DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR									
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
345378		B. WING _			C 04/18/2022				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE				
	EALTH-ROCKINGHAM			804 SOUTH LONG DRIVI	E				
FROM				ROCKINGHAM, NC 28379					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	OULD BE COMPLETION			
F 000	INITIAL COMMENTS		FC	00					
		site complaint survey was . 1 of 3 allegations for intake ostantiated resulting							
F 623 SS=B	Notice Requirements Before Transfer/Discharge		Fe	23		4/29/22			
	<ul> <li>§483.15(c)(3) Notice before transfer.</li> <li>Before a facility transfers or discharges a resident, the facility must-</li> <li>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</li> <li>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</li> <li>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</li> </ul>								
	<ul> <li>(c)(8) of this section, f</li> <li>discharge required ur</li> <li>made by the facility a</li> <li>resident is transferred</li> <li>(ii) Notice must be ma</li> <li>before transfer or disc</li> <li>(A) The safety of indiv</li> <li>be endangered under</li> <li>this section;</li> <li>(B) The health of indiv</li> </ul>	d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the d or discharged. ade as soon as practicable							
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITL	E	(X6) DATE			

**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.

04/29/2022

PRINTED: 05/16/2022

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/16/2022 APPROVED D: 0938-0391		
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 04/18/2022			
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
PRUITTHE	EALTH-ROCKINGHAM			804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE		
F 623	this section; (C) The resident's hea allow a more immedia under paragraph (c)(7 (D) An immediate tran required by the reside under paragraph (c)(7 (E) A resident has nor days. §483.15(c)(5) Conten notice specified in pai must include the follo (i) The reason for tra (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such reques to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omt (vi) For nursing facility and developmental dia disabilities, the mailin telephone number of the protection and ad developmental disabi C of the Developmen and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility	alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 ats of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; nich the resident is rged; e resident's appeal rights, iddress (mailing and email), er of the entity which its; and information on how orm and assistance in and submitting the appeal es (mailing and email) and the Office of the State oudsman; y residents with intellectual isabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402,	F	623					

Facility ID: 923337

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	-	D HUMAN SERVICES			FOR	D: 05/16/2022 M APPROVED	
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345378	B. WING		C 04/18/2022		
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	ALTH-ROCKINGHAM		8	04 SOUTH LONG DRIVE			
FROITINE			R	OCKINGHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (X5) ACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 623	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally III Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents and staff, the facility failed to notify the resident and/or resident's responsible party in writing of the reason for transfer/discharge for 2 of 3 sampled resident #2, Resident #3). The findings included: 1.Resident #2 was admitted to the facility on 4/23/2021. Resident #2's quarterly Minimum Data Set (MDS) dated 1/3/2022 indicated the resident was		F 623	Corrective Action for the Resident Affected Resident # 2 was transferred on 2/8 and re-admitted on, 02/11/2022. Re #3 was transferred on 3/15/22 and re-admitted on 03/18/2022. On 04/25/2022, the Director of Nursing Services, (DNS) visited resident #2 a #3 and discussed their transfer to hospital. Corrective Action for Residents Pote	sident and		
	-	- , ,		Affected			

Event ID: TITJ11

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING \_\_\_\_ С 345378 B. WING 04/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **804 SOUTH LONG DRIVE** PRUITTHEALTH-ROCKINGHAM **ROCKINGHAM, NC 28379** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 623 Continued From page 3 F 623 cognitively intact. All residents have the potential to be Record review revealed Resident #2 was affected. On 04/20/2022, the Business discharged to the hospital on 2/8/2022. Office Manager reviewed residents being Documentation indicated the resident's transferred/discharged over last 30 days. representative was notified by phone. There was Approximately 3 residents were no documentation a written notification of transferred to another skilled facility and transfer/discharge was completed. or hospital and 1 was discharged home. During an interview on 4/18/2022 at 10:50 AM Systemic Changes Resident #2 non-verbally indicated (by shaking her head side to side) she received no written On 04/21/2022, an in-service was initiated notification of the reason for her transfer to the to DNS, Assistant Director of Nursing hospital on 2/8/2022. Services, (ADNS) and the Business Office Manager, (BOM) by the Administrator. An interview was conducted with the Admissions Director on 4/18/2022 at 2:00 PM. He stated he The in-service consisted of reviewing the was not responsible for providing the resident NC Medicaid form-9050 (Nursing Home and/or resident's responsible party with written Notice of Transfer/Discharge), when to notification of the reason for transfer/discharge to issue and notification to resident and/or the hospital. The written notice of resident□s representative(s). The transfer/discharge was previously the Administrator also provided education on responsibility of the Social Worker (SW). He documentation of discharges to include: further stated the facility did not have a SW and reason for discharge, resident⊡s had been without a SW for 7-8 months. The condition prior to discharge, whom the Admissions Director stated the duties of the SW resident was discharged with (EMS, were being covered by several different staff family), physician order with members including the Business Office Manager. MD/responsible party notification. The Business Office Manager was on vacation. On 04/21/2022, an in-service was initiated to the licensed nurses by the DNS and or Attempts to contact the Business Office Manger were not successful. ADNS. The in-service consisted of reviewing the NC Medicaid form-9050 On 4/18/2022 at 2:25 PM an interview was (Nursing Home Notice of conducted with the Director of Nursing (DON). Transfer/Discharge), when to issue and notification to resident and/or resident s She stated providing the written notification of the reason for transfer/discharge to the hospital was representative(s). The DNS and or ADNS normally the responsibility of the SW. The facility also provided education on did not have a SW and she did not know how documentation of discharges to include: long the facility had been without a SW. She reason for discharge, resident⊡s

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 05/16/2022

		MEDICAID SERVICES					<u>VO. 0938-03</u>
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 04/18/2022	
345378							
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-ROCKINGHAM					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 PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETIO DATE	
F 623	Continued From page	24	F 6	23			
	10	e was no SW the Business		20	condition prior to discharge, whom the		
		I) was responsible for			resident was discharged with (EMS,		
	providing the notificat			family), physician order with			
	could not find any doo			MD/responsible party notification. Any	/		
	responsible party rece			staff unavailable will receive the			
	included the reason for			re-education prior to next scheduled sl			
	2/8/2022 hospitalizati	on.			New hires will receive education during	g	
	2. Resident #3 was a 5/6/2020.	dmitted to the facility on			the orientation process.		
					The DNS, ADNS and or BOM will cond		
	-	ly Minimum Data Set (MDS)			random reviews of resident⊡s dischar	ges	
	dated 11/4/2021 indic cognitively intact.			to emergency room/hospital to ensure documentation complete to include			
					reason for discharge, resident		
	Record review reveal	ed Resident #3 was			condition prior to discharge, whom the		
	discharged to the hos	pital on 3/15/2022 for			resident discharged with (EMS, family)		
	-	and signs of urinary tract			physician order with MD and responsit	ble	
	infection. Documenta	tion in the medical record			party notification on residents 2 times	а	
		's responsible party (RP)			week for 8 weeks then weekly for 4		
	-	e of the resident's transfer.			weeks.		
	There was no documentation a written notification of transfer/discharge was completed.						
	of transfer/discharge	was completed.			Quality Assurance		
	During an interview o	n 4/18/2022 at 10:45 AM			The result of these reviews to be		
	-	ally indicated (by shaking			submitted to the QAPI Committee by the	he	
		he received no written			DNS for review by the IDT members		
		son for his transfer to the			monthly. Quality monitoring schedule		
	hospital on 3/15/22.				modified based on findings. The QAPI		
					Committee to evaluate the effectivenes	SS	
		ducted with the Admissions 2 at 2:00 PM. He stated he			and modify monitoring as needed.		
		or providing the resident			Date of compliance		
	and/or resident's resp			4/29/2022			
		son for transfer/discharge to					
	the hospital. The writt						
	transfer/discharge wa						
		ocial Worker (SW). He					
	further stated the faci	lity did not have a SW and					

Facility ID: 923337

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO. (	PPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE <sup>-</sup>	RVEY
		345378	B. WING		C 04/18	/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
PRUITTH	EALTH-ROCKINGHAM			804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETION DATE
F 623	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 had been without a SW for 7-8 months. The Admissions Director stated the duties of the SW were being covered by several different staff members including the Business Office Manager. The Business Office Manager was on vacation. Attempts to contact the Business Office Manger were not successful. On 4/18/2022 at 2:25 PM an interview was conducted with the Director of Nursing (DON). She stated providing the written notification of the reason for transfer/discharge to the hospital was normally the responsibility of the SW. The facility did not have a SW and she did not know how long the facility had been without a SW. She stated that since there was no SW the Business Office Manager (BOM) was responsible for providing the notification. She further stated she could not find any documentation Resident #2's responsible party received a written notice that included the reason for transfer/discharge for the 2/8/2022 hospitalization.		F 623			

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