	-	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		, ,		(X3) DATE SURVEY COMPLETED	
		345378	B. WING		C 05/24/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
DDUUTTU			8	04 SOUTH LONG DRIVE	
PRUITIHE	EALTH-ROCKINGHAM		F	ROCKINGHAM, NC 28379	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD B           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)				
F 000	INITIAL COMMENTS		F 000		
	was conducted 5/23/2 NC00198369, NC001 NC00202278, NC002	site complaint investigation 2023 through 5/24/2023. 98329, NC00202322, 201958, NC00199841, 99073, NC00198855, and vestigated.			
	17 of 17 allegations did not result in a deficiency. Event ID# SWZO11				
F 641 SS=B	, ,	ents	F 641		6/15/23
	resident's status.	of Assessments. t accurately reflect the is not met as evidenced			
	Based on record rev facility failed to code	iews and staff interviews, the the Minimum Data Set		Corrective Action for the Residents Affected	
		ly in the area of Activities of or 4 of 13 resident records #4, #5, #6 and #8).		On 6/13/2023, resident #4⊡s MDS assessment ARD was modified for toil use in section G by the MDS nurse.	et
	<ul> <li>The findings included:</li> <li>1. Resident #4 was admitted to the facility on 1/16/23 with diagnoses that included dementia and a stroke affecting the left side.</li> <li>a. The admission Minimum Data Set (MDS) assessment was dated 1/23/23. The Functional Status section indicated Resident #4 required</li> </ul>			On 6/13/2023, resident #5⊡s MDS assessment was modified for toilet use section G by the MDS nurse. On 6/13/2023 resident #6⊡s MDS	in
				assessment was modified for toilet use section G by the MDS nurse.	in
	toilet use was coded	with dressing, was al hygiene and bathing, but as the activity did not occur period. The Bladder and		On 6/13/2023, resident #8⊡s MDS assessment was modified for toilet use section G by the MDS nurse.	in
		ed Resident #4 was always		Action for the Residents Potentially	
					(X6) DATE
		SUPPLIER REPRESENTATIVE'S SIGNATUR	Ē	TITLE	
∟iectroni	cally Signed				06/16/202

**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.

PRINTED: 07/18/2023

	S FOR MEDICARE &	MEDICAID SERVICES					O. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345378	B. WING			C 05/24/2023	
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-ROCKINGHAM		804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379				
				RU			
(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 641	Continued From page	e 1	F 64	1			
	incontinent.				Affected		
	b. The quarterly Minir	num Data Set (MDS) ed 4/20/23. The Functional			On 6/14/2023, the MDS nurse reviewed assessments for 31 resident related to	d	
	Status section indicat			toilet use. Of the 31 assessments			
	extensive assistance			reviewed 31 were noted to be coded			
	hygiene, and bathing,			incorrectly. Of the 31 assessments coo	ded		
	the activity did not oc			incorrectly, section G was properly			
	period. The Bladder a			assessed.			
	Resident #4 was alwa	ays incontinent.			Systemic Changes		
	A review of the nursin	ng progress notes from			Systemic Ghanges		
	1/16/23 through 5/23/			On 6/14/2023, he Clinical Reimbursem	ent		
	required assistance w			Consultant in-serviced the MDS nurse			
	use.				and the Administrator on proper coding		
	On 5/22/22 at 2:00 D	M an interview with the MDS			the MDS and accuracy of assessments On 6/14/2023, the Administrator	5.	
	Nurse was conducted			in-serviced the DHS, RN Supervisor,			
	and 4/20/23 MDS ass			Therapy Outcomes Coordinator, Social			
	toilet use portion was			Worker, and Activity Director on MDS			
	not occur during the l			coding and accuracy of assessments.			
	explained she was ne			The facility has reviewed its MDS			
	u u u u u u u u u u u u u u u u u u u	he section that way if the			Assessment Accuracy Policy with no		
	incontinence.	cally use the toilet due to			revisions needed.		
					Quality Assurance		
		d with Nurse #3 on 5/24/23 at					
		miliar with Resident #4 and			The Administrator, the Director of Healthcare Services and/or the RN		
		tensive to total assistance ovided assistance with			Supervisor will review the accuracy of 3	3	
		ery two to three hours and as			assessments per week x4 weeks and	-	
	needed.	,			then 5 assessments per month for 3		
					months, utilizing the QA Monitoring Toc	bl	
		AM, the Administrator was			for Accuracy of Assessments.		
		d it was his expectation for			The regults of the MDC accuracy sector		
	assessment	ts to be coded accurately.			The results of the MDS accuracy review will be submitted to the Quality Assurar		
					Performance Improvement (QAPI)	100	
	2 Resident #5 was a	dmitted to the facility on			Committee by the DHS and or ADHS for	hr.	

Event ID: SWZO11

Facility ID: 923337

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		MEDICAID SERVICES		E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY		
AND PLAN OF CORRECTION		· · ·	A. BUILDING	COMPLETED			
					С		
		345378	B. WING	05/24/2023			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHEALTH-ROCKINGHAM							
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE		
F 641	Continued From page 2 1/16/23 with diagnoses that included history of a		F 64	1 review by the Interdisciplinary Tea	n		
	stroke and muscle we			members monthly or until three mo compliance is sustained. Quality monitoring schedule modified base	onths of		
	assessment was dated 1/23/23. The Functional Status section indicated Resident #5 required extensive assistance with dressing, was dependent for personal hygiene and bathing, but toilet use was coded as the activity did not occur during the look back period. The Bladder and Bowel section indicated Resident #5 was always incontinent.			findings. The QAPI Committee to evaluate and modify monitoring as needed.			
				Date of compliance: June 15, 2023	3		
	4/21/23. The Function Resident #5 required dressing, was dependent and bathing, but toile						
	A review of the nursing progress notes from 1/16/23 to 5/23/23 revealed Resident #5 required assistance with ADLs to include toilet use and incontinence care.						
	5/23/23 at 10:51 AM, incontinent of bowel a	d with Resident #5 on who confirmed she was and bladder. She stated the nence care every two to equested.					
	1:57 PM, who was fa explained Resident # and bladder and rece	vas interviewed on 5/23/23 at miliar with Resident #5. She 5 was incontinent of bowel eived total assistance with ery two to three hours and as					

	-	D HUMAN SERVICES				FORM	0: 07/18/2023		
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345378	B. WING			05/2	C 24/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE				
				804 SOUTH LONG DRIVI	E				
PRUITTHEALTH-ROCKINGHAM				ROCKINGHAM, NC 2	8379				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 641	Continued From page	2.3	F 64	41					
	MDS Nurse was comp 1/23/23 and 4/21/23 M verified the toilet use p activity did not occur of back period. She expl position and had been that way if the resident toilet due to incontined On 5/24/23 at 10:40 A interviewed and stated the MDS assessment 3. Resident #6 was ac 11/14/18 with diagnos weakness and lack of a. A quarterly Minimul assessment was date Status section indicate extensive assistance dependent for bathing as the activity did not period. The Bladder a Resident #6 was alwa b. A quarterly MDS as 4/22/23. The Function Resident #6 required personal hygiene and coded as the activity of back period. The Blac	M, the Administrator was d it was his expectation for s to be coded accurately. dmitted to the facility on ses that included muscle coordination. m Data Set (MDS) d 1/23/23. The Functional ed Resident #6 required with personal hygiene, was g, but toilet use was coded occur during the look back and Bowel section indicated ays incontinent.							

Facility ID: 923337

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	-	D HUMAN SERVICES				FORM	: 07/18/2023 APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		345378	B. WING		_	05/2	C 24/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-ROCKINGHAM		-	04 SOUTH LONG DRIVE ROCKINGHAM, NC 283	79		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	required assistance we use. On 5/23/23 at 3:00 PM MDS Nurse was comp 1/24/23 and 4/22/23 M verified the toilet use activity did not occur of back period. She expl position and had beer that way if the resider toilet due to incontine Nurse Aide (NA) #2 w 10:15 AM and explain incontinent of bowel a total assistance with i to three hours and as On 5/24/23 at 10:40 A interviewed and state the MDS assessment 4. Resident #8 was ac 1/6/23 and discharged 2/28/23. Her diagnose and degenerative join The quarterly MDS as indicated Resident #8 assistance with perso toilet use was coded a during the look back p	with ADLs to include toilet M, an interview with the pleted. She reviewed the MDS assessments and portion was marked as the during the seven-day look lained she was new to the in taught to code the section at did not physically use the nce. was interviewed on 5/24/23 at need that Resident #6 was and bladder. She required ncontinence care every two needed. AM, the Administrator was d it was his expectation for s to be coded accurately. dmitted to the facility on d to another facility on es included spinal stenosis t disease. ssessment dated 2/19/23	F 641				
		g progress notes from aled Resident #8 required					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	ED: 07/18/2023 RM APPROVED NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	ITE SURVEY
		345378	B. WING			C 05/24/2023
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO		
PRUITTHEALTH-ROCKINGHAM				04 SOUTH LONG DRIVE ROCKINGHAM, 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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 641	assistance with ADLs Nurse Aide (NA) #1 w 2:10 PM and explained incontinent of bowel at total assistance with it to three hours and as On 5/23/23 at 3:00 PI MDS Nurse was com 2/19/23 MDS assess use portion was mark occur during the seve explained she was ne been taught to code the resident did not physic incontinence.	to include toilet use. vas interviewed on 5/23/23 at ed that Resident #8 was and bladder. She required ncontinence care every two	F 641		.,	

Facility ID: 923337

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