i) Residents were move		
	damage around the v				out of room 122 on 2/11/2019 until root		
		om 122 on 2/5/19 at 2:45 PM			over the residents□ room is repaired.	ĺ	
		above the room's window			Roof repair is scheduled on begin on	ſ	
		vidence of moisture damage.			3/14/2019. (j) The roof area over the		
		sident, who resided in the			multi-purpose room will be sealed by the Maintenance Director and the ceiling	e	
		ow, stated when it rained, the ne staff moved his bed and			repaired by 3/12/2019.	ſ	
	_	r the leak to catch the water			10pailed by 5/12/2013.	ĺ	
	that leaked from the				B. Processes that lead to the deficienc	,	
		PM, the ceiling in the dining			cited included facility not having an	,	
		eas of moisture damage.			effective monitoring system to identify,		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	1, ,	DATE SURVEY COMPLETED
			A. BOILDII			С
		345378	B. WING _			02/08/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u>.</u>	
DDIIITTUI	EALTH-ROCKINGHAM			804 SOUTH LONG DRIVE		
FROITIN	LALITI-ROOKINGITAW			ROCKINGHAM, NC 28379		
(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 COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 584	rehabilitation room had damage to the ceiling 4:00 PM, the Physical therapy staff used the resident therapy and to use trash cans to cleaked from the ceiling. In an interview on 2/5 and Nurse #3 stated and dining room leaked trash cans to catch the signs when it rained. In an interview on 2/6 Assistant (NA) #7 and leaked every time it rained the ceiling had been In an interview on 2/6 NA #6 stated every till leaked all over the fact trash can to catch the was aware of the ceil stated she did not repknew it leaked. In an interview on 2/6 Environmental Direct every time it rained, a catch the rain water. Swet floor signs and she rain water in the halls	ulti-purpose room off from ad multiple areas of moisture p. In an interview on 2/5/19 at all Therapist stated the emulti-purpose room for that when it rained, they had collect the rain water that g. 6/19 at 12:10 PM, Nurse #2 the ceiling in the hallways ed often and the staff used are rain and put out wet floor 6/19 at 1:30 PM, Nursing daned. Both aides reported leaking for a few years. 6/19 at 1:40 PM, NA # 5 and me it rained, the ceiling cility. NA #5 stated they used a water. NA #6 stated she ing leak in room 122. She port it because everyone 6/19 at 1:45 PM, the cor stated the ceiling leaked and staff used trash cans to She stated the facility put out the frequently mobbed up	F	remove, and replace privacy of are too long in length and soil 2/7/2019 facility Environmental Director replaced privacy curtice rooms 104,112,117, 131, 145, 156, and 162 with clean curtate not touch the floor. Curtains follong in length were discarded. 2) The procedure for implement acceptable Plan of correction identification of other potential affected for the deficiency cite follows: A. Facility Maintenance Direct conducted visual inspection of ceilings on 2/27/2019 to ensurareas had holes in need of represidents in rooms with visible water damage. Inspection did other areas on ceiling with hold resident rooms with evidence damage. B. Facility Environmental Service Director conducted a visual attacility privacy curtains on 2/7, curtains identified as too long soiled and were discarded by Environmental Services Direct 2/7/2019. 3) The Facility implemented the systemic changes to ensure of	ed. On al Services eins in 146, 151, ins that do bund too on thing an including al residents d is as for a signs of not show es or of water vices udit of all the 1/2019. 14 or visibly facility tor on e following	
		stated he had worked at . He stated the ceiling		deficiency does not reoccur: A. Facility Administrator edu Department Heads on March educate employees which the	5, 2019 to	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			1 551.251	_		(С
		345378	B. WING			l	08/2019
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIIITTUI	EALTH-ROCKINGHAM			8	04 SOUTH LONG DRIVE		
FICOLLINE	LALITI-KOCKINGITAM			R	OCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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
	Continued From page Maintenance Director Maintenance Director placement of the roof facility was still waitin stated another quote recently, but the facili approval. He stated in ceiling leak in room 1 Maintenance Director corner room and that leaking. He stated he using an acrylic resin cover that expands a He stated the acrylic it eventually leaks ag The Maintenance Diraware of the ceiling leaketctor on C hall and ceiling outside room hall yesterday and wawith a fire sealant that the dining room and reben repaired and the bepainted to hide the The Maintenance Dir two roof quotes dated 11/13/18. He status of the roof heard anything regard corporate would let the status. In an interview on 2/8	e 8 r stated the previous r obtained a quote of the f about 2 years ago and the g on corporate approval. He was sent to corporate ity was still waiting on ne was not aware of the 22 but was aware of a 08 that was repaired. The r stated that room 122 was a would explain why it was e patched the ceiling holes that forms a thick rubber nd contracts with the roof. resin worked for a while, but ain, and he would re-patch it. ector stated he was not eak around the smoke d he noticed the hole in the 150 around the vent on C as planning to patch it today at acts as a barrier. He stated multi-purpose room had at the ceiling just needed to e staining. ector provided evidence of d 1/9/18 and another quote tated he was not aware of repairs since he had not ding the quotes and ne Administrator know of the	TAG		CROSS-REFERENCED TO THE APPROPRIA	ain g to ed port g in ye es ntil s	
	from corporate regard	she received no response ding the most recent quote			soiled or too long in length via facility		
		s roof dated 11/13/18. She f work during that time, but to			electronic Preventative Maintenance system. Facility Environmental Service	s	
	Juliou Sile was out of	work during that time, but to			System i domity Environmental Service	-	I

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI	_		,	
		345378	B. WING				08/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIUTTUE	ALTU DOCKNOUAM			80	04 SOUTH LONG DRIVE		
PRUITIHE	EALTH-ROCKINGHAM			R	OCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page her knowledge there approval. The Admini expectation that the raware of the accident leaking roof. 2. Observations during on 2/5/19 at 10:30 AM curtains on A hall in robserved dirty with viresting on the floor. To in room 131 was observed dirty with viresting on the floor. To in room 131 was observed dirty with viresting on the floor. To in rooms 156 and 162 visible shoe prints and During an interview with the privacy of and when they return the She stated she though circulation, but she appears the rooms identified with the rooms identi	had been no corporate istrator stated it was her roof not leak, and she was trisk associated with the risk and the risk and the risk associated with visible shoe gon the floor. The privacy coms 145, 146 and 151 were sible shoe prints and dust risk and the risk an		584		cy coo ed ent g he	
	need to be changed a the computer prograr know what rooms need Review of the electro	and laundered. She stated in used at the facility let her ed to be deep cleaned. inic deep cleaning schedule			weeks, then monthly thereafter, to ensi on privacy curtains in residents□ room are soiled or too long. Facility Environmental Services Director will present audit results with proof of	S	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			7 56.25			(С
		345378	B. WING _			02/	08/2019
	ROVIDER OR SUPPLIER			80	TREET ADDRESS, CITY, STATE, ZIP CODE 14 SOUTH LONG DRIVE OCKINGHAM, NC 28379		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600 SS=J	cleaned on 1/4/19, ro on 1/7/19, room 162 of 1/15/19, room 162 of 1/15/19, room 117 was room 131 was deep of 145 was deep cleaned on 145 was deep cleaned on 15 was deep cleaned on 16 was deep cleaned on 17 Administrator stated if the resident privacy of resident floor. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from 16 Exploitation 17 was proposed and exploitation as definited but its not limit corporal punishment, any physical or chemistreat the resident's most series was physical abuse, corpositivoluntary seclusion; This REQUIREMENT by: Based on record revision 17 was deep 17 was 17 was 18 was 19 wa	1/3/19, room 145 was deep om 156 was deep cleaned was deep cleaned on 1/21/19, sleaned on 1/25/19, room d on 2/4/19 and room 146 2/4/19. /19 at 5:10 PM, the t was her expectation that urtains be clean and off the Neglect m Abuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or or oral punishment, or		584	Quality Assurance and Performance Improvement Committee to ensure continued compliance. 5)Date of Completion 3/14/2019 1)Processes that lead to the deficiency cited were not providing a safe	Y	3/14/19
	protect a resident from	ews, the facility failed to in staff to resident physical ents (Resident #1) reviewed ouse.			environment and protecting resident from physical abuse when Certified Nursing Assistants (NA#1 &NA#2) were returned to work on January 17, 2019 in light of	ed	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345378	B. WING _				08/2019
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		00.20.0
				8	04 SOUTH LONG DRIVE		
PRUITTHE	EALTH-ROCKINGHAM			F	ROCKINGHAM, NC 28379		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Laboratory Phleboton Assistant #1 hit a cog (Resident #1) on her on the shoulder with a Assistant #2 restraine wheelchair. Immedia on 2/8/19 when the fa implemented an acce Immediate Jeopardy remain out of complia severity level of D (no for minimal harm that to ensure monitoring and to complete emp The findings included Resident #1 was adm 12/21/18 with diagnos aphasia, and dement Resident #1's undate indicated she had an environment related t diagnosis of psychoso The interventions incl mood and behavior a psychosocial needs. indicated Resident #1 Living (ADL) decline, and was a fall risk rel paralysis/weakness fe accident (CVA). The encouraging Residen	began on 1/9/19 when a nist observed Nursing initively impaired resident face with a closed fist and an open hand as Nursing and the resident in her ate Jeopardy was removed acility provided and eptable credible allegation of removal. The facility will ance at a lower scope and actual harm with a potential is not Immediate Jeopardy) of systems are put in place loyee in-service training. It is not the facility on ses that included stroke, ia. It is dealy a seed baseline care plan adjustment difficulty to new or recent admission and a ocial adjustment difficulty. Indeed: assess and monitor and address emotional and This baseline care plan also I had an Activities of Daily impaired physical mobility,	Fé	500	statements of Laboratory Phlebotomist and Certified Nursing Assistant (NA#1 NA#2) stating they placed hand on the body of resident#1. On 2/8/2019 NA#1 NA#2 were terminated from employme of the facility. 2)The procedure for implementing an acceptable Plan of correction including identification of other potential resident affected for the deficiency cited is as follows: Brief Interview of Mental Status (BIMS) 8 or above to find out if they have been abused or have witnessed abuse. If residents have statements positive for abuse those residents will be re-interviewed by Administrator and Director of Health Services to ensure the are free from harm and statements are thoroughly investigated and reported to appropriate agency. Six residents made negative comments and were re-interviewed on 2/6/2019 and 2/7/2016 by Facility Administrator, Director of Health Services, and Assistant Director Health Services. Two of the six resident was describing an event prior to admission the facility, two residents stated the state was trying to help them but needed mon than one person to give care to them, at the last one stated they did not want the staff to speak negatively about other statements were asked again about abuse and stated they were not abused and he not witnessed abuse. The residents call	& & ant s of n ney ne ney ne ne ney ne	
	accident (CVA). The encouraging Residen possible, keep enviro	interventions included t #1 to do as much as			members in their presence. All six residents were asked again about abus and stated they were not abused and h	se nad	

PRINTED: 04/10/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345378	B. WING		C 02/08/2019
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/00/2010
				804 SOUTH LONG DRIVE	
PRUITTHE	EALTH-ROCKINGHAM			ROCKINGHAM, NC 28379	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 600	Continued From page	e 12	F 60	0	
	On 12/26/18 the base	eline care plan was updated		and/or behaviors. Staring 2/6/2019	and
	to include the area of	behavioral symptoms with a		ending 2/7/2019 facility Administrat	ive
	handwritten note that	stated a new physician ' s		Nurses conducted and documented	l skin
	orders was received	for Resident #1 for Aricept		audits for current facility residents to	
	(cognition enhancing	medication) related to		include those with a Brief Interview	of
	dementia with behavi	iors. There were no		Mental Status (BIMS) of 7 or below	to
		o the baseline care plan		ensure residents were identified via	
	related to behavioral	symptoms.		audits for potential abuse. No areas	
				found during this audit to indicate a	buse.
	The admission Minim				
		2/28/18 for Resident #1 was		3)The Facility implemented the follo	owing
	•	area of cognition as the		systemic changes to ensure cited	
		mental status and staff		deficiency does not reoccur:	
		status were blank. She was		The Regional Senior Nurse Consul	ant
		ntion and disorganized		conducting education with facility	Lloolth
		presence. Resident #1 had s, no verbal behaviors, and		Administrator, Assistant Director of Services, Clinical Competency	пеаш
		She was noted with other		Coordinator and Director of Health	
	_	and wandering behaviors		Services related to facility policy reg	narding
		dent #1 was assessed as		prevention of abuse, indicators of a	_
		assistance of 1 for bed		reporting abuse, and investigation a	
	. •	nd locomotion on/off the unit.		on 2/6/2019 to ensure resident safe	
	-	ensive assistance of 1 with		2/6/2019 the Regional Senior Nurse	-
	•	nd personal hygiene. She		Consultant conducted education wi	
	_	er feet and was only able to		facility Administrator, Assistant Dire	
	_ <u>-</u>	sistance. Resident #1		Health Services, Clinical Competer	
	utilized a walker and	wheelchair, she was		Coordinator and Director of Health	
	occasionally incontin	ent of bladder and bowel,		Services related to prevention of ab	ouse,
	she had no skin issue	es, and she had sustained		indicators of abuse, reporting abuse	e, and
	no falls.			investigation abuse. On 2/6/2019 th	ie
				facility Clinical Competency Coordi	nator
	· ·	ted 1/5/19 indicated no		began educating Licensed and	
	_	#1 on her facial region or any		Unlicensed Nursing Clinical staff, D	
	other area.			staff, Environmental staff, Administ	
				staff, and Rehabilitation staff on pro	-
		(24-hour report) dated 1/9/19		procedures for preventing and repo	_
		ministrator indicated an		abuse to ensure resident safety. Fa	-
		to resident physical abuse.		staff who have not completed educ	
	The incident occurred	d on 1/9/19 at approximately		will be removed from the schedule	until

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345378	B. WING _			C 02/08/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	02.00.2010
				804 SOUTH LONG DRIVE		
PRUITTHE	EALTH-ROCKINGHAM			ROCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	Continued From page	e 13	F 6	00		
F 6000	5:15 AM. The allegar Laboratory Phlebotor Assistant (NA) #1 "sti shoulder while NA #2 stated that she staye #1 to ensure she was #1 or NA #2. Both Na noted to leave the rod #1 in her wheelchair details of physical or "Body audit revealed Resident #1]." This for Administrator on 1/9/ The investigation reputated 1/16/19 comple repeated the same all comments written in a "additions/changes/u allegation details". The provided conflicting in initial allegation as it injury/harm and no sufor Resident #1 and it bruises to Resident #1 and it bruis	tion details stated that mist (LP) witnessed Nursing rike" Resident #1 on her left theld her by the shirt. LP d in the room with Resident to not touched anymore by NA As (NA #1 and NA #2) were om and LP pushed Resident to the nurse's station. The mental injury/harm read, bruise to the face area [of orm was completed by the 19. ort (5-working day report) eted by the Administrator legation details and had no the section for pdates to description of his investigation report information from the previous stated no physical substantial risk of injury/harm thade no mention of the their's face area identified by audit (as indicated on the their's face area identified by audit (as indicated on the their's emotional cors indicated, "No emotional has severe cognitive deficit The investigative actions indicated the following: substantiated. It is prevention and training mbative/agitated resident.	F 6	education is complete. On 2/6 facility Clinical Competency Cobegan educating Licensed ar Unlicensed Nursing Clinical staff, Environmental staff, Ad staff, and Rehabilitation staff Concepts and Guidelines for for individuals with Dementia resident safety. Facility staff completed education will be rethe schedule until education in New hires will be educated by RN Clinical Competency Nursorientation on facility policy a related abuse prevention and well as Basic Concepts and Caregiving for individuals with ensure resident safety. 4)To ensure solutions are susfacility will implement the folloprocedures to monitor perform Starting 2/6/2018 residents will Interview of Mental Status (Babove were interviewed by fa Administration interviewed to they have been abused or has abuse. Continued monitoring occurrence of resident to staffinclude random interviews of with 8 or above Brief Interview Status (BIMS) and 10 random for residents Brief Interview Status (BIMS) below 8 daily for the weekly for three weeks, monthly. Starting 2/7/2019 far of Healthcare Services, Assis	coordinator and staff, Dietary ministrative on Basic caregiving to ensure who have not removed from a complete. If the facility seeduring and procedure a reporting as Guidelines for a Dementia to stained the owing mance: with Brief IMS) of 8 or acility Nursing find out if the with the swing man control of abuse will a skin audits of Mental a skin audits of Mental or 14 days, then cility Director stant Director stant Director stant Director control of the staff was stant of the stant Director stant Director stant Director stant Director care with the stant of the stant Director stant D	
	response as resident at time of incident". section of this report - Allegation was unsu-The accused individe - Other employment awere to receive written safety as well as aburon the care of the corsummary of facility	has severe cognitive deficit The investigative actions indicated the following: ubstantiated. luals were not terminated. actions: Accused individuals in warning related to resident se prevention and training mbative/agitated resident.		occurrence of resident to staff include random interviews of with 8 or above Brief Interview Status (BIMS) and 10 random for residents Brief Interview of Status (BIMS) below 8 daily for the weekly for three weeks, monthly. Starting 2/7/2019 factors	f abuse will 10 residents w of Mental skin audits of Mental for 14 days, then cility Director stant Director stered Nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 55.25			c l	
		345378	B. WING			/08/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
				804 SOUTH LONG DRIVE			
PRUITIHE	EALTH-ROCKINGHAM			ROCKINGHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	incident), residents #1 an NA #2, and o Resident #1. The m was noted to be revenued in the facility is mallegations of abuse accused [NA #1 and agitated resident [Runtrained person not [LP]." The Administrator or Resident #1 's reconstruction of staff typed summary stars showed purple bruing [Resident #1 's] fact 1/17/2019 showed s] facebruise on a skin audit perform A review of the med documentation of sl Resident #1 on 1/9/2019 showed with a modern and summary of Resider that showed An interview was considered that showed review that indicate in the review of the med accumentation of sl Resident #1 on 1/9/2019 showed An interview was considered that showed an interview was considered that showed review that indicate indicate in the resident was not a summary of Residered that indicate in the review that indicate in the review that indicate in the review of the med accumentation of sl Residered that showed an interview was considered that showed review that indicate in the review of the review that indicate in the review of the review that indicate in the review that indicate in the review that indicate in the review of the review that indicate in the review that indicate in the review of the review that indicate in the review of the review that indicate in the review of the review of the review that indicate in the review of the re	uty during the time of the on the hallway assigned to NA ther staff who provided care to hedical record of Resident #1 viewed as well as skin audits. Views and results of the skin hot able to substantiate the e. The facility did find the d NA #2] at fault for leaving an hesident #1] in the care of an obt in the employ of the facility completed a typed summary of ord review related to the fit to resident abuse. This hed, "Skin audit on 1/9/2019 se to lower right side of theskin audit conducted on no bruising [on Resident #1' resident's face was noted on hed on 12/13/2019". Idical record showed no kin audit conducted for 19. Additionally, there were d in Resident #1's medical any mention of facial bruising.	F 60		ordinator, and nt Nurses will audits of staff to caregiving aily for 14 days, d monthly to to resident agional Area al Senior Nurse -hoc Quality be eeting related ant abuse. The insultant will audits weekly or ensure the implying with esults of the insultant will be istrator monthly a Performance aintain plan of		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	OATE SURVEY COMPLETED
		345378	B. WING _			C 02/08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	'	02/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	that showed no bruis region was reviewed Administrator revealed the information about came from. She also 12/13/2019, was a tyknown what the correadministrator review record and she was adocumentation of the #1. The Administrator #1's facial bruising an injury from the 1/5 allegation. Her explained reported to her by ph #1 with a closed fist of LP reporting that NA face in addition to the Administrator was un Resident #1's facial The following interviet to Resident #1's facial The following interviet was converse #1 on 2/6/19 as she and Treatment Naudit forms weekly.	ing to Resident #1 's facial with the Administrator. The ed she had not known where it Resident #1 's facial bruise or revealed that the date, po, but that she had not ect date was. The ed Resident #1 's medical unable to find any additional efacial bruising for Resident for was asked how Resident for was that the LP had one that NA #1 hit resident for the shoulder. She denied #1 hit Resident #1 in the eshoulder. The lable to explain how bruising was sustained. Even were conducted related that but was were conducted related that was were conducted on the that NA She stated that but shoulder was unaware for Resident #1 at any time to efacility. Enducted with Treatment that 9:30 AM. She stated that but shoulder was unaware for Resident #1 at any time that 9:30 AM. She stated that but she was unaware for Resident #1 at any time	F 6			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		STRUCTION		PLETED
		345378	B. WING _				C (08/2019
	ROVIDER OR SUPPLIER			804 S0	T ADDRESS, CITY, STATE, ZIP CODE DUTH LONG DRIVE KINGHAM, NC 28379	1 02	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 16	F	500			
	2/6/19 at 10:00 AM. recalled Resident #1 face during her stay at - A family interview w Resident #1 's Respect 8:50 AM. He state bruise on her face se	anducted with Nurse #1 on She stated that she had not ever having a bruise to her at the facility. as conducted by phone with bonsible Party (RP) on 2/6/19 d that Resident #1 had a veral weeks ago, but he was d sustained the bruise.					
	the Administrator on PM was transcribed in Administrator. The restriction that she heard a loud grunting and hollering She reported she open is room without known her, "you need to turn want you to see what Resident #1 was sea was behind the wheele pulling the resident be keep her seated in the her "fist drawn back, [left] shoulder [Resimeracting to being his seen NA #2 strike Resident #1 is blood NA #2 were still in the stayed with Resident room.	eport from the LP indicated in noise that sounded like grom a resident's room. Ened the door to the resident king and NA #1 stated to a around because I don't in I do to her". LP stated that ted in her wheelchair, NA #2 elchair and appeared to be any the back of her shirt to be wheelchair. NA #1 had struck [Resident #1] on her ident #1] had hands up to the indicated she had not be sident #1, but that NA #2 in I LP indicated she drew as ordered while NA #1 and the room. She indicated she indicated, signed by the LP					
		ndated, signed by the LP 19 at approximately 5:45 AM					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	l' '	(X3) DATE SURVEY COMPLETED	
		345378	B. WING			C 2/08/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		210012019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	complete a blood dr. that when she started she heard several voor "grunting and hollerid opened the door and behind Resident #1 wheelchair and anoth Resident #1. LP indidoor wider and NA # want to go somewhed see what I am about she told NA #1 that the Resident #1 's blood was "very agitated" name several times explain why she was proceeded to chang and then left the rood completed the blood Resident #1 in her was desk and Nurse #1 care of Resident #1 had not reported the instead continued was completed her dutie facility, and then call reported the inciden. A phone interview was 2/5/19 at 2:24 PM. and 6:00 AM on 1/9, facility hallway enroth draw blood as order reported that as she which was partially counds of "distress" moaning, hollering, and some properside the sounds of "distress" moaning, hollering, and the start and some properside the sounds of "distress" moaning, hollering, and the start and some properside the sounds of "distress" moaning, hollering, and the start and some properside the sounds of "distress" moaning, hollering, and the start and the sta	vard Resident #1 's room to aw as ordered. She reported ad getting close to the room bices along with Resident #1 ng". LP wrote that she disaw an NA (NA #2) standing holding her down in the ther NA (NA #1) "hitting" is cated that she opened the #1 said to her, "you might here else so that you don't at to do to her". LP reported she was there to draw did. LP wrote that Resident #1 hat that point, so she called here to get her attention and is there. NA #1 and NA #2 he Resident #1 's bed linens m. LP reported that she here in the was going to take from there. LP indicated she incident to Nurse #1, but ith blood draws. She is around 6:45 AM, left the led her direct supervisor and	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		Ι ,	С	
		345378	B. WING				08/2019	
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, v=,</u>	00/2010	
				8	804 SOUTH LONG DRIVE			
PRUITTHE	EALTH-ROCKINGHAM			F	ROCKINGHAM, NC 28379			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 600	Continued From pag	ne 18	F	600				
	· -	she heard coming from the						
		ied. LP indicated that when						
		n Resident #1 was seated in						
		#1 was standing in front of the						
		was standing behind the						
		ted that NA #2 was holding						
		shirt at the shoulders (from						
	-	seated in the wheelchair.						
		Resident #1 was moving						
		chair and it appeared NA #2						
	was "restraining" her by holding her back in the							
	chair to keep her from moving around. LP stated							
	that NA #1 said to he	er something like, "you might						
	want to go and do so	omeone else because I don ' t						
	want you to see wha	t I ' m going to do to her".						
	She reported that sh	e witnessed NA #1 hit						
		cheek area with a closed fist						
		shoulder with an open hand.						
		esident #1 was swinging her						
		action after she was hit by NA						
		appeared NA #1 was						
		lent #1 as she was "gritting						
		dent. LP reported that she						
		A #2 hit Resident #1, she had						
	.	olding the resident back in the						
		ed that after NA #1 had						
		she told NA #1 and NA #2 she						
	_	room until she completed the						
		ported that she was unable to						
		ny marks or bruising to						
		at that time. LP revealed she incident to the nurse on duty						
		_						
	_	t. She stated that she NA #2 were friends with						
		adn ' t felt comfortable						
		t to her because she feared						
		taff. LP reported that she						
		or around 7:00 AM when she						
		ort the incident and he						

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
	345378	B. WING			C)2/08/2019	
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-ROCKINGHAM			STREET ADDRESS, CITY, STATE, ZIP COD 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		210012013	
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
to him the allegation of some stated that LP was vecrying during the phone. A verbal statement by Note Administrator and include 1/17/19 summary of the allegation of abuse involution reviewed. This statement asked her to help NA #2 out of bed on 1/9/19. Note Resident #1 was not material and NA #2 were in the result. LP entered the room and left side of Resident #1 was standing behind the tried to get up and NA #2 [Resident #1 ' s] chest and forehead. Pushed her both in the wheelchair". NA #1 touched Resident #1 whom nor did she tell the She indicated that she and after asking LP to bring for the side of the she indicated the she and	onducted with LP 's 4:35 PM. He confirmed y phone on 1/9/19 g the facility and reported staff to resident abuse. Bery upset and audibly call. A #1 typed by the ed in the facility 's investigation for the ving Resident #1 was not indicated that Nurse #1 with getting Resident #1 with getting Resident #1 with getting Resident #1 with getting Resident #1 with getting any noises while she som. She reported that dishe was standing to the s wheelchair. Resident #1 2 "put one hand on and another on her ack to an upright position will be the LP was in the LP to leave the room. Ind NA #2 changed and then left the room Resident #1 to the nurse done with her blood draw. A #2 typed by the ed in the facility 's investigation for the	F 60				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	ATE SURVEY OMPLETED
		345378	B. WING			C 02/08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	I	02/06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	went to ask Nurse #1 resident up. Nurse # with Resident #1. No NA #2 got Resident #2 wheelchair. She indimaking noises the wither up. NA #2 stated standing in front of R2 the room. NA #2 rept to stand up from her wanted the resident in the center of [Resiother hand on [her] for back to an upright poindicated that LP prosident #1 to the number of the prosident #1 to the number of the morning of 1/9/19 is room and saw that bed. She indicated sassistance with gettin because she had bel hitting at staff. NA #2 to help her. The NAst that Resident #1 was yelling out, grunting, behaviors of swinging morning and they ha resident out of the becare, getting her drest the wheelchair. The	ving around in bed and she for help with getting the 1 sent NA #1 to help NA #2 A #2 reported that she and 1 dressed and into her cated that Resident #1 was hole time they were getting I that she and NA #1 were esident #1 when LP entered orted that Resident #1 tried wheelchair and she had not to fall so she "put one hand dent #1 's] chest and the brehead and pushed her esition in the chair". NA #2 ceeded to draw Resident #1 NA #1 changed the bed om after asking LP to bring urse 's station when she was	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345378	B. WING _			2/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE,	ZIP CODE		
				804 SOUTH LONG DRIVE			
PRUITTHE	EALTH-ROCKINGHAM			ROCKINGHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 600	Continued From pa	ge 21	F	600			
	wheelchair and that LP like, "oh honey yhere". NA #1 stated recalled laughing whecause she and Ngetting Resident #1 that NA #2 was star and NA #1 was star wheelchair. Reside forward in the wheelchair. Reside forward in the wheelchair and the tip over and land he stated that she asked the wheelchair, but revealed she put or forehead and one hregion and pushed upright position in the moved to the back or emained at the side then preparing for Ference the resident started #2 reached from be one hand on her for shoulder/chest region upright position. No preparing for the block of the back of the preparing for the preparing for the block of the back of the preparing for the block of the preparing for the prep	#1 was already seated in the NA #1 said something to the rou might not want to come in that this was a joke and she hen she said this to the LP A #2 had such a difficult time up that day. They indicated ading in front of Resident #1 ading on the side of the ent #1 was reportedly leaning elchair. NA #1 and NA #2 ent #1 rarely attempted to had frequently leaned forward by were afraid she was going to ead first on the floor. NA #2 end Resident #1 to sit back in she had not complied. She had not complied. She had to Resident #1's and to her shoulder/chest the resident back into an enewheelchair. Then NA #2 end the wheelchair and NA #1 er of the wheelchair and NA #1 er of the wheelchair and placed to lean forward again so NA hind the resident and placed the end and one on her on to pull her back into an A #1 stated that when LP was and draw that Resident #1 ands around, so she placed					
	one hand in front of behind her shoulder to swing around the be drawn from. NA on the face and/or of witnessing NA #1 h denied Resident #1	her shoulder and one hand to keep her from being able arm that blood was going to #1 denied hitting Resident #1 on the shoulder. NA #2 denied it Resident #1. They both having any bruising or on 1/9/19 or on any other					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345378	B. WING _			C 02/08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		02/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 600	statement to the Adm Resident #1 was not care on the morning unable to explain wh touching Resident #1 room and denied telli #1 and NA #2 were userported this allegation if it had not happened been no previous continued. NA #1 states had been re-eductombative behaviors would not have chan by herself or NA #2 are-education. NA #2 she had been re-eductombative behaviors not thought any of the NA #1 were inapproposed with the re-education thing she might have been to stand back for Resident #1 swinging time to calm down. An interview was con Administrator was as substantiated the allegables related to the Resident #1. She state any negative physical findings on behalf of from her previous into the stand had to the previous into the previous i	able to explain why her verbal hinistrator indicated that making any noises during of 1/9/19 and also was y she previously denied while the LP was in the ing LP to leave the room. NA inable to explain why LP on of staff to resident abuse d. They indicated there had inflicts with LP. with NA #1 and NA #2 ated that after the incident cated on abuse and and the state of the state o	F			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345378	B. WING _				08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CI 804 SOUTH LONG DI ROCKINGHAM, NO		1 02	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	reported to her that N closed fist on the sho stated that another fathe LP had not immediately allegation to the nurse incident, she doubted She explained that shobserved NA #1 hit R ve have immediately waiting until she left the stated that she had the of placing her hands and chest/shoulder reway to manage the lecombative resident. That because there was either staff, NA #1 or this was physical abut A re-interview was coon 2/6/19 at 2:45 PM. Administrator denied #1 hit Resident #1 wit LP stated that she tolephone call on 1/9/19 hitting Resident #1 or closed fist and once copen hand. LP's typ NA #2 was holding Rewheelchair while NA was reviewed with LF used the word "hitting She stated that in him more specific when significant was considered." An interview was considered was considered with the stated that in him more specific when significant was considered.	njury because the LP had A #1 hit Resident #1 with a ulder. The Administrator ctor for her was that since diately reported the e on duty at the time of the that it actually happened. The thought that if the LP had resident #1 that she would 'reported it rather than the facility. The Administrator rought that NA #2 's actions on Resident #1 's forehead region twice was not the best raning behaviors of a The Administrator explained as no negative intent from NA #2, she had not thought se. Inducted by phone with LP She was informed that the LP reporting to her that NA the a closed fist on the cheek. If the Administrator during a that NA #1 was observed fince on the cheek with a conthe left shoulder with an one distance of the explained that she provided that she provided that she provided that she provided that she should have been the typed her statement.	F	600			
	Nursing (DON) on 2/8 asked if there were an	3/19 at 8:48 AM. She was ny previous concerns					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345378	B. WING			C 02/08/2019		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		02/00/2019		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 600	#2 had no previous revealed that NA # year ago related to reported that NA #1 resident 's covers I in bed and said sor this hall". The DON most recent quarter showed that she had customer service dithrough 9/30/18). An observation was lying in bed in her receited that was all the resident #1 was all the receited that the received that the received that the receited that the receited that the receited that the received that the receited that the receited that the received tha	or NA #2. She stated that NA concerns reported. She had disciplinary action over a customer service. The DON pulled an alert and oriented back as the resident was lying mething like, "I hate working N also revealed that NA #1 's ray performance evaluation and grievances on file related to uring the review period (7/1/18) as conducted of Resident #1 oom on 2/5/19 at 10:45 AM. ert with confusion and she atterviewed. There were no	F 60	00				
	On 2/7/19 at 5:17 F following credible a	and DON were notified of ly on 2/6/19 at 5:43 PM. PM the facility provided the llegation of Immediate						
	allegation of substate and Medicaid requivexecution of this conduction of this conduction of the condu	ion constitutes a written antial compliance with Federal rements. Preparation and/or wrection does not constitute ment by the provider of the ed or conclusions set forth for incies. The plan of correction is ecuted solely because it is vision of the state and federal strates our good faith and						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345378	B. WING _			C 02/08/2019	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	•	02/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	- Process that lead to On 1/9/2019 Laborar facility Administrator at 1:15p by phone the 1/9/2019 she witness. Nursing Assistants of when she entered the blood. When further call by facility Administrator of Health Sephlebotomist stated. Nursing Assistant (Noresident #1 on her less Certified Nursing assistant (Noresident #1 on her less Certified Nursing assistant Director of Phlebotomist why she charge nurse at the stated she felt the Cliphandle information of the health Services by handle information of the to do the right the stated she waited to of Health Services by handle information of the to do the right the stated she waited to of Health Services by handle information of the latter of the placed under Administration of the next day (1/10/20) placed under Administration of the lebotomist stated	improve the quality of care esidents.	F6				
	another Certified Nu hitting her. Certified	g resident #1 down while rsing Assistant NA #1 was Nursing Assistants (NA #1 & scription provided by the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	' '	E SURVEY PLETED
							С
		345378	B. WING _			02	/08/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				804 S	OUTH LONG DRIVE		
PRUITTHE	EALTH-ROCKINGHAM			ROC	KINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From pa	ge 26	F	500			
	while statements we Certified Nursing As provided by the Lab suspended pending another shift on 1/9 Assistant (NA #2) wapproximately 2:45 Certified Nursing As suspended approximately 2:45 Certified Nurse (Nurse. Statements Assistants (NA #1 a facility Administrato Services, and RN Crevealed NA #2 planchest/shoulder area resident #1 from fall while Certified Nurse Resident #1 is a resident #1 is	comist were not in the facility ere taken via phone. Both assistants fitting the description poratory Phlebotomist were investigation prior to working /2019. Certified Nursing /ho was suspended po by facility Administrator and assistant (NA #1) was mately 10:30p by facility RN) Clinical Competency provided by Certified Nursing and NA #2) on 1/9/2019 to ar, Assistant Director of Health Clinical Competency Nurse and hand on forehead and an of resident #1 to prevent ling forward out of wheelchair ing Assistant NA #1 watched. Sident with a diagnosis of 1019 at 1:15p with the phone boratory Phlebotomist and ar and Assistant Director of an investigation of the vestigation was closed on y facility Administrator with an ding and Certified Nursing					
	education from facil	ity RN Clinical Competency cility abuse policy and Care of					
	protect resident from Certified Nursing As returned to work on statements of Labo	vide a safe environment and m physical abuse when ssistants (NA #1 &NA #2) were January 17, 2019 in light of ratory Phlebotomist and ssistant (NA #1 & NA #2)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345378	B. WING_			C 02/08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	<u> </u>	02/00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	#1. Resolution includes Nursing Assistants (I and Certified Nursing approximately 10:30 facility Administrator ensure safety of curr Resolution also inclu Nurse Consultant co facility Administrator Services, Clinical Co Director of Health So of abuse, indicators and investigation ab To help resolve this skin audits conducte Treatment Nurse and starting 2/6/2019 to while in facility. Residents with a Brid (BIMS) score of 8 or facility Activities Dire Services, MDS Coor Practical Charge Nu staff to resident abus investigated appropri- Process for implement for specific deficiency The facility Administr if this issue could or On 2/6/2019 the Res	re-suspension of Certified NA #1) approximately 5:30p g Assistant (NA #2) p on February 7, 2019 by and Director of Nursing to tent facility residents. Ided the Regional Senior inducting education with gasistant Director of Health impetency Coordinator and tervices related to prevention of abuse, reporting abuse, use to ensure resident safety. Current facility Registered Nurse diffacility Charge nurses ensure residents remain safe above were interviewed by ctor, Director of Health dinator, and Licensed rise to ensure any possible se was reported and liately. Interview of Mental Status above were interviewed by ctor, Director of Health dinator, and Licensed rise to ensure any possible se was reported and liately. Interview of Mental Status above were interviewed by ctor, Director of Health dinator, and Licensed rise to ensure any possible se was reported and liately. Interview of Mental Status above were interviewed by ctor, Director of Health dinator, and Licensed rise to ensure any possible se was reported and liately.	F 6			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345378	B. WING		C 02/08/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLETION	
F 600	Services, Clinical Codirector of Health Services of abuse, indicators and investigation about the coordinator began of Unlicensed Nursing Environmental staff, Rehabilitation staff of preventing and report resident safety. Faci completed education schedule until education	ant Director of Health Impetency Coordinator and Prices related to prevention of abuse, reporting abuse, Juse. Ility Clinical Competency ducating Licensed and Clinical staff, Dietary staff, Administrative staff, and In proper procedures for ring abuse to ensure Ility staff who have not In will be removed from the tion is complete. Ility Clinical Competency ducating Licensed and Clinical staff, Dietary staff, Administrative staff, and In Basic Concepts and Iving for individuals with Iresident safety. Facility staff Event ed education will be Inhedule until education is 19 accused Certified Nursing In #2) were re-interviewed In gurther investigation to	F 60			
	have witnessed abus	ney have been abused or se. If residents have for abuse those residents will Administrator and Director of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345378	B. WING _			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	1	02/08/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	harm and statements and reported to approsent to approxe to ap	are they are free from are thoroughly investigated opriate agency. ending 2/7/2019 facility is conducted and lits for current facility hose with a Brief Interview of of 7 or below to ensure fied via these audits for abnormal bruising will be investigation to be or of Nursing and Assistant ith report to appropriate rent facility residents are resident as well as Basic ines for caregiving for entia to ensure that the effective, and that specific ins corrected and/or in regulatory requirements idents with Brief Interview of	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345378	B. WING			C 02/08/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	'	02/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	then monthly. Starting 2/7/2019 far Services, Assistant Services, Registered Coordinator, Registered Registered Nurse and Registered N	cility Director of Healthcare Director of Healthcare d Nurse Clinical Competency ered Nurse MDS Coordinator, se Treatment Nurses will visual audits of staff to during caregiving procedures or 14 days, weekly for three to ensure no instance of staff gional Area Vice President r Nurse Consultant attended assurance and Performance ittee meeting related to esident abuse. r Nurse Consultant will review audits weekly for 4 weeks then the facility Administration is egulatory guideline. consible for implementing the	F 60				
	conducted for all cui	ated skin audits were rent residents on 2/6/19 and oriented residents were					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	SURVEY LETED
			7 50.25)
		345378	B. WING _		02/0	08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600 F 607 SS=J	possible staff to reside investigated properly. were documented on inservice sign in sheet verified education was proper procedures for abuse, and basic concaregiving for individual who had not received were to be removed feducation was complewere re-interviewed or re-suspended on 2/7/	ent abuse was reported and . These resident interviews an audit form. A review of ets as well as staff interviews s provided on 2/6/19 on r preventing abuse, reporting acepts and guidelines for uals with dementia. Staff I the inservice on 2/6/19 from the schedule until eted. NA #1 and NA #2 on 2/6/19 and were 1/19.	F 6			3/14/19
	§483.12(b)(1) Prohibit neglect, and exploitat misappropriation of results in sappropriation of results	it and prevent abuse, tion of residents and esident property, sh policies and procedures ch allegations, and e training as required at is not met as evidenced iew, facility staff interviews, any staff interviews, the ment their policy and		1)Processes that lead to the deficiency cited were facility abuse prevention pol and procedure were not followed when Certified Nursing Assistants (NA#1 &NA#2) were returned to work on Janu 17, 2019 in light of witness statements Laboratory Phlebotomist Certified Nurs	uary of	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			, 50.25				С
		345378	B. WING_	B. WING			2/08/2019
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		2/00/2010
					04 SOUTH LONG DRIVE		
PRUITTHE	ALTH-ROCKINGHAM				OCKINGHAM, NC 28379		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFII TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
F 607	Continued From pag	e 32	F	607			
	trained on abuse rep	orting requirements for 1 of 2			Assistant (NA#1 & NA#2) statements		
	-	#1) reviewed for staff to			given on 1/9/2019 to facility		
	resident abuse.				administration. Laboratory Phlebotomi	st	
					failed to follow contractual standards of	ıf	
		began on 1/9/19 when a			conduct related to resident safety and		
		mist failed to immediately			facility policy and procedure related to		
		n of Nursing Assistant #1			reporting of abuse to facility when they		
		mpaired resident (Resident			not immediately report the incident after		
	· ·	a closed fist and on the			witnessing it on 1/9/2019. On 2/8/2019	,	
	,	en hand while Nursing			NA#1 & NA#2 were terminated from	^	
		ed the resident in her			employment of the facility. On 1/9/201	9	
	on 2/8/19 when the f	ate Jeopardy was removed			Laboratory Phlebotomist was verbally trained via phone by Assistant Director	r of	
		eptable credible allegation of			Nursing regarding timely and appropris		
		removal. The facility will			abuse reporting. Management of the	110	
		ance at a lower scope and			Laboratory Phlebotomist were trained	on	
		o actual harm with a potential			2/7/2019 by facility Registered Nurse		
		t is not Immediate Jeopardy)			Clinical Competency Nurse regarding		
		of systems are put in place			facility policy related to abuse preventi	on,	
	and to complete emp	oloyee in-service training.			identification, and reporting. On 2/7/20	19	
					Management of the Laboratory		
	The findings included	d:			Phlebotomist told the Registered Nurs	е	
					Clinical Competency Nurse they would	ţ	
		y ' s Reporting Patient			ensure staff assigned to the facility		
		loitation, Mistreatment, and			receive training prior to working with		
		Property policy, last revised			facility residents.		
		this policy applied to all facility					
		ffiliated entities that provided			2)The procedure for implementing an		
	_	residents. This policy			acceptable Plan of correction including	•	
		legation of resident abuse			identification of other potential residen	เร	
	was to be immediate	nvestigation of Patient			affected for the deficiency cited is as follows:		
		loitation, Mistreatment, and			Current facility residents had skin audi	te	
		Property policy, last revised			conducted by facility Registered Nurse		
		he Administrator was			Treatment Nurse and facility Charge	•	
		ring that an accurate and			nurses starting 2/6/2019 to ensure		
		vas completed. This policy			residents remain safe while in facility.		
		or investigations when the			These audits ensure residents with Bri	ef	
		vas a Nursing Assistant that			Interview of Mental Status (BIMS) of 7		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345378	B. WING			02/	08/2019
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PRUITIHE	EALTH-ROCKINGHAM			R	OCKINGHAM, NC 28379		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 607	Continued From page	e 33	F	607			
		ation was to include any	' '	501	below were checked for signs of possib	No.	
	, ,	ken by the facility. The No			physical abuse. No areas were found	n e	
	-	Faith Reporting of Patient			during this audit to indicate abuse.		
		oitation, Mistreatment, and			Residents with a Brief Interview of Men	tal	
		Property policy, last revised,			Status (BIMS) score of 8 or above were		
		nat if there was any suspicion			interviewed by facility Activities Director		
		ed staff was not to have			Director of Health Services, MDS		
	direct contact with the	e resident at issue until the			Coordinator, and License Practical		
	_	npleted and the issue was			Charge Nurse starting 2/6/2019 and		
	resolved.				ending 2/7/2019 to ensure any possible		
	.				staff to resident abuse was reported an		
		nitted to the facility on			investigated appropriately. Six resident	S	
	_	ses that included stroke,			made negative comments and were re-interviewed on 2/6/2019 and 2/7/201	0	
	aphasia, and dement	ild.			by Facility Administrator, Director of	9	
	The admission Minim	num Data Set (MDS)			Health Services, and Assistant Director	of	
		2/28/18 for Resident #1 was			Health Services. Two of the six residen		
		area of cognition as the			were hallucinating, one resident was		
	-	mental status and staff			describing an event prior to admission	to	
	interview for mental s	status were blank. She was			the facility, two residents stated the sta	ff	
		ntion and disorganized			was trying to help them but needed mo		
		presence. Resident #1 had			than one person to give care to them, a		
		s, no verbal behaviors, and			the last one stated they did not want th		
	•	She was noted with other			staff to speak negatively about other st	aff	
	- ·	s and wandering behaviors			members in their presence. All six		
	•	dent #1 was assessed as assistance of 1 for bed			residents were asked again about abused and b		
	. •	nd locomotion on/off the unit.			and stated they were not abused and hot witnessed abuse. The residents car		
	_	ensive assistance of 1 with			plans were updated with their request	C	
		nd personal hygiene. She			and/or behaviors.		
	•	er feet and was only able to					
	,	sistance. Resident #1			3)The Facility implemented the following	g	
	utilized a walker and				systemic changes to ensure cited		
	occasionally incontine	ent of bladder and bowel,			deficiency does not reoccur:		
	she had no skin issue	es, and she had sustained			The Regional Senior Nurse Consultant		
	no falls.				conducting education with facility		
					Administrator, Assistant Director of Hea	alth	
		,_,			Services, Clinical Competency		
	The initial allegation ((24-hour report) dated 1/9/19			Coordinator and Director of Health		

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compliallegal incide AM ar on 1/9 stated witness Reside her by the root touched (NA # and the tothe mental bruise form with 1/9/19 The prequire. The indicated repeated comme "additial allegal provided initial allegal pro	tion of staff to rept occurred on the facility be /19 at 1:15 PM that Laborator sed Nursing Asient #1 on her let the shirt. The om with Reside danymore by I and NA #2) we LP pushed Rourse's station I injury/harm reto the face are /as completed. NA #1 and Note that pending the replice were notified. Vestigation repolice were notified. Vestigation repolice were notified. Vestigation repolice the same all ents written in sons/changes/ution details". The conflicting in allegation as it tharm and no subsident #1 and it is to Resident #1 and i	ministrator indicated an esident physical abuse. The 1/9/19 at approximately 5:15 ecame aware of the incident. The allegation details y Phlebotomist (LP) esistant (NA) #1 "strike" eft shoulder while NA #2 held LP stated that she stayed in ent #1 to ensure she was not NA #1 or NA #2. Both NAs ere noted to leave the room esident #1 in her wheelchair en. The details of physical or ead, "Body audit revealed era [of Resident #1]." This by the Administrator on A #2 were suspended on esults of the investigation. Eled on 1/9/19 at 2:08 PM as	F	607	Services related to facility policy regard prevention of abuse, indicators of abus reporting abuse, and investigation abus on 2/6/2019 to ensure resident safety. 2/6/2019 facility Administrator, Director Healthcare Services, Assistant Director Healthcare Services, Registered Nurse (RN) Clinical Competency Nurse and Registered Nurse (RN) MDS Coordinat received education from Registered Nu (RN) Regional Senior Nurse Consultan regarding facility abuse policy to includinvestigation procedures. On 2/6/2019 facility Administrator, Director of Healthcare Services, Assistant Director Healthcare Services, Registered Nurse (RN) Clinical Competency Nurse and Registered Nurse (RN) MDS Coordinat received education from Registered Nu (RN) Regional Senior Nurse Consultan on F607 Regulatory Guideline interpretation and adherence thereof. C2/6/2019 the facility Registered Nurse (RN) Clinical Competency Coordinator began educating Nursing Clinical staff, Dietary staff, Environmental staff, Administrative staff, and Rehabilitation staff on facility policy and procedures related to preventing abuse and reporting abuse to ensure resident safety. Facility staff who have not completed education have been removed from the schedule until education is completed. On 2/6/20 the facility Clinical Competency Coordinator started educating Nursing Licensed and Unlicensed staff, Administrative staff, Environmental staff, Administrative staff, and Rehabilitation staff on Basic	e, se On of or	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 607	- Other employment a were to receive writte		F	607	for individuals with Dementia to ensure resident safety. Facility staff who have completed education have been remove from the schedule until education is completed. On 1/9/2019 Laboratory	not	
	on the care of the cor - Summary of facility interviewed the LP, N (charge nurse on dut incident), residents o #1 an NA #2, and oth Resident #1. The me was noted to be revie "Based on the intervie audit the facility is no	mbative/agitated resident. investigation: Facility IA #1, NA #2, and Nurse #1 y during the time of the n the hallway assigned to NA her staff who provided care to dical record of Resident #1 ewed as well as skin audits. ews and results of the skin t able to substantiate the			Phlebotomist was verbally trained via phone by Assistant Director of Nursing regarding timely and appropriate abus reporting. Management of the Laborate Phlebotomist were trained on 2/7/2019 facility Registered Nurse Clinical Competency Nurse regarding facility policy related to abuse prevention, identification, and reporting. On 2/7/20 Management of the Laboratory	e ory 0 by	
	accused [NA #1 and agitated resident [Re- untrained person not [LP]." NA #1 and NA	The facility did find the NA #2] at fault for leaving an sident #1] in the care of an in the employ of the facility #2 returned to work on appletion of the investigation.			Phlebotomist told the Registered Nurs Clinical Competency Nurse they would ensure staff assigned to the facility receive training prior to working with facility residents. Beginning on 2/6/201 accused Certified Nursing Assistants (NA#1 & NA#2) were re-interviewed as suspended pending investigation to	9	
	Administrator on 2/5/24-hour report and the summary of Resident review that indicated Resident #1's lower 1/9/19 was reviewed part of the summary resident's face was performed on 12/13/2 Administrator. The bothat showed no bruisi region was reviewed Administrator revealed	19 at 12:57 PM. The le Administrator 's typed t #1's medical record a bruise was present on right side of her face on with the Administrator. The that indicated, "bruise on noted on a skin audit 2019" was reviewed with the ody audit form dated 1/5/19 ing to Resident #1's facial with the Administrator. The led she had not known where			ensure resident safety. On 2/8/2019 accused Certified Nursing Assistants (NA#1 & NA#2) were terminated from facility employment by facility Administrator and Registered Nurse Regional Senior Nurse Consultant. Starting 2/6/2019 facility Assistant Dire of Nursing, Director of Nursing, and MI Coordinator interviewed residents with BIMS of 8 or above to find out if they have been abused or have witnessed abuse Residents having statements positive possible abuse will be re-interviewed to	os ave a.	
	the information about	Resident #1 ' s facial bruise prevealed that the date,			Administrator and Director of Health Services to ensure they are free from		

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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				804 SOUTH LONG DRIVE		
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F 607	record and she was a documentation of the #1. The Administrator #1's facial bruising of an injury from the 1/9 allegation. Her explareported to her by ph #1 with a closed fist of the LP reporting that face in addition to the Administrator was un Resident #1's facial A family interview wa Resident #1's Respat 8:50 AM. He state bruise on her face senot sure how she had Resident #1's RP rean allegation of staff involving Resident #1 been made aware of investigation. A verbal statement by the Administrator on PM was transcribed in Administrator. The restriction of the Administrator on PM was transcribed in Administrator. The restriction of the reported she open is room without known her, "you need to turn want you to see what was seated in her who	ect date was. The ed Resident #1's medical unable to find any additional facial bruising for Resident or was asked how Resident on 1/9/19 was ruled out as l/19 staff to resident abuse unation was that the LP had one that NA #1 hit Resident on the shoulder. She denied NA #1 hit Resident #1 in the e shoulder. The able to explain how bruising was sustained. s conducted by phone with onsible Party (RP) on 2/6/19 and that Resident #1 had a everal weeks ago, but he was d sustained the bruise. Evealed he was aware that to resident abuse was made 1, but he stated he had not the results of the y the LP made by phone to 1/9/19 at approximately 1:15	F 60	investigated and reported. Ne be educated by the facility RN Competency Nurse during or facility policy and procedure rabuse prevention and reporting Basic Concepts and Guideline caregiving for individuals with ensure all facility personnel presidents. 4)To ensure solutions are susfacility will implement the follor procedures to monitor perform Facility Administrative team warandom interviews of 10 reside or above Brief Interview of Me (BIMS) and RN Treatment Nur 10 random skin audits for resolutive of Mental Status (Bledaily for 14 days, then weekly weeks, then monthly. Starting facility Director of Healthcare Assistant Director of Healthcare Assistant Director of Healthcare Registered Nurse Clinical Concoordinator, and Registered Nurse Coordinator, and Registered Nurse Coordinator, and Registered Nurse Coordinator, and Registered Nurse Staff to reside during caregiving procedures shift daily for 14 days, weekly weeks, and monthly to ensure of staff to resident abuse. Sta 2/8/2019 facility Registered Nurse, Houseke Supervisor, Dietary Supervisor Counselor, Social Worker, an Admissions Director interview random staff members regard	A Clinical dentation on related to ag as well as ses for a Dementia to rotect facility stained the owing mance: vill conduct lents with 8 sental Status reses conduct idents Brief IMS) below 8 or for three graph of the provides of the prov	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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F 607	Continued From page	∋ 37	F	607			
	seated in the wheelch	nair. NA #1 had her "fist			members have knowledge of and are a	ıble	
	drawn back, struck [F	Resident #1] on her [left]			to implement facility policy and procedu	ıre	
	shoulder [Resident	#1] had hands upreacting			regarding staff to resident abuse		
	•	reported she had not seen			identification and prevention daily for 1	4	
		t #1, but that NA #2 had not			days, then weekly for three weeks, the		
		LP indicated she drew			monthly. On 2/7/2018 the Regional Are		
		as ordered while NA #1 and			Vice President and Regional Senior Nu		
		e room. She indicated she			Consultant attended the ad-hoc Quality	′	
	stayed with Resident #1 until both NAs left the				Assurance and Performance	\d	
	room.				Improvement committee meeting related to facility following policy and procedur		
	Δ typed statement jur	ndated, signed by the LP			regarding abuse investigation to ensure		
		19 at approximately 5:45 AM			continued resident safety. Starting	•	
		ard Resident #1 's room to			2/8/2019 the Regional Senior Nurse		
	_	w as ordered. She reported			Consultant or will review the facility		
	-	I getting close to the room			random audits and 24 hour abuse for		
		ices along with Resident #1			timely reporting as well as thorough an	d	
	"grunting and hollerin	g". The LP wrote that she			timely completion of subsequent		
	-	saw an NA (NA #2) standing			investigation weekly for 4 weeks then		
		olding her down in the			monthly to ensure the facility		
		er NA (NA #1) "hitting"			Administration is complying with the		
		indicated that she opened			regulatory guideline. Results of the BIN	IS	
		A #1 said to her, "you might			interviews and skin audits will be	41- I	
	_	re else so that you don't			presented by facility Administrator mon	-	
	see what I am about t				at facility Quality Assurance Performan	CE	
	·	#1 that, "I don ' t have at, I ' m here to draw her			Improvement Meeting to maintain continued compliance with plan of		
		on my list". The LP wrote			correction.		
		"very agitated" at that point,			CONTROLION.		
		ne several times to get her			5)Compliance Date3/14/2019		
		why she was there. NA #1					
		Resident #1 's bed and then					
	left the room. The LF						
	•	draw and then pushed					
		neelchair toward the nurse '					
		said she was going to take					
		rom there. The LP indicated					
	•	the incident to Nurse #1, but					
	⊔instead continued to d	complete blood draws.					1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	IP CODE	02/00/20 10
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F 607	facility, and then calle reported the incident. recommended she re to the Director of Nurs. She indicated she ph of Nursing (ADON) and during the phone call call because she was attend to a patient. The became very busy and call back to finish her. A phone interview was 2/5/19 at 2:24 PM. She and 6:00 AM on 1/9/16 facility hallway enround draw blood as ordere reported that as she which was partially crosounds of "distress" of moaning, hollering, and that she opened the obecause the sounds of moaning, hollering, and that she opened the she	around 6:45 AM, left the ed her direct supervisor and The LP's Supervisor port the incident "urgently" sing (DON) at the facility. oned the Assistant Director round 11:00 AM, but that she had to disconnect the at work and needed to the LP wrote that she dit took a while for her to report of the incident. s conducted with the LP on the stated between 5:00 AM 9 she was walking down a see to Resident #1's room to diby the physician. She was approaching the door, tacked open, she heard described as grunting, and screaming. She stated door without knocking she heard coming from the led. The LP indicated that the room Resident #1 was shair, NA #1 was standing She reported that NA #2 was by her shirt at the shoulders	F	507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345378	B. WING			C 02/08/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	E, ZIP CODE	2/06/2019	
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F 607	NA #1 hit Resident # closed fist and then open hand. She indiswinging her arms at was hit by NA #1. The not witnessed NA #2 only observed her how wheelchair. The LP struck Resident #1 s was not leaving the reblood draw. She indivanted to leave Reswith either of the NA reported that she app the NAs left her side linens on Resident # after the NAs had chroom and she was a draw with no issues. #1 was not combative draw. The LP stated #1 from her room to was not alone. She to recall if there were Resident #1 's face she had not reported duty following the incident retaliation from the separation from the separations hip with the make sure the informatic populations.	e 39 sported that she witnessed on the cheek area with a control left shoulder with an incated that Resident #1 was round in a reaction after she he LP reported that she had a hit Resident #1, she had a liding the resident back in the stated that after NA #1 had he told NA #1 and NA #2 she room until she completed the icated that she had not ident #1 alone in the room is (NA #1 or NA #2). She proached Resident #1 and and began to change the 1's bed. She stated that anged the linens they left the ble to complete with blood. She reported that Resident is with her during the blood. It that she pushed Resident the nurse 's station, so she reported that she was unable any marks or bruising to at that time. The LP revealed if the incident to the nurse on cident. She stated that she NA #2 were friends with and 't felt comfortable to her because she feared taff. The LP reported that ervisor around 7:00 AM when report the incident to the facility stated that she had a good ADON and she wanted to nation got into the right hands seriously. She reported that	F	607			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
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F 607 Continued From page 40		F	607				
	10:00 AM/11:00 AM to was asked why she he AM/11:00 AM and she ADON was not prese so she proceeded to the ADON when she away from work. A phone interview was upervisor on 2/6/19 that the LP contacted immediately after least to him the allegation of the stated that the LP crying during the phoinstructed her to contreport the incident. Tasked if they provided employees related to abuse. He revealed to	e stated that she knew the nt at the facility at 7:00 AM her next job and she phoned had an opportunity to step s conducted with the LP's at 4:35 PM. He confirmed him by phone on 1/9/19 ving the facility and reported of staff to resident abuse. was very upset and audibly ne call. He stated that he act the facility's DON and he LP's supervisor was					
	2/5/19 at 4:20 PM. S contacted her by pho AM and reported an i abuse. She indicated her with the resident members name durin reported that she wal room and she saw 1 behind the resident "r	ne on 1/9/19 around 10:00 ncident of staff to resident of the LP had not provided s name or the staff g this phone call. The LP ked into the resident's staff member standing estraining" her in the					
	resident from the from the LP was crying wh information. She indi	other staff member hit the t. The ADON stated that en she reported the cated the LP told her that b get involved, but that she					

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			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		02/08/2019
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F 607	She indicated that th was reporting this inf ADON she had to ca stated that she repor DON and the Admini was not until later that Administrator spoke the more detailed version of the allegation of the allegatio	job to protect the residents. e LP was at work while she ormation and she told the III her back later. The ADON ted this phone call to the strator. She reported that it at afternoon that she and the to the LP by phone to obtain rbal statement. Inducted with the 19 at 4:00 PM. The that she was initially ation of staff to resident around 10:00 AM/11:00 AM d that at that time she had ation because she had no to staff names. She reported to least have a resident or their initial allegation report estigation. The Administrator ADON to try to get in touch their information. She to contacted the LPs d him to have the LP contact sible. She indicated it was the remoon, around 1:00 PM, that the touch with the LP by phone the port identifying Resident #1, The Administrator stated that the other were notified by phone and conducted with NA #1 and	F 6	07		
		:05 PM. The DON was riew. NA #2 stated that on				

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F 607	Continued From page	e 42	F 6	507		
	the morning of 1/9/19 's room and saw that bed. She indicated sassistance with gettir because she had bethitting at staff. NA #2 to help her. The NAsthat Resident #1 was yelling out, grunting, behaviors of swinging morning and they had resident out of the becare, getting her dresthe wheelchair. They in the room without k that time Resident #1 wheelchair and that NLP like, "oh honey yohere". NA #1 stated recalled laughing who because she and NA getting Resident #1 uthat NA #2 was stand and NA #1 was stand wheelchair. Residen forward in the wheelc revealed that Resides stand, but that she had in the chair and they tip over and land hea stated that she asked the wheelchair, but she revealed she put one forehead and one had region and pushed the upright position in the moved to the back of	she walked by Resident #1 It she was trying to get out of the went to ask Nurse #1 for tog Resident #1 out of bed the wasted that NA #1 was sent to (NA #1 and NA #2) stated thaving verbal behaviors of the moaning and physical tog and hitting at them that tod a tough time getting the tod, providing incontinent tosed, and then transferred to the reported that the LP walked thocking. They stated that at the was already seated in the that H said something to the that this was a joke and she ten she said this to the LP the H2 had such a difficult time that this was a joke and she ten she said this to the LP the H2 had such a difficult time that this was reportedly leaning thair. NA #1 and NA #2 the #1 rarely attempted to the that day the the that the tha				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		345378	B. WING			C 02/08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		210012010
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 607	NA #2 reached from placed one hand on shoulder/chest region upright position. NA was preparing for the #1 was swinging her placed one hand in find hand behind her should be able to swing around going to be drawn from Resident #1 on the find NA #2 denied witnes. They both denied Resident #1 on the find NA #2 denied witnes. They both denied Resident witnes any other date. NA #1 her verbal statement indicated that Resident indicated that	ted to lean forward again so behind the resident and her forehead and one on her in to pull her back into an #1 stated that when the LP is blood draw that Resident hands around, so she cont of her shoulder and one ulder to keep her from being the arm that blood was in. NA #1 denied hitting face and/or on the shoulder. Sing NA #1 hit Resident #1. It is ident #1 having any in her face on 1/9/19 or on it is was unable to explain why in the morning of 1/9/19 and explain why she previously ident #1 while the LP was in telling the LP to leave the intelling the LP to leave the	F 60			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345378	B. WING _			C 02/08/2019	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIAT		1
F 607	Continued From page been to stand back for Resident #1 was swir give her time to calm. An interview was con Administrator on 2/6/Administrator was as substantiated the alleabuse related to the Resident #1. She stany negative physica findings on behalf of from her previous interfacial bruising noted of was ruled out as an in reported to her that N closed fist on the sho stated that another fathe LP had not immediately that had not immediately waiting until she left to stated that she had the of placing her hands and chest/shoulder reway to manage the lecombative resident.	or a few minutes when aging her arms around to down. ducted with the 19 at 4:00 PM. The ked why she had not gation of staff to resident 1/9/19 allegation involving ated that she had not found 1 or mental/emotional the resident. She re-iterated erview that Resident #1 's fon the 1/9/19 24-hour report injury because the LP had 1A #1 hit Resident #1 with a sulder. The Administrator cotor for her was that since diately reported the 19 on duty at the time of the 19 that it actually happened. The thought that if the LP had the esident #1 that she would 'reported it rather than the facility. The Administrator arought that NA #2 's actions for Resident #1 's forehead agion twice was not the best saning behaviors of a The Administrator explained	F 6	DEFICIE			
	either staff, NA #1 or this was physical abu or NA #2 had any pre during their employm reported she was uns their personnel record this information was re	as no negative intent from NA #2, she had not thought se. She was asked if NA #1 vious disciplinary actions ent at the facility and she sure and needed to look at ds to find out. She indicated not included in their o resident abuse involving					

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F 607	reporting to their conthe LP. She stated to she thought the contresponsible for provious taff. She revealed solution above reportation of their staff. A re-interview was controlled interview that took pointerview that took pointerview that took pointerview that took pointerview that the Advireporting to her that closed fist on the chetold the Administration 1/9/19 that NA #1 wa #1 once on the chee on the left shoulder with the LP. She expression word "hitting" for implicated that in hindsign more specific when so the stated that in hindsign more specific when so the stated that in hindsign more specific when so the stated that in hindsign more specific when so the stated that in the concerns reported. So the stated that in concerns reported.	and NA #2. The en asked who was ding training on abuse tracted providers, such as hat she was not sure, but	F	507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	E	02/06/2010
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F 607	F 607 Continued From page 46		F 6	507		
	oriented resident. N performance evaluat grievances on file reduring the review per A final interview was Administrator on 2/8, indicated that she excontracted providers allegation of abuse, that she expected abuthorough to ensure rephysical abuse. The that the LP failed to the procedure related to when she had not imincident after witness acknowledged that the unsubstantiated, and to work on 1/17/19 d	ding care to an alert and A #1 's most recent quarterly ion revealed that she had ated to customer service riod (7/1/18 through 9/30/18). conducted with the (19 at 10:33 AM. She pected all staff, including, to immediately report any She additionally indicated buse investigations to be esidents were protected from a Administrator acknowledged follow facility policy and reporting of abuse to facility amediately reported the sing it on 1/9/19. She also the facility failed to follow its the allegation of abuse was at NA #1 and NA #2 returned the espite a verbal statement by the LP of staff to resident				
	Immediate Jeopardy On 2/8/19 at 10:54 A	d DON were notified of on 2/6/19 at 5:43 PM. M the facility provided the				
	following credible allo Jeopardy removal:	egation of Immediate				
	allegation of substan and Medicaid require execution of this corn admission or agreem truth of items alleged	on constitutes a written tial compliance with Federal ements. Preparation and/or rection does not constitute nent by the provider of the I or conclusions set forth for ies. The plan of correction is				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 607	required by the prov law. It also demonst desire to continue to and services to our - Process that lead to On 1/9/2019 Labora facility Administrator	ecuted solely because it is ision of the state and federal rates our good faith and improve the quality of care residents. To the deficiency tory Phlebotomist reported to and Assistant Administrator	F 6	07			
	1/9/2019 she witnes Nursing Assistants of when she entered the blood. When further call by facility Admir Director of Health S Phlebotomist stated Nursing Assistant (N resident #1 on her le Certified Nursing as by the back of her s her wheelchair. Fac	nat at approximately 5:45a on sed two facility Certified on night shift hit resident #1 ne resident 's room to draw questioned during this phone istrator and facility Assistant ervices the Laboratory she saw one Certified IA #1) draw back a fist and hit eft shoulder while the second sistant (NA #2) held resident hirt while she was sitting in illity Administrator and					
	Phlebotomist why slicharge nurse at the stated she felt the Chandle information of her to do the right the stated she waited to of Health Services in the health	rhursing asked Laboratory ne did not report this to time of the incident she harge Nurse would not correctly and she did not trust ing. Laboratory Phlebotomist speak with Assistant Director recause she trusted her to correctly as she feared ified Nursing Assistants (NA oed statement signed by the omist provided to the facility 019) at approximately 6:00a istrative door the Laboratory one Certified Nursing as standing behind the air holding resident #1 down					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345378	B. WING _				08/2019
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F 607	was hitting her. Certi #1 & NA #2) fitting the Laboratory Phlebotor while statements wer Certified Nursing Ass provided by the Labo suspended pending in another shift on 1/9/2 Assistant NA#2 who wa approximately 2:45p Certified Nursing Ass suspended at approx Registered Nurse (RI Nurse. Statements pr Assistants (NA #1 an facility Administrator, Services, and RN Clir revealed NA #2 place chest/shoulder area or resident #1 from fallir while NA#1 watched. with a diagnosis of Do 1:15p with the phone Phlebotomist and fac Assistant Director of I investigation of the al was closed on Janua Administrator with an Certified Nursing Ass were returned to emp	d Nursing Assistant (NA#1) fied Nursing Assistants (NA e description provided by the nist were not in the facility e taken via phone. Both istants fitting the description ratory Phlebotomist were nvestigation prior to working 019. Certified Nursing was suspended at by facility Administrator and istant (NA#1) was imately 10:30p by facility N) Clinical Competency ovided by Certified Nursing d NA#2) on 1/9/2019 to Assistant Director of Health nical Competency Nurse d hand on forehead and of resident #1 to prevent neg forward out of wheelchair Resident #1 is a resident ementia. On 1/9/2019 at call between the Laboratory ility Administrator and Health Services started an leged incident. Investigation	Fé	507			
	abuse policy and Car behaviors. Facility failed to follow	Nurse regarding facility e of Dementia residents with v abuse prevention policy dent abuse when Certified IA #1 & NA #2) were					

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F 607	witness statements of and Certified Nursing statements given on administration. Labor follow contractual statesident safety and farelated to reporting of did not immediately resident safety and farelated to reporting of did not immediately resident safety of current of the Laborator statement and statement an	anuary 17, 2019 in light of f Laboratory Phlebotomist Assistant (NA #1 & NA #2) 1/9/2019 to facility atory Phlebotomist failed to indards of conduct related to acility policy and procedure f abuse to facility when they eport the incident after 019. e-suspension of Certified IA #1) approximately 5:30p Assistant (NA#2) on February 7, 2019 by and Director of Nursing to ent facility residents. Facility igional Registered Nurse tant terminated NA #1 and ent on February 8, 2019 of resident abuse with y Phlebotomist witness nents of NA #1 and NA #2. not work in facility after oruary 7, 2019 in accordance arding protecting residents Phlebotomist being verbally Assistant Director of Nursing appropriate abuse reporting. aboratory Phlebotomist of 19 by facility Registered etency Nurse regarding to abuse prevention,	F	607		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
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F 607	residents. Resolution also inclu Nurse Consultant co facility Administrator, Services, Clinical Co Director of Health Se policy regarding prevabuse, reporting abus on 2/6/2019 to ensure Current facility reside conducted by facility Nurse and facility Ch 2/6/2019 to ensure re facility. These audits Interview of Mental Se were checked for signification were checked for signification were checked for signification Residents with a Brie (BIMS) score of 8 or facility Activities Dire Services, MDS Coor Practical Charge Nur ensure any possible reported and investigation - Process for implement for specific deficiency The facility Administry a thorough investigation Could or would affect On 2/6/2019 facility A Healthcare Services, Healthcare Services,	ded the Regional Senior inducting education with Assistant Director of Health impetency Coordinator and envices related to facility rention of abuse, indicators of se, and investigation abuse in resident safety. The stand skin audits is registered Nurse Treatment arge nurses starting residents remain safe while in rensure residents with Brief status (BIMS) of 7 or below ins of possible physical reference interviewed by coor, Director of Health dinator, and Licensed resident abuse was gated appropriately. The standard senior in the senior is a plan of correction of the standard is a plan of correct	F6	507		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		OMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 607	Registered Nurse (R Consultant regarding include investigation On 2/6/2019 the fact Healthcare Services, Healthcare Services, Clinical Competency (RN) MDS Coordinat Registered Nurse (R Consultant on F607 interpretation and ad On 2/6/2019 the facil Clinical Competency educating Nursing C Environmental staff, Rehabilitation staff oprocedures related to reporting abuse to er staff who have not coremoved from the socompleted. On 2/6/2019 the facil Coordinator started eand Unlicensed staff staff, Administrative on Basic Concepts a for individuals with D safety. Facility staff veducation will be remeducation is completed. On 1/9/2019 Laborat verbally trained via p	or received education from N) Regional Senior Nurse facility abuse policy to procedures. Ility Administrator, Director of Assistant Director of Registered Nurse (RN) Nurse and Registered Nurse or received education from N) Regional Senior Nurse Regulatory Guideline herence thereof. Ity Registered Nurse (RN) Coordinator began linical staff, Dietary staff, Administrative staff, and facility policy and preventing abuse and asure resident safety. Facility ompleted education will be hedule until education is Ity Clinical Competency educating Nursing Licensed, Dietary staff, Environmental staff, and Rehabilitation staff and Guidelines for caregiving ementia to ensure resident who have not completed loved from the schedule until ed. Ory Phlebotomist was hone by Assistant Director of nely and appropriate abuse	F	607		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OATE SURVEY COMPLETED
		345378	B. WING _			C 02/08/2019
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	E	02/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	Registered Nurse CI regarding facility poliprevention, identifica 2/7/2019 Manageme Phlebotomist told the Competency Nurse that assigned to the facility working with facility in Beginning on 2/6/20 Assistants (NA#1 & I and suspended penderesident safety. On 2 Nursing Assistants (Iterminated from facil Administrator and Resenior Nurse Consultanting 2/6/2019 fact Nursing, Director of Coordinator interview or above to find out in have witnessed abustatements positive for interviewed by Administrator and statements and reported. Starting 2/6/2019 fact conducted and docutour facility resided be flagged for furthe Administrator and Diresident safety. These statements affety. These statements affety. These statements affety.	rained on 2/7/2019 by facility inical Competency Nurse cy related to abuse attion, and reporting. On an of the Laboratory related Nurse Clinical they would ensure staff ty receive training prior to residents. 19 accused Certified Nursing NA#2) were re-interviewed sing investigation to ensure 1/8/2019 accused Certified NA#1 & NA#2) were ity employment by facility registered Nurse Regional litant. 19 itity Assistant Director of Nursing, and MDS are residents with BIMS of 8 for they have been abused or see. Residents having for possible abuse will be ministrator and Director of nesure they are free from a re thoroughly investigated control of the nurse see audits on the see audits ensure residents or below are audited for	F6	507		

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	CODE	02/33/2313
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACCURATE CONSIDER OF CEACH CORRECTIVE ACCURATE CONSTRUCTION OF CEACH CONST	TION SHOULD BE	
F 607	Clinical Competency facility policy and proprevention and report Concepts and Guide individuals with Dempersonnel protect factor on 2/7/2019 the Regard Regional Senior the ad-hoc Quality As Improvement commit facility following policy abuse investigation to safety. - Monitoring to ensur Starting 2/6/2019 residental Status (BIMS interviewed by facility interviewed by facility interviewed to find our or have witnessed at to ensure no occurre will include random in 8 or above Brief Interview of Medaily for 14 days, the then monthly. Starting 2/7/2019 facts Services, Assistant Eservices, Registered Coordinator, Registered Coordinator, Registered Nurs conduct 10 random versident interaction of on each shift daily for	Nurse during orientation on ocedure related to abuse ting as well as Basic lines for caregiving for entia to ensure all facility cility residents. Igional Area Vice President Nurse Consultant attended assurance and Performance ttee meeting related to be yeard procedure regarding or ensure continued resident effectiveness of POC cidents with Brief Interview of	F	507		

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	ı	02/06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	Clinical Competency Supervisor, Dietary S Counselor, Social Wo Director interviewed regarding facility abuse ensure staff members able to implement facility abuse and prevention daily three weeks, then mo On 2/7/2019 the Reg and Regional Senior the ad-hoc Quality As Improvement commit review of facility policiabuse. Starting 2/8/2019 the Consultant will review and 24 hour abuse for thorough and timely convestigation weekly from the facility Admits the regulatory guither the plan of correction Date of Allegation of the credible allegation of the credible allegation and the credible allegation and the credible allegation of the credible allegation and the cr	dility Registered Nurse Nurse, Housekeeping supervisor, Financial orker, and Admissions 10 random staff members se policy with scenarios to shave knowledge of and are defility policy and procedure dent abuse identification for 14 days, then weekly for onthly. Identify the consultant attended surance and Performance the meeting related to the facility random audits or timely reporting as well as completion of subsequent for 4 weeks then monthly to ministration is complying dideline. Compliance 2/8/2019 In of Immediate Jeopardy d on 2/8/19 at 10:55 AM.	F 6	07		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	'	2210012010
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 636 SS=D	2/8/19. A review of instaff interviews verified on 2/6/19 to facility adfacility abuse policy to procedures and on Frinterpretation and adlivas also verified to be 2/6/19 on proper procedures, reporting abuse, reporting abuse, reporting abuse guidelines for caregived dementia. Staff who inservice on 2/6/19 we schedule until educate Education was also verified until educate Education was also verified identification, and replacements and control of the facility policy related identification, and replacements of the facility prior to working with the review indicated skin all current residents of alert and oriented residents of alert and 2/7/19 to 2/6/19 and 2/6/19 an	and terminated on a service sign in sheets and ad education was provided diministrative staff on the conclude investigation include investigation includes investigated includes investigated includes investigated includes investigated includes investigated includes investigated interviews were undit form. In sessments & Timing	F 60			3/14/19
	§483.20 Resident As: The facility must cond a comprehensive, ac	sessment duct initially and periodically				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		1	8	TREET ADDRESS, CITY, STATE, ZIP CODE 04 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		
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F 636	A facility must make a assessment of a resident assessment by CMS. The assess the following: (i) Identification and of (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavid (vii) Psychological were (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutritic (xii) Skin Conditions. (xii) Activity pursuit. (xiv) Medications. (xvi) Discharge plann (xvii) Discharge plann (xvii) Documentation regarding the addition on the care areas trig the Minimum Data Set (xviii) Documentation assessment. The assinclude direct observation with the resident, as a licensed and nonlicer members on all shifts §483.20(b)(2) When a timeframes prescribe	ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least demographic information ensions dent and structural problems. dent and health conditions. dent and health conditions. dent and procedures. dent and procedures. dent and procedures. dent and procedures derect of summary information and assessment performed derect by the completion of det (MDS). detect of participation in desessment process must detect of the communication deserved direct care staff	F	636			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
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F 636	timeframes specified through (iii) of this seprescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmissic significant change in mental condition. (For "readmission" means following a temporary or therapeutic leave. (iii) Not less than one This REQUIREMENT by: Based on record revision facility failed to compresident on the Minimassessment in the arrand also failed to compresident on the Minimassessment within the admission for 1 of 5 st. #1). The findings included Resident #1 was addr 12/21/18 with diagnoral aphasia, and demental that the diagnoral aphasia is and usually	dent in accordance with the in paragraphs (b)(2)(i) ection. The timeframes 43(b) of this chapter do not ar days after admission, ons in which there is no the resident's physical or or purposes of this section, are a return to the facility absence for hospitalization of every 12 months. This not met as evidenced are and staff interview, the orehensively assess a num Data Set (MDS) eas of cognition and mood emplete the admission MDS are first 14 days after sampled residents (Resident definition).	F 6	1) Processes that lead to the cited were resident Minimum I (MDS) completion is optimally two Registered Nurse(RN) ME Coordinators and facility has be operating with one RN MDS C Resident #1 received mood ar assessment with 30 day compassessment completed on 1/1 2) The procedure for implemacceptable Plan of correction identification of other potential affected for the deficiency citerfollows: Facility Administrator conducted ending 3/5/2019 of residents at the facility in the past 30 days completion of admission assessmood (Section PHQ9) and cog (Section C) section completed residents found without compleadmission assessments will have a complete admission assessments.	Data Set handled by DS been coordinator. nd cognition brehensive 8/2019. menting an including residents d is as ed an audit admitted to for timely sement with gnitive . Four eted	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		SURVEY PLETED
		345378	B. WING _				C /08/2019
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	00/2019
TO UNIC OF TH	TO VIDER ON OUT FEIER				04 SOUTH LONG DRIVE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636	Continued From page	e 58	F 6	336			
	through C0500 were	not assessed indicating the			3/10/2019. Residents needing complet	ion	
	•	eted with Resident #1.			of mood and cognition section had their		
	Section D, the Mood				completed by members of the		
		essed for Resident #1.			Interdisciplinary Team (IDT) to include		
		coded to indicate a resident			Social Worker, Dietary Supervisor,		
	mood interview was t	o be conducted for Resident			Activities Director, and Nursing		
	#1. Questions D0200	0 through D0300 were not			Administration by 3/8/2019.		
	assessed indicating t	he resident mood interview					
		Section C and D of Resident			The Facility implemented the follow	ving	
		was completed by the MDS			systemic changes to ensure cited		
	Coordinator. Section				deficiency does not reoccur:		
		n, revealed this 12/28/18			Facility has a RN MDS Coordinator		
		Resident #1 was signed as			helping with timely completion of	10	
	complete by the MDS	S Coordinator on 1/24/19.			admission assessments starting 3/1/20	19.	
	An interview was con	ducted with the MDS			Facility Administrator assigned facility Social Worker, Activities Director,		
		9 at 12:35 PM. She stated			Admission Director, Director of Health		
		ection C and Section D of			Services, Therapy Outcomes Coordinate	tor	
	· ·	/18 admission MDS. She			and Dietary Supervisor education via	itor,	
		lity 's previous Social			facility electronic training system on		
		pposed to complete this			3/2/2019 to be completed by 3/8/2019		
	, ,	out she had not done so.			regarding timely completion of MDS		
	She stated this SW w	as no longer employed at			Sections PHQ9 and Section C. The		
	the facility. She repo	rted that when she realized			assessment calendar will be provided t	0	
	•	had not completed the			and reviewed by facility Interdisciplinar	y	
		dent mood interview for			Team to include facility Social Worker,		
	Resident #1 it was af				Director of Health Services, Activities		
		D) and therefore she had to			Director, Dietary Supervisor, and Thera		
		erviews for Section C and			Outcomes Coordinator each morning in	ו	
	Section D as not asso	esseu.			clinical meeting to ensure timely completion of admission assessments.		
	Δ second interview w	as conducted with the MDS			completion of aumission assessments.		
		9 at 11:20 AM. Section Z of			4)To ensure solutions are sustained the	۵	
		/18 admission MDS that			facility will implement the following	•	
		ment was completed on			procedures to monitor performance:		
		d with the MDS Coordinator.			The facility Administrator and Director	of	
	She revealed that this				Health Services will review the	-	
		further revealed that she			assessment calendar for Admission		
	•	urse at the facility and she			assessments to include mood and		

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PRUITTHEALTH-ROCKINGHAM	NAME OF PROV
ROCKINGHAM, NC 28379	DDIIITTUE AI
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMMITTED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX
had difficulty completing the assessments on time. She stated that occasionally she had a corporate MDS Nurse help her out with some of the assessments, but primarily she had been on her own for almost a year. An interview was conducted with the Administrator on 2/8/19 at 10:33 AM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS and for the assessments to be completed timely as per the regulations. F 657 SS=D F 657 Care Plan Timing and Revision CFR(s): 483.21(b)(2) (A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to— (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (C) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident.	ha tin co the he h

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345378	B. WING _			C 02/08/2019
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE
F 657	team after each assecomprehensive and cassessments. This REQUIREMENT by: Based on record reviacility failed to compilan within 21 days of sampled residents (Resident #1 was admits a sample of the findings included Resident #1 was a sample of the findings in the findings included Resident #1 was a sample of the findings in the findings	ised by the interdisciplinary ssment, including both the quarterly review is not met as evidenced iew and staff interview, the lete the comprehensive care f admission for 1 of 5 esident #1). : iitted to the facility on ses that included stroke, ia.	F 6		to the deficiency comprehensive facility residents two RN MDS has been DS Coordinator. The care 9.	
	indicated the followin - Discharge planning - Activities of Daily Lit to cerebrovascular ac - Risk for falls related - Risk for impaired sk - Risk for cardiac out and Coronary Artery - Candidate for bowe evidence by continen - Adjustment difficulty to recent admission a psychosocial adjustm - Potential for social i participation related t stay resident - Alteration in dentitio - Nutrition and/or hyd chewing problems	ying (ADL) Decline relayed ccident (CVA) to right sided weakness in integrity out relayed to hypertension Disease (CAD) I and bladder retraining as t with incontinent episodes to new environment related and diagnosis of the integrity onew admission and short		affected for the deficiency follows: Facility Administrator cone ending 3/5/2019 of reside the facility in the past 30 completion comprehensive within 21 days of admission regulation. Five residents comprehensive assessments be completed had them on the RN MDS Coordinator by 33. The Facility implements systemic changes to ensure the deficiency does not reoccupate the properties of the p	ducted an audit ents admitted to days for timely ve care plan sons per so found with ents needing to completed facility 3/10/19. Ented the following the cited cur: igned facility Director, ctor of Health mes Coordinato ducation via	y ng

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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				R	ROCKINGHAM, NC 28379		
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F 657	Continued From page	e 61	F 6	357			
	was initiated on 12/24 of the potential for so admission. This was on 12/24/18. On 12/26/18 the base #1 was updated to incompleted in the admission Minimassessment dated 12 not completed in the resident interview for interview for mental sassessed with inattenthinking fluctuating in no physical behaviors no rejection of care. behavioral symptoms on 1 to 3 days. Residently, transfers, and She required the external sassessed with experience of the sample of the	4/18 with the problem/need cial isolation due to facility the only focus area initiated eline care plan for Resident clude the area of behavioral dwritten note that stated a ers was received for pt (cognition enhancing o dementia with behaviors.		007	3/2/2019 to be completed by 3/8/2019 regarding OBRA completion requiremer for resident care plans. The facility Administrator and Director of Health Services will review comprehensive caplan due date calendar with IDT in clini meeting to ensure comprehensive assessments are completed within 21 days of resident admitting to the facility. 4) To ensure solutions are sustained facility will implement the following procedures to monitor performance: The facility Administrator and Director of Health Services will review the assessment calendar for Admission assessments to include mood and cognition section completion 5 days a week for 4 weeks, then weekly for 3 months and then monthly thereafter to ensure timely completion. Findings of the review will be reported to the facility Quality Assurance Performance Improvement Committee monthly by facility Administrator and/or RN MDS Coordinator to maintain compliance. 5) Compliance Date 3/14/2019	re ical /. the	
	was not steady on he stabilize with staff assutilized a walker and occasionally incontine she had no skin issue no falls. Section Z, t Administration section admission MDS for R complete by the MDS	er feet and was only able to sistance. Resident #1 wheelchair, she was ent of bladder and bowel, es, and she had sustained he Assessment n, revealed this 12/28/18 esident #1 was signed as a Coordinator on 1/24/19.			-, 33p		
	The comprehensive of	care plan for Resident #1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE		
F 657	problems/needs: - Advance Directive Resident wants to re - Risk for falls due to weakness, shortness noted, impaired cogn and a fall since admis - Alteration in elimina bowel and bladder - Requires limited to ADLs due to impaired hemiparesis status perelated to diagnosis of does not wear denturnoted with exertion a - Potential for alterati impaired mobility, incand bladder, cellulitis - Exit seeking behavi wanderguard device that alarms and locks cognitively impaired rehaviors attempt to - Socially inappropria as yelling, fluctuating thinking - Risk for constipation needed use of opioid - At risk for complicate hypo/hyperglycemia, Mellitus (DM) - Potential for weight does not wear dentur impaired cognition, u	Do not Resuscitate (DNR) eturn home impaired mobility, right sided of breath with exertion ition related to dementia, ssion tion: incontinent episodes of extensive assistance with mobility, right sided ost CVA, impaired cognition of dementia, edentulous and es, shortness of breath and while lying flat on in skin integrity due to continent episodes of bowel to lower extremities or noted, required use of (an electronic alert system at the facility exit doors when residents with wandering exit the building) te/disruptive behavior such inattention/disorganized and due to impaired mobility, as as ions related to diagnosis of Diabetes loss due to: edentulous, es, new surroundings, se of diuretic for edema of nities, admitted with 2000 cc	F 6	57				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345378	B. WING			02/	08/2019
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		04 SOUTH LONG DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	s 12/28/18 admission assessment was comreviewed with the MD revealed that this assilate. She further rev MDS Nurse at the faccompleting the assess Coordinator stated the assessment was comprehensive care late. She explained so Care Area Assessme so 12/28/18 admission was why she had not plans until 1/24/19. Splan for Resident #1 if the care plan related created by the Activition The MDS Coordinator comprehensive care president is care as it goals, and intervention meet the goals of each She further revealed multiple care needs the put in place for, so stappropriate intervention behaviors, exit seeking risk. An interview was con Administrator on 2/8/2 indicated her expectations.	ducted with the MDS at 11:20 AM. Resident #1 ' MDS that indicated the spleted on 1/24/19 was as Coordinator. She essment was completed ealed that she was the only sility and she had difficulty sments on time. The MDS at when the MDS spleted late the clan was also completed the had not completed the ints (CAAs) for Resident #1 ' MDS until 1/24/19 which developed any of the care she stated that the only care in place prior to 1/24/19 was to activities which was es Director on 12/24/18. It revealed that the clan was pertinent to a identified problems/needs, ins for the staff to utilize to the identified problem/need. Ithat Resident #1 had mat required care plans to be aff were aware of the ons, such as inappropriate and ADL assistance, and fall ducted with the	F	657			
F 835	admission as per the Administration		F	835			3/14/19

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345378	B. WING _			C 02/08/2019	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 835 SS=E	Continued From page	e 64	F 8	335			
	§483.70 Administration A facility must be admenables it to use its refficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on record revistaff interviews and relaboratory company of failed ensure contract standards of care for resident abuse for 1 of staff to resident abuse provide leadership are facility's roof in good multiple leaks in the fincluding; 1 resident multi-purpose room, and the findings included This tag is cross-refermed to the finding abuse for 1 sampled for staff to resident sprofessional standard reporting abuse for 1 sampled for staff to resident interviews and failed to maintain the	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced liews, observations, facility esident interviews, and staff interviews, the facility ted staff met professional immediately reporting of 2 residents reviewed for e (Resident #1) and to not oversight to maintain the repair with evidence of facility's ceiling in areas from, hallways, the and the dining room. It: Tred to: Cord review, facility staff tory staff interview, the re contracted staff providing within the facility met dis of care for immediately of 2 residents (Resident #1) esident physical abuse.		1) Processes that lead to the cited were: A) Laboratory Phlebotomist fai contractual standards of conduto resident safety as well as fa and procedure related to report abuse to facility when they did immediately report the incident witnessing it on 1/9/2019 with Phlebotomist was verbally train phone by Assistant Director of regarding timely and appropriate reporting on 1/9/2017, Manage Laboratory Phlebotomist were 2/7/2019 by facility Registered Clinical Competency Nurse regacility policy related to abuse identification, and reporting. Of Management of the Laboratory Phlebotomist told the Register Clinical Competency Nurse the ensure staff assigned to the fareceive training prior to working facility resident. B) Flat top roof on facility is in replacement. Facility roof appropriate procedure in the start on 3/1 and Hallway ceiling vents on Birth in the start on 3/1 and the sta	iled to follow uct related icility policy ring of not t after Laboratory ned via Nursing ate abuse ement of the trained on I Nurse garding prevention, n 2/7/2019 y red Nurse ey would cility g with need of roved for d scheduled 4/2019. (1)		

Facility ID: 923337

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345378	B. WING		0.	C 2/08/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		100/2013	
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F 835		e 65 1 resident room, on the propose room and the dining	F	of rooms 125 and 126 will have rook sealed to prevent future moisture of and repair of current moisture dam facility Maintenance Director by 3/8 (b) Hallway ceiling on A Hall outsid room 104 will have roof sealed and current water damage repaired by Maintenance Director by 3/8/2019. Facility Maintenance Director will seroof and repair ceiling outside of roby 3/8/2019. (d) Ceiling on D hallw around the fire detector near the metation will be repaired by the facili Maintenance Director and the Maintenance Director will seal the above this area by 3/8/2019. (e) Familia Maintenance Director closed the habove this area by 3/8/2019. (e) Familia Maintenance Director closed the habove this area by 3/8/2019. (g) The roabove the hallway ceiling outside of 141 and repair cracks in ceiling our room 141 by 3/12/2019. (g) The roabove the hallway ceiling outside of 143 will have the roof sealed and ceiling repaired by facility Maintenance Diby 3/12/2019. (h) The roof above the hallway ceiling outside of room 145 have the roof sealed and ceiling reby facility Maintenance Director by 3/12/2019. (i) Residents were mov of room 122 on 2/11/2019 until root the residents room is repaired. Repair is scheduled on begin on 3/14/2019. (j) The roof area over the multi-purpose room will be sealed Maintenance Director and the ceilin repaired by 3/12/2019. The procedure for implementing the procedure	amage age the id/2019. The of ideal the ideal		

Facility ID: 923337

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345378	B. WING			C 2/08/2019	
	ROVIDER OR SUPPLIER	1 11 1		STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		200/2019	
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F 835	Continued From page	e 66	F 83	acceptable Plan of correction incidentification of other potential reaffected for the deficiency cited is follows: A. On 2/7/2019 Management of contracted Laboratory service prefacility received training from facility received training from facility received training from facility received training from facility reporting of abuse. Management competency Coordinator regarding abuse prevention policy to including reporting of abuse. Management contracted Laboratory service prestated they will train phlebotomis abuse prevention policy prior to the working in facility. B. Facility Maintenance Director conducted visual inspection of faceilings on 2/27/2019 to ensure rareas had holes in need of repair residents in rooms with visible significations and reporting with holes resident rooms with evidence of admage. 3) The Facility implemented the systemic changes to ensure cited deficiency does not reoccur: A. Management of the Laboratory Phlebotomist were trained on 2/7 facility Registered Nurse Clinical Competency Nurse regarding fact policy related to abuse prevention identification, and reporting. On 2 Management of the Laboratory Phlebotomist told the Registered Clinical Competency Nurse they ensure staff assigned to the facility ensures the facili	esidents s as rovider to ility ing facility de timely t of rovider st on them acility no other r or gns of ot show or water e following d ory 7/2019 by cility in, 2/7/2019 I Nurse would		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED	
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		345378	B. WING		02/08/2019
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				ROCKINGHAM, NC 28379	
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F 835 C	Continued From page	e 67	F 83	,	e o o de

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F 835	Continued From page	e 68	F 83	and a copy of the form iden problem ceiling is given to the Maintenance Director. 4) To ensure solutions are facility will implement the form procedures to monitor perform. A. Facility Starting 3/1/20. Administrative personnel intrandom contracted service facility residents regarding from policy with scenarios to ensure able to implement facility procedure regarding staff to abuse identification and reprocedure regar	e sustained to allowing promance: 19 facility terviewed 4 providers to facility abuse aure contract whedge of artity policy and president porting week or three eafter. Resulted by RN inator or allity Quality provement onths then are continued be Director with the continued are continued as a committee of	e ed dd dd dy ts rill ed dd		

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F 840 F 840 SS=D	qualified professional service to be provided must have that service person or agency out arrangement described. Act or an agreement (2) of this section. §483.70(g)(2) Arrang section 1861(w) of the pertaining to services resources must speciassumes responsibilit (i) Obtaining services standards and princip professionals providing and (ii) The timeliness of the This REQUIREMENT by: Based on record reviand laboratory staff in ensure contracted staresidents within the fastandards of care for for 1 of 2 residents (Fastaff to resident physiam The findings included Resident #1 was admits a great or agency of the provided resident physiam The findings included Resident #1 was admits agreement of the provided resident physical page 1.	tside resources. acility does not employ a person to furnish a specific d by the facility, the facility e furnished to residents by a side the facility under an ed in section 1861(w) of the described in paragraph (g) ements as described in e Act or agreements furnished by outside fy in writing that the facility ty for- that meet professional oles that apply to ng services in such a facility; the services. The is not met as evidenced sew, facility staff interview, hereview, the facility failed to acility met professional immediately reporting abuse desident #1) sampled for cal abuse.		840	1)Processes that lead to the deficiency cited were Laboratory Phlebotomist fail to follow contractual standards of condirelated to resident safety as well as facility and procedure related to reportir of abuse to facility when they did not immediately report the incident after witnessing it on 1/9/2019. Laboratory Phlebotomist was verbally trained via phone by Assistant Director of Nursing regarding timely and appropriate abuse	ed uct illity ng	3/14/19
	12/21/18 with diagnos aphasia, and dement	ses that included stroke, ia.			reporting on 1/9/2019. 2)The procedure for implementing an		

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 840	not completed in the resident interview for interview for mental sassessed with inatter thinking fluctuating in An initial allegation (2 completed by the Adrallegation of staff to rincident occurred on AM and the facility be on 1/9/19 at 1:15 PM stated that Laborator witnessed Nursing As Resident #1 on her leher by the shirt. LP sroom with Resident # touched anymore by (NA #1 and NA #2) wand LP pushed Resident murse's station. mental injury/harm rebruise to the face are form was completed 1/9/19. A phone interview was 2/5/19 at 2:24 PM. SAM and 6:00 AM on hit Resident #1 on the fist and then on the lehand as NA #2 held if the shoulders (from be her wheelchair. LP reported the incident	area of cognition as the mental status and staff status were blank. She was ntion and disorganized presence. 24-hour report) dated 1/9/19 ministrator indicated an resident physical abuse. The 1/9/19 at approximately 5:15 recame aware of the incident. The allegation details y Phlebotomist (LP) resistant (NA) #1 "strike" reft shoulder while NA #2 held retated that she stayed in the reft to ensure she was not NA #1 or NA #2. Both NAs rere noted to leave the room dent #1 in her wheelchair to the details of physical or read, "Body audit revealed rea [of Resident #1]." This by the Administrator on the stated that between 5:00 1/9/19 she witnessed NA #1 recheek area with a closed reft shoulder with an open resident #1 by her shirt at behind) to keep her seated in revealed she had not	F	840	acceptable Plan of correction including identification of other potential resident affected for the deficiency cited is as follows: On 2/7/2019 Management of contracte Laboratory service provider to facility received training from facility Registere Nurse(RN) Clinical Competency Coordinator regarding facility abuse prevention policy to include timely reporting of abuse. Management of contracted Laboratory service provider stated they will train phlebotomist on abuse prevention policy prior to them working in facility. 3)The Facility implemented the following systemic changes to ensure cited deficiency does not reoccur: Management of the Laboratory Phlebotomist were trained on 2/7/2019 facility Registered Nurse Clinical Competency Nurse regarding facility policy related to abuse prevention, identification, and reporting. On 2/7/2019 Management of the Laboratory Phlebotomist told the Registered Nurse Clinical Competency Nurse they would ensure staff assigned to the facility receive training prior to working with facility residents. By 3/12/2019 facility F Clinical Competency Coordinator completed training for other contracted service providers to facility residents regarding facility abuse policy to includitimely reporting of possible abuse.	d d by 19 RN	
		NA #2 were friends with			facility will implement the following	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
				_		(
		345378	B. WING _			02/	08/2019
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		04 SOUTH LONG DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 840	retaliation from the stashe phoned her supershe left the facility to a instructed her to reposit administration. She state a left the facility to a distribute of the ADON and she wan information got into the was taken seriously. In phoned the ADON late 10:00 AM/11:00 AM to was asked why she has ADON was not presenso she proceeded to be the ADON when she haway from work. The until that afternoon, 1 werbal statement to the She explained that she work and was unable account of the incider 1/9/19. A phone interview was supervisor on 2/6/19 at that the LP contacted immediately after leave to him the allegation of the stated that he instacility is administration. The LP is supervisor any training to their energorting allegations of the state of the reporting allegations of the state of the state of their energy allegations of the state of the state of their energy allegations of the state of their energy allegations of the state of the state of their energy allegations of the state of their energy allegations of the state	dn't felt comfortable to her because she feared aff. The LP reported that rvisor around 7:00 AM when report the incident and he rt the incident to the facility tated that she had a good assistant Director of Nursing ted to make sure the ise right hands and that it She reported that she er that morning around or report the incident. She ad waited until 10:00 e stated that she knew the int at the facility at 7:00 AM her next job and she phoned had an opportunity to step e LP stated that it was not report the incident and gotten tied up with to provide a detailed int until after 1:00 PM on s conducted with LP's at 4:35 PM. He confirmed him by phone on 1/9/19 ring the facility and reported of staff to resident abuse. ructed her to contact the on and report the incident. was asked if they provided in any training related to	F	840	procedures to monitor performance: Starting 3/1/2019 facility Administrative personnel interviewed 4 random contracted service providers to facility residents regarding facility abuse policy with scenarios to ensure contracted service providers have knowledge of at are able to implement facility policy and procedure regarding staff to resident abuse identification and reporting week for 4 weeks, then monthly for three months, and quarterly thereafter. Resure of interviews will be presented by RN Clinical Competency Coordinator or Facility Administrator to facility Quality Assurance Performance Improvement Committee monthly for 4 months then quarterly thereafter to ensure continued compliance. 5)Compliance Date 3/14/2019	d d dly lts	

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		345378	B. WING _			02/	08/2019		
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-ROCKINGHAM				80	TREET ADDRESS, CITY, STATE, ZIP CODE 14 SOUTH LONG DRIVE OCKINGHAM, NC 28379				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
F 840	Continued From page 72 An interview was conducted with the ADON on 2/5/19 at 4:20 PM. She stated that the LP contacted her by phone on 1/9/19 around 10:00 AM and reported an incident of staff to resident abuse. She indicated the LP had not provided her with the resident 's name or the staff members name during this phone call. The LP reported to the ADON that she walked into a resident 's room and she saw 1 staff member standing behind the resident "restraining" her in the wheelchair while the other staff member hit the resident from the front. The ADON indicated the LP told her that she had not wanted to get involved, but that she also knew it was her job to protect the residents. She indicated that the LP was at work while she was reporting this information and she told the ADON she had to call her back later. The ADON stated that it was not until later that afternoon that she and the Administrator spoke to the LP by phone to obtain the more detailed verbal statement which allowed them to initiate an investigation. An interview was conducted with the Administrator confirmed the LP had not immediately reported the allegation of staff to resident abuse. She was asked who was responsible for providing training on abuse reporting to their contracted providers, such as the LP. She stated that she was not sure, but she thought the contracted provider was responsible for providing training to their own staff. She revealed she had not checked with the laboratory company after this 1/9/19 incident to verify if training on abuse reporting had been provided to their staff. A follow up interview was conducted with the		F	340					

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		345378	B. WING _			1	08/2019
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-ROCKINGHAM				STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379			
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F 840	that she expected con professional standard	e 73 19 at 10:33 AM. She stated intracted providers to meet is of practice and report any abuse to her immediately.	F8	40			