STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	**615 RIDGE ROAD ROXBORO, NC 27573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and compliant investigation survey was conducted on 9/15/24 through 9/19/24 The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #46S011.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 9/15/24 through 9/19/24. Event ID# 46SO11. The following intakes were investigated: NC00218993, NC00218949, NC00218165, NC00209540, NC00219038, NC00221407, and NC00221521. 5 of 14 complaint allegations resulted in deficiency.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with	F 577		10/17/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 10/07/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 1 respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, residents and staff interviews, the facility failed to post the notice of location and make accessible the facility survey results for residents in a wheelchair. This was observed on 4 of 5 days of the survey. The findings included: During initial tour on 9/15/24 at 9: 10 AM, an observation was made of the survey results located in a small hall area near the eye wash station. On a large bulletin board was a black caddy with the survey book, which was not wheelchair accessible. The caddy was in the center of the bulletin board out of reach of residents in wheelchairs. There was no signage posted throughout the facility regarding the availability and location of the recent survey results. Multiple observations were conducted from 9/15/24 to 9/18/24. Observations were made on 9/15/24 at 9:58 AM, on 9/16/24 10:30 AM, on 9/17/24 10:00 AM and on 9/18/24 at 11:02 AM. Observations revealed there was no notice posted in the facility regarding the availability and location of the recent survey results. The location of the survey remained unreachable for residents in wheelchairs.	F 577	Person Memorial Hospital acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of this Summary of the finding is factually correct in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of corrections is submitted as written allegation of the compliance. Person Memorial Hospitals response to the Statement of Deficiencies and the Plan of Correction does not denote agreement With the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Person Memorial Hospital reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal procedures, and/pr other administrative or legal proceedings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	**615 RIDGE ROAD ROXBORO, NC 27573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 2 During the Resident Council Members meeting on 9/18/24 at 11:02 AM, the resident council members who attended the meeting (Resident #28, Resident #25; Resident #21; Resident #10; Resident #22; Resident #18; Resident #44; Resident #20; and Resident #3) stated they had no knowledge of the location of the survey result notebook. The members of the group further stated they were unaware of any signage posted indicating the location of the results. An interview was conducted on 9/18/24 at 11:45 AM, with the Social Worker and the Activity Director, who both confirmed there was no visible posting that informed residents and families where the survey results were located. They both staff stated the survey book was originally located under the bulletin board where the master activity calendar was posted with a sign informing residents/family and visitors. The facility administrator moved the book to the current location and did not post any information of where the book could be found. The Social Worker further stated all the public postings should be accessible to everyone and the previous location was visible upon entry to the facility, however things had been moved out of resident, visitor/family view by the administrator. An interview was conducted on 9/18/24 at 11:56 AM, with the facility Administrator who confirmed the current location of the survey book was not accessible to the residents/families or visitors. He also confirmed there was no visible posting to inform residents/families or visitors of the location of the survey book.	F 577	It is the policy of the facility to provided appropriate information and provide a copy of Survey Results/POC to residents/RP and make publicly available. The Survey Result/POC were openly available in a Blue Binder in a wall pocket attached to the wall in an accessible hallway off the main hall located in front of the Main Nursing Station. The binder was clearly labeled SURVEY / Information and assessable to the public. When made aware of the concern about the potential for WC accessibility the Adm. checked immediately and then contacted maintenance to lower the wall pocket slightly to accommodate more easily. Maintenance checked to ensure other wall pockets were easily assemble to residents in a WC. Corrected 9/18/24 Administrator also posted a sign that day to with an arrow on the wall of the main hall and Nursing station pointing to the location of the Survey Information Binder. A Notice was also posted on the wall alerting the residents and public of the location. These posting went up at the Back Elevator area and in the Activities Room. The notice was also provided to the Admissions Coordinator to add to the new admissions packets going forward on 9/30/24. To be monitored by Admission Coordinator for new admit paperwork and checked by Medical Records with Admission Audits in papers provided.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	**615 RIDGE ROAD ROXBORO, NC 27573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 3	F 577	Admission Coordinator will develop a list of the forms provided to the Resident/RP to sign off on when reviewing the admission packet and agreement and maintained in the admission file. By 10/17/24 Activities Director Posted the Notice of the location of the Survey Information in the Activitieis Room and verbally informed those residents present of the posting and location 9/18/24. AD will request with Resident Council to ask Adm/or assigned to review the current survey results at the October Resident Council meeting scheduled for October 2024 . Staff will be in-serviced by DSD, DON or Adm on the Location of the Survey Results location and the to Included the Grievance Form location by 10/17/24 Processes implemented, task and current Survey POC will be Reviewed at the facility monthly QAPI meetings X3 and ongoing as needed.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC	F 585		10/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	**615 RIDGE ROAD ROXBORO, NC 27573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 4	F 585		

facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 5 conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 585 Continued From page 6

result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on record review, family and staff interviews, the facility failed to provide a written grievance summary for 1 of 1 residents (Residents #24) reviewed for grievances.

Finding included:

Resident #24 was admitted to the facility on 3/5/22.

Review of the quarterly Minimum Data Set (MDS) assessment dated 8/8/24 indicated the Resident #24 was assessed as severely cognitively impaired.

Review of the Grievance /Concern Form dated 6/24/24 indicated a concern that was reported by Resident #24's responsible party (RP) regarding bruising of the resident's left arm, left hand and right forearm. Action indicated was the management was notified, abuse investigation sheet completed, law enforcement was notified and the staff member in question was taken off of the schedule. The form indicated the grievance was under investigation. This was signed by Administrator indicating the grievance was received. There was no indication on the form that indicated the complainant, resident, or family was contacted to inquire if the grievance was resolved to their satisfaction. The grievance was not signed off as resolved.

During an interview on 9/16/24 at 11:50 AM, Resident #24's RP indicated she had reported her

F 585

It is the policy of the facility to have the residents voice grievances; to hear the grievance, investigate, resolve and develop correction action as needed.
The Adm and SS /Grievance coordinator reviewed the Grievance Log and sheet so to review and ensure sign off and noted communication to the resident/RP on 9/30/24. Grievances were presented at QAPI meeting for 10/1/24.
Administrator and SS checked the Grievance Form location of form in the wall pocket on 9/21/24. Forms where present in the wall pocket and public notification was posted at the site on the wall by main nursing station close to the exit door to the stairs.

Grievance will continue to be reviewed at the Morning Management Meeting and SS Grievance Coordinator will inform and document plus monitor for the completion and timeliness of the communication to the resident and family or investigation and action taken as needed. Daily monitoring of grievance investigation will continue to be reviewed on daily business day morning management meeting for completion and outcomes.

DSD, DON, Adm will in-service staff on the location of the grievance process and the form location, recording the resident /RP concerns and having the SS and Adm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 7 concerns about the bruising on resident's arms to the Administrator and to the hospital management. The RP stated both the nursing home administration, and the hospital administration were in the same building and under same management. Resident #24's RP stated she had not been made aware as to how her allegation was investigated nor how it was resolved. She explained no written summary of the grievance investigation or resolution was provided to her. During an interview on 9/16/24 at 3:37 PM, the Social Worker (SW) indicated she was the grievance coordinator. When any grievance was received from any resident or family member by any staff, it was directed to the appropriate department for investigation and resolution. Once the grievance was investigated and a resolution was reached, it would be discussed in the morning team meeting with all nursing staff. The SW further indicated that she would notify the family about the resolution and that the resolution was to the satisfaction of the family/ resident. The resolved Grievance was placed in a folder and entered in the log. The Social Worker stated she was not aware of the grievance written on 6/24/24 from Resident #24's RP and hence not documented in the Grievance log. The SW stated the resident's RP concern was investigated as abuse investigation. Due to being investigated as abuse, the investigation was conducted by the Administrator. During an interview on 9/19/24 at 2:20 PM, the Administrator, stated he had spoken with the resident's RP regarding the abuse allegation 1-2 days after the grievance was received. The Administrator further stated the resident's RP was	F 585	ware to investigate. By 10/17/24 And in-service was conducted with staff on 9/27/24 regarding abuse reporting and the DSD/Don will in-service other shifts on abuse by 10/17/24 Public Posting regarding contact of governmental agencies to report to are posted on the consumer information wall and resident rights posting are located at the consumer wall area, Activities Room , Heritage Room and Employee Break Room . Admin visually checked for posting 10/4/24. The resident in question grievance was reviewed on 10/4/24 by Adm/ SS; summary was noted on grievance of the alleged abuse investigation what was completed acted upon and reported by regulation to appropriate agencies/police. That was timely and the summary to the DHHS was completed on the Alleged Abuse and the summary was completed in that report. Facility will continue to report allegation of abuse per Governmental regulations as out lined for the timely report to local police and regulatory agencies. Abuse cases are reported to Hospital Leadership of the Acute and VP of SNFs and compliance, risk and legal will monitor as occurrence happens for timely investigation and reporting steps. Abuse/ Neglect Allegation will continue to be reviewed at monthly QAPI after theoccurrence.by Admin or assigned. SS/Grievance Coordinator will reach out to family of resident #24 to follow up and document the said interaction and summary of the abuse investigation by 10/17/24 with daughter of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 8 made aware that the abuse allegation was been investigated. The NA involved was suspended and would not be returning to the facility. The NA was an agency staff, and the agency was made aware about it. The Administrator stated he had not documented the resolution as it was an abuse investigation, nor did he record any information regarding his conversation with the family in the grievance form. The investigation findings were sent to the state. He further stated the family was aware of the outcome of the investigation. The family was made aware the allegation was unsubstantiated. The Administrator stated he did not provide them with any written documentation regarding the resolution. He indicated it was an abuse investigation and no findings were discussed with the family. With regards to the grievance given to the Hospital Quality Director, he indicated it was a different entity and unsure of the outcome.	F 585	said resident. On 9/30/24 Admin provided the Admission Coordinator the Grievance process posting to be included the admission paperwork packet going forward and the admission coordinator will develop a list of the admission notices to have resident/Rp acknowledge when receiving the admission papers. By 10/17/24. To be monitored By Admission Coordinator at the time of the completion of the paperwork and medical records on admission audits. AD will review in the monthly Resident Council Meeting (new form developed 10/4/24) To be monitored by Admin, DON on monthly sign off on Resident Council Minutes. Grievance will continue to be monitored as reviewed at Morning Management meetings. Admin will monitor the timeliness and sign off with SS/Grievance Coordinator. Will ne reviewed and monitored at monthly QAPI meeting X3 months an on-going as needed	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide fingernails and	F 677	It is the policy of the Facility to provide for the ADL /care of dependent residents.	10/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 677 Continued From page 9

toenails care for 2 of 2 residents, dependent on staff for activities of daily living (ADL) care. (Resident # 37 and Resident #24)

Findings included:

1. Resident #37 was admitted to the facility on 6/20/23 with diagnoses that included Parkinson disease.

Review of the Annual Minimum Data Set (MDS) assessment dated 6/26/24 revealed the resident was assessed as moderately cognitively impaired. The assessment indicated that Resident #37 was dependent on staff for Activities of Daily Living (ADL) including personal hygiene, toileting and showers/ bathe self.

Review of the care plan dated 6/27/24 indicated the resident was care planned for ADL self-care performance deficit due to impaired balance, activity intolerance, and confusion. Interventions for bathing and showering included checking nail length, trimming and cleaning on bath day and as necessary. The resident was totally dependent on staff to provide bed bath and/or shower.

The "Skin monitoring: comprehensive Certified Nurse Aide (CNA) shower review" for 9/12/24 and 9/16/24 were reviewed. On the form the question does the resident need his/her fingernails/toenails cut? Was marked as "NO".

Review of the ADL Tracking Documentation for August and September 2024 revealed bathing activity was marked on every Monday and Thursday of the week during the 3 PM- 11 PM shift. The resident was noted to be totally dependent on staff and needed one-person

F 677

When made aware of the concern the Acting DON printed a list of the residents in house 9/17/24 and did a visual assessment of nails. She assigned along with the DSD the Licensed Nurses to check provide nail care as needed and per residence acceptance of service.
DON and DSD immediately worked with nursing staff to ensure residents in question when made aware of concern were provided services for nail care.
Diabetic residents were accessed by nursing for the need of nail care and the DON/DSD Charge nurses will coordinate obtaining needed orders and services at outside providers upon availability of the provider by 10/17/24. There is no local podiatry provider so facility will continue to reach out to other areas for a provider to service resident’s needs. This is to be monitored by review of the weekly bath sheets and Charge Nurses with weekly oversight monitoring by DON, DSD an at quarterly care plan reviews as assigned for residents via MDS cycle.
CNAs will be in-serviced by DSD, DON on proper completion, reporting need for nail care and providing nail care to non-diabetic residents. Staff person and Licensed Nurses will be in-service by 10/17/24 on proved supervision of resident care and follow up on report from CNAs of needs from Shower Sheet observation from the time of shower an ADL care.
To be monitored daily by Charge Nurses and weekly reviewed of Shower sheets by DON/DSD for need follow up of care.
To be reviewed and monitored at monthly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 10 physical assistance. The documentation did not indicate if the resident received a bed bath or shower. During an observation and interview on 9/15/24 at 10:20 AM, Resident #37's fingernails on both her hands were observed to be about 1 to 1 and one fourth inch long from the nail bed. There was some light black deposit under the fingernails. The resident stated she preferred her fingernails trimmed, however there was on one who could trim her nails. During an interview on 9/16/24 at 10:33 AM, Resident #37 indicated she had asked a Nurse Aide (NA) to trim her nails in the morning. The NA had reported to her that her nails would be cleaned and trimmed at 2 PM that day. Resident indicated she wanted her nails cleaned and trimmed so she asked the NA who was assisting her with care that morning. During an observation on 9/17/24 at 8:25 AM, Resident #37 was observed propped up in her bed and turned to her left side. Observation revealed the resident's fingernails were not trimmed. Resident indicated no staff had come back to trim her nails on 9/16/24. On 9/17/24 at 8:38 AM, Nurse #5 was interviewed. Nurse #5 observed Resident #37's fingernails and indicated the resident's nails should have been trimmed. Nurse #5 stated when residents were provided a bed bath or shower, the assigned NA completed a skin and nails check. The NA should indicate on the shower sheets if the nails needed to be trimmed and/or if the nails were trimmed. Nurse stated if the resident was not diabetic then the NAs could trim	F 677	QAPI for services level and compliance. Of care X3 months. Administrator will continue seek in-house podiatry provider , if none available residents will be transported to service provided as needed with available health professional out of market To be reviewed and monitored at monthly QAPI x3 months an on going as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11	F 677		

their nails. However, if the resident was diabetic then the NA needed to inform the assigned nurse. Resident #37 was not diagnosed with diabetes mellitus and the NA should have trimmed her nails. Nurse#5 stated the resident received a completed bed bath the day prior (9/16/24) and should had her nails checked and trimmed.

During an interview on 9/19/24 at 10:12 AM, NA #1 indicated she was assigned to Resident #37 and had offered a bed bath on 9/16/24. NA #1 stated the resident did not request her to trim her nails on the 9/16/24. NA indicated skin and nails check were completed during bed bath and/or shower. Nails were trimmed if needed. NA indicated she had not noticed the resident's fingernails and hence had not trimmed them.

During an interview on 9/17/24 at 8:44 PM, the Director of Nursing (DON) stated the NAs were responsible to trim residents' finger and toenails when the residents were not diabetic residents. The DON further stated the NAs had to complete a full body check when bed bath or shower was offered. The DON observed Resident #37's fingernails and stated the assigned NAs should have trimmed her nails when a complete bed bath was offered.

2. Resident #24 was admitted to the facility on 3/5/22 with diagnoses that included secondary malignant neoplasm of the bone.

Review of the quarterly Minimum Data Set (MDS) dated 8/8/24 indicated the resident was assessed as severely cognitively impaired. The assessment indicated that the resident was dependent on staff for Activities of Daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	**615 RIDGE ROAD ROXBORO, NC 27573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677		F 677		

Continued From page 12

A revised care plan dated 8/9/24 indicated Resident #24 was care planned for ADL care due to diagnoses of cancer, dementia and depression. Interventions included providing a sponge bath when a full bath or shower was not tolerated. Resident was totally dependent on staff for showers and bed bath. NAs to provide skin inspection daily with care.

On 9/15/24 at 10:06 AM, during an observation, Resident #24's toes nails on both feet were observed to be one and a half inches beyond the nail bed. The pinky toe nails on both feet had toenails growing into the toe next to it.

On 9/17/24 at 1:25 PM, during the observation of incontinence care, Resident #24's toenails were observed clean and approximately one and a half inches long, with deformities. The resident did not have signs of discomfort.

During an interview on 9/19/24 at 10:12 AM, NA #1 indicated she was assigned to Resident #24. NA stated the resident received bath and showers from both facility and hospice staff. NA indicated she did provide the resident a bed bath and had not looked at or noticed the resident's toenails.

During an interview on 9/17/24 at 8:38 AM, Nurse #5 stated the resident was under hospice care. Both facility staff and hospice staff provided care for the resident. Nurse #5 stated the hospice staff were responsible for trimming resident's nails.

During a telephone interview on 9/19/24 at 8:23 AM, the hospice nurse stated the hospice NAs do not trim the resident's finger or toenails. It was the responsibility of facility nursing staff to provide nail care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	**615 RIDGE ROAD ROXBORO, NC 27573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 13 During an interview on 9/17/24 at 8:44 PM, the Director of Nursing (DON) indicated the NAs were responsible to trim residents' finger and toenails when the residents were not diabetic residents. The DON further stated the NAs had to complete a full body check when bed bath or shower was offered. The DON stated the nursing staff should be checking and providing nail care to all residents as needed.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to provide an on-going activity program that met the individual interest and needs for 3 of 3 cognitively impaired residents reviewed for activities(Resident #22, Resident #27 and Resident #28). The findings included: 1.Resident #22 was admitted to the facility on 4/14/22 . The diagnoses included cognitive impairment and dementia. Resident #14 was	F 679	It is the policy of the facility to provide activities that meet the needs and interests the residents. Admin and AD spoke about the activity start times and potential adjustments on 9/20/24. AD will see if start times are in agreement with residents and review at the next resident council meeting in October 2024. Input of the residents will be accessed when planning activities for future events.	10/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	**615 RIDGE ROAD ROXBORO, NC 27573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 14 coded on the annual Minimum Data Set(MDS) dated8/24/24 as having cognition impairment and she needed assistance with activities. The MDS also coded Resident 22 's activity interest as very important to participate in favorite activities to include music, religious service and outside events. The resident was coded for total assistance with transfers and locomotion. The annual activity assessment dated 8/24/24 revealed Resident #'22s preference with interest in listening to music, religious services, and outside events. A focus area on the care plan dated 8/25/24 revealed Resident #22 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations. The goal included Resident #22 would maintain involvement in cognitive stimulation, social activities as desired. The interventions included to ensure the activities Resident #22 attended was compatible with physical and mental capabilities; compatible with known interests and preferences; adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), compatible with individual needs and abilities and age appropriate. Invite the resident to scheduled activities. Introduce the resident to other residents in similar activities. The facility developed a list on 8/20/24 of residents who needed assistance to be transported to activities and Resident #22 was identified as person who needed assistance to activities. Record review revealed there were no activity notes available after the assessment 8/24/24 for	F 679	Admin. provided in service nursing and other staff about the importance of offering and getting resident up to daily /coordinating routines and resident requests for activities as desired 9/20/24. DSD/assiged to follow up with further staff in-services by 10/17/24 CNAs will offer and ask residents. Noted residents will be asked staff if they would like to attend activities daily and Nursing will work to provide care and transport timely. To be monitored daily by Charge nurses and all dept heads to encourage residents up and able to attend activities of their choice. CNAs will check the get-up list on day shifts and work to coordinate care to allow those resident desiring to get up for activities; and night nurse along with DON and DSD will review what residents desire to be up early and receive care and be dressed and ready for daily early activities. This will be monitored by Charge Nurses, DON DSD, AD for attendance to activities. DSD and DON will monitor CNAs for routines and coordinating care to multi residents. Administrator request for WC was reviewed and new WC arrived 10/1/24 for use on the ECU. Other devices for resident transport are in the ordering process and communication with vendors and product availability are being monitored by Purchasing/ Material and Adm. weekly until delivered. AD will continue to report the attendance at the Morning Meeting and will report the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 679 Continued From page 15

Resident #22.There were no documented notes of participation in activities for Resident #22 prior to 8/24/24.

The activity calendar on 9/15/24 offered the following activities at 10:00 AM coffee time,10:30AM at 11:00 AM gospel hymns, 1:00 PM-2:00 PM, room visits movies and 2:00 PM-4:00 PM activities with Ladystany. Staff were observed passing by the resident's room and did not stop to offer the resident assistance to participate in the scheduled activity.

An observation was conducted on 9/15/24 at 9:58 AM, there was an activity calendar posted on the resident's bulletin board where resident could see the events of the day. Resident #22 was observed in bed staring at the wall. Resident#22 reported she does like church/gospel events. She reported the activity person does ask but nursing staff does not usually ask. She indicated no one asked her this morning to go anywhere. The scheduled activity for 9/15/24 at 10:00 AM coffee time, 10:30AM at 11:00 AM gospel hymns, Resident #22 was not up or dressed to participate in any of the scheduled activity of her interest.

The activity calendar on 9/16/24 offered the following activities at 10:00 AM devotion, 11:00 AM bowling 11:30 AM snack activity and 2:00 PM-4:00 PM tic-tac-toe.

Observations was conducted on 9/16/24 at 10:00 AM, the scheduled activity was devotion and 10:30 AM, Resident #22 was lying in bed, staring at the wall. The television was not on, and the resident reported she had attended some activities in the past but was not able to get herself up and ready for the activity. She stated

F 679

Daily Activities attendance monthly at QAPI x 3 months to monitor the percentage of residents attending. AD will continue to do daily activity announcement and post the weekly activities on the staff notification page in PCC weekly. Posting to be monitored by Admin, DON for weekly notification of staff, AD will continue to develop the list of residents to assist to activities. Charge nurse will monitor and review at daily shift huddles for those residents that desire to get up. DON/DSD/MDS will review and work with AD and Charge Nurse and CNAs on those residents that may desire to be up early so that the night staff can start to work with those desiring to get up early. This will be dependent on resident choices to be up early and dressed prior to day shift start time. To be monitor with QAPI process and reviewed at monthly QAPI meeting on going. Administrator will monitor resident attendance and input into the activities program on daily rounding of ECU.

AD will ensure that resident preferences are noted in charts and document in plan of care. AD will review all residents' activities plans for preferences by 10/17/24 and work with MDS cycle to update and document at quarterly and annual assessments or when a change in condition of resident and participation level. To be monitored by MDS at time of schedule reviews and reported to Admin for further follow up as needed to ensure activities plans are current in resident records. Process will be monitored and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	**615 RIDGE ROAD ROXBORO, NC 27573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 16	F 679		

she depended on staff. She reported staff don't get most residents up on the weekend. She reported she would have liked to participate in the devotion. Staff were observed in other resident rooms providing care.

An interview was conducted on 9/16/24 at 1:45 PM, with the Activity Director who stated she developed a list of residents who needed staff assistance and transport to activities on 8/20/24 and provided the information to the management team. She indicated several residents who benefited and enjoyed activities were not ready or transported to activities when scheduled activities on their interest was being conducted. The Activity Director stated she would go room by room asking residents to participate and attend activities, but they would not be ready or get to the activity until nearly the end or not at all. She reported the concern was discussed in the management meetings and the plan was for all staff to ask residents if they wanted to participate and attend activities. The nursing team was in-serviced in August to get the identified resident up for activities and transport them to activities. She further stated was unable to escort all the residents, resulting in the identified residents not participating in activities. She further stated she was unaware she needed to document resident participation in the resident record. The Activity Director stated she only kept resident attendance and primarily the same residents attend the activities. She confirmed after review of the record there had been no documented activities notes since 2022 of resident participation in activities.

Observation on 9/16/24 at 2:00 PM, tic -tac-toe in progress: Observation and interview were

reviewed at QAPI for x3 months and ongoing if needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 17	F 679		

conducted and revealed Resident #22 remained in bed watching television. Resident #22 stated she would like to participate in activities, but staff did not get her out of bed, and she would have loved to see what was going on.

An interview was conducted on 9/17/24 at 4:42 PM, with the Administrator who stated the nurse aides were responsible for asking resident daily if they wanted to get up and participate in facility activities. He reported there was a list of residents identified based on the quality improvement of residents who needed assistance with transport to activities. The identified residents included the residents who would participate in activities either morning or the afternoon scheduled activities. The Nurse Aides and Nursing should be asking all residents and assisting residents to the desire activities. The Nurses would document in the record the resident refusal to participate in activities.

An interview was conducted on 9/18/24 at 8:40 AM, with the Staff Development Coordinator who stated all staff were in-serviced on 8/8/24 regarding the quality improvement plan to ensure staff were getting the identified residents who needed assistance with transport to activities up for scheduled activities. Staff were informed to notify the nurse and activity director when a resident refused to get up for an activity and document in the resident record.

An interview was conducted on 9/19/24 at 9:43 AM, with Nurse #1 who stated she worked the weekend and during the week stated and she did not receive a report from any of the aides that any resident on the activity list refused to participate in activities. She indicated the training consisted of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 18 aides reporting to nursing when a resident refused to get up or participate in activities and she would document in the record the resident refused activities. Staff were expected to assist and transport resident to activities. She indicated nursing would attempt to encourage the resident to participation. An interview was conducted on 9/18/24at 10:00 AM, the Nurse Aide#1 who was assigned to Resident #22 stated everyone was responsible for asking residents if they wanted to get up and participate in activities. She reported when she worked on 9/15/24 she did not report to nursing that any of the resident refused activities. An interview was conducted on 9/19/24 at 9:43 AM, the Director of Nursing stated the staff should be encouraging/offering and assisting residents to participate in their preferred activities of interest daily. The Nurse Aide should notify nursing and the Activity Director of any resident who refused activities.Nursing should be documenting in the resident chart when a resident refused participation in activities. An interview was conducted on 9/19/24 at 1:00 PM, with the Social Worker who stated the resident was identified in the quality improvement program as one of the residents who needed assistance to activities. Several meetings and discussions have been held with nursing and management staff about getting resident up and ready for activities and providing transport to the activities, however the nurses and aides continue to not assist residents. Nurse Aides and Nursing staff have received an in-service in August about assisting residents to activities and reporting directly to nurse when the residents on the	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 19	F 679		

identified list refused to get up for activities. Nursing would encourage residents to participate in activities and document in the resident record, however, there had been no consistent follow-up the quality improvement plan.

2. Resident #27 was admitted to the facility on 12/16/22 . The diagnoses included cognitive impairment and dementia. Resident #27 was coded on the Minimum Data Set(MDS) dated 5/10/24 as having cognition impairment and she needed assistance with activities. The MDS also coded Resident #27 's activity interest as very important to participate in favorite activities to include music and news and current events. The resident was coded for total assistance with transfers and locomotion.

The annual activity assessment dated 5/10/24 revealed Resident #'27s preference with interest in listening to music, news, current events bingo, animals, religious events and outside activities.

A focus area on the care plan dated revealed Resident #27 had little, or no activity involvement related to physical limitations and depression. The goal included Resident #27 would express satisfaction with type of activities and level of activity involvement when asked. The interventions included invite/encourage the resident's family members to attend activities with resident to support participation.

The facility developed a list on 8/20/24 of residents who needed assistance to be transported to activities and Resident #27 was identified as person who needed assistance to activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 20	F 679		

Record review revealed there were no activity notes available after the assessment 5/10/24 for Resident #27. There were no documented notes of participation in activities for Resident #27 prior to 5/10/24.

The activity calendar on 9/15/24 offered the following activities at 10:00 AM coffee time, 10:30AM at 11:00 AM gospel hymns, 1:00 PM-2:00 PM, room visits movies and 2:00 PM-4 PM activities with Ladystany. Staff were observed passing by the resident's room and did not stop to offer the resident assistance to participate in the scheduled activity.

An observation was conducted on the hall at 9:55 AM-10:00 AM at 9/15/24 of the Nurse Aide#1 assigned to Resident #27. The Nurse Aide #1 stated the Aides should offer the resident the opportunity to get up and go to the activities of the day and assist with transport to the activity. The Nurse Aide #1 stated if the nurse aides were providing care, they were unable to take residents to activities at the start of the activities and maybe only able to take the residents toward the end of the activity. The Nurse Aide#1 stated she would let the nurse know when a resident refused activities. Nurse Aide#1 did not state why she did not offer the resident assistance to get up for activities.

An observation was conducted on 9/15/24 at 11:30 AM, Resident #27 was in bed she stated she does like to go to activities. She reported on Sunday afternoons her husband and son visits, so going in the morning was fine unless she did not feel well. She reported on the weekends, no one really asks, and she was no sure if activities were happening. She pointed to the calendar on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 21	F 679		

the wall and stated she had not been asked to go to anything in the morning.

The activity calendar on 9/16/24 offered the following activities at 10:00 AM devotion, 11:00 AM bowling 11:30 snack activity and 2:00 PM -4 PM tic-tac-toe.

An observation was conducted on 9/16/24 at 10:30 AM the scheduled activity was devotion; Resident #27 was in her room and staff were observed passing by the resident's room and did not stop to offer the resident assistance to participate in the scheduled activity. Resident #27 was observed in bed humming some church songs in her room. She stated she really loved church services and music and food parties the facility had down in the activity room. She indicated no one came to and get her out of bed anymore for activities. She stated she could not take herself to activities without assistance so just ended up hanging out in bed. Resident #27 further stated she would have liked to go to the devotion activities, but no one asked her if she wanted to get up for activities. Nurse Aide #9 who was assigned to Resident #27 stated she was working with another resident and could not assist with taking resident to the activity. She indicated all residents should be asked if they wanted to participate in activities. She reported she was aware of the list of residents that needed assistance, however, due to care responsibilities she was unable to get residents up early enough prior to the activities. She does her best to get individuals to the remaining activities.

An interview was conducted on 9/16/24 at 1:45 PM, with the Activity Director who stated she developed a list of residents who needed staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 22 assistance and transport to activities on 8/20/24 and provided the information to the management team. She indicated several residents who benefited and enjoyed activities were not ready or transported to activities when scheduled activities on their interest was being conducted. The Activity Director stated she would go room by room asking residents to participate and attend activities, but they would not be ready or get to the activity until nearly the end or not at all. She reported the concern was discussed in the management meetings and the plan was for all staff to ask residents if they wanted to participate and attend activities. The nursing team was in-serviced in August to get the identified resident up for activities and transport them to activities. She further stated was unable to escort all the residents, resulting in the identified residents not participating in activities. She further stated she was unaware she needed to document resident participation in the resident record. The Activity Director stated she only kept resident attendance and primarily the same residents attend the activities. She confirmed after review of the record there had been no documented activities notes since 2022 of resident participation in activities. The activity calendar on 9/17/24 offered the following activities at 10:00 AM pet therapy, 10:30 AM perfection , 11:00AM coffee activity and 2:00 PM-4:00 PM bowling. An interview was conducted on 9/17/24 at 1:46 PM, the scheduled activity was bowling at 2:00 PM. Resident #27 reported staff did not come and ask her if she wanted to participate in activities. She reported she enjoyed the bingo, music. There was an overhead announcement but of the	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 23 activity, but no staff came to the room to ask if she wanted to get up and go to the activity. 3. Resident #28 was admitted to the facility on 6/22/22 . The diagnoses included cognitive impairment and dementia. Resident # 28 was coded on the admission Minimum Data Set(MDS) dated 6/24/24 as having cognition impairment and she needed assistance with activities. The MDS also coded Resident#28 's activity interest as very important to participate in favorite activities to include music, pets group activities, religious services and outside events. The resident was coded for total assistance with transfers and locomotion. The activity assessment dated 7/11/24 revealed Resident #'28s preference with interest include music, pets group activities, religious services and outside events. The resident was coded for total assistance with transfers and locomotion. The facility developed a list on 8/20/24 of residents who needed assistance to be transported to activities and Resident #28 was identified as person who needed assistance to activities. A focus area on the care plan dated 6/25/24 revealed Resident #28 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations. The goal included Resident #28 would maintain involvement in cognitive stimulation, social activities as desired. The intervention included invite the resident to scheduled activities. Staff would provide Resident #28 with an activities calendar. Notify resident of any changes to the calendar of activities. Resident #28 needs	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 24	F 679		

assistance/escort to activity functions.

Record review revealed there were no activity notes available after the7/11/24 assessment for Resident #28. There were no documented notes or participation records for Resident #28 prior to the 7/11/24.

The activity calendar on 9/15/24 offered the following activities at 10:00 AM coffee time, 10:30AM at 11:00 AM gospel hymns, 1:00 PM-2:00 PM, room visits movies and 2:00 PM-4:00 PM activities with Ladystany. Staff were observed passing by the resident's room and did not stop to offer the resident assistance to participate in the scheduled activity.

The activity calendar on 9/16/24 offered the following activities at 10:00 AM devotion, 11:00 AM bowling 11:30 AM snack activity and 2:00 PM-4 PM tic-tac-toe.

An observation was conducted on 9/15/24 at 9:55 AM, Resident #28 was in her resident sitting up in bed. There was no television on, and the resident continued to ask what was going on in the hall area. She reported she liked to go to activities but had to wait for people to come get and get her up and take her down to the room. She indicated no one asked if she wanted to go to the activities. Resident #28 reported she liked to get up every day, enjoyed church music, table activities, bingo and food stuff. The resident was not asked to participate in the scheduled 10:00 AM coffee activity. The assigned Nurse Aide #13 was in another room, all other aides were in other rooms.

Observation was conducted on 9/15/24 at 1:59

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 25	F 679		

PM, Resident #28 resident was not in any activity, she was resident was in her room. She stated was not asked to be taken to any of the activities for the day. Resident #28 stated she did not know what was going on and would have like to go to activities, but no one got her out of bed.

An observation was conducted on 9/16/24 at 10:30 AM, Resident #28 was in her room yelling out to get out of bed, the assigned Nurse Aide #9 was in another room. resident was not taken to the activity room until 11:30 AM. Nurse Aide #9 stated she was working with other residents and had not been able to get the resident up any early. She further stated the nurse aides should offer the resident the opportunity to get up and go to the activities of the day. The nurse aide stated if the nurse aides were providing care, they were unable to take residents to activities at the start of the activities and maybe only able to take the residents toward the end of the activity. She indicated the weekends were very difficult to get all residents to activities due to limited staff.

An interview was conducted on 9/16/24 at 1:45 PM, with the Activity Director who stated she developed a list of residents who needed staff assistance and transport to activities on 8/20/24 and provided the information to the management team. She indicated several residents who benefited and enjoyed activities were not ready or transported to activities when scheduled activities on their interest was being conducted. The Activity Director stated she would go room by room asking residents to participate and attend activities, but they would not be ready or get to the activity until nearly the end or not at all. She reported the concern was discussed in the management meetings and the plan was for all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 26	F 679		

staff to ask residents if they wanted to participate and attend activities. The nursing team was in-serviced in August to get the identified resident up for activities and transport them to activities. She further stated was unable to escort all the residents, resulting in the identified residents not participating in activities. She further stated she was unaware she needed to document resident participation in the resident record. The Activity Director stated she only kept resident attendance and primarily the same residents attend the activities. She confirmed after review of the record there had been no documented activities notes since 2022 of resident participation in activities.

An interview was conducted on 9/17/24 at 4:42 PM, with the Administrator who stated the nurse aides were responsible for asking the resident if they wanted to get up and participate in facility activities. He reported there was a list of residents identified based on the quality improvement of residents who needed assistance with transport to activities. The identified residents included the residents who would participate in activities either morning or the afternoon scheduled activities. The Nurse Aides and Nursing should be asking all residents and assisting residents to the desire activities. The Nurses would document in the record the resident refusal to participate in activities.

An interview was conducted on 9/18/24 at 8:40 AM, with the Staff Development Coordinator who all staff were in-serviced on 8/8/24 regarding the quality improvement plan to ensure staff were getting the identified residents who needed assistance with transport to activities up for scheduled activities. Staff were informed to notify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 27 the nurse and activity director when a resident refused to get up for an activity and document in the resident record. An interview was conducted on 9/19/24 at 9:30 AM, Nurse Aide #13 stated she had been assigned to Resident #28 the weekend and was unable to transport resident to the activity due to assisting other residents. The Nurse Aide #13 stated staff should offer the resident the opportunity to get up and go to the activities of the day. The nurse aide stated if the nurse aides were providing care, they were unable to take residents to activities at the start of the activities and maybe only able to take the residents toward the end of the activity. Nurse Adie #13 stated she did not report any residents who refused activities on the weekend due to being busy providing care. An interview was conducted on 9/19/24 at 9:43 AM, the Director of Nursing stated the staff should be encouraging/offering and assisting residents to participate in their preferred activities of interest daily. The Nurse Aide should notify nursing and the Activity Director of any resident who refused activities. Nursing should be documenting in the resident chart when a resident refused participation in activities. An interview was conducted on 9/19/24 at 1:00 PM, with the Social Worker who stated the resident was identified in the quality improvement program as one of the residents who needed assistance to activities. Several meetings and discussions have been held with nursing and management staff about getting resident up and ready for activities and providing transport to the activities, however the nurses and aides continue to not assist residents. Nurse Aides and Nursing	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 28 staff have received an in-service in August about assisting residents to activities and reporting directly to nurse when the residents on the identified list refused to get up for activities. Nursing would encourage residents to participate in activities and document in the resident record, however, there had been no consistent follow-up the quality improvement plan.	F 679		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 2 of the 33 days reviewed for staffing. The findings included: A review of the daily posted nursing staff forms, daily nursing staff assignment sheets, and staff clock-in sheets from 8/17/24 through 9/18/24 was conducted on 9/19/24.	F 727	It is the policy of the Facility to have a RN 8 hours a day and Full time DON. The Facility is actively recruiting for RN staff and works with agencies for temporary staffing on a contracted period with renewal options if no direct hire staff are available. Facility is following the staffing protocol as directed and provided by governmental policy and regulations. Facility makes every attempt to provide RN coverage of 8 hours daily. Admin	10/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 29 A. On 8/24/24 the daily staff posting indicated 1 RN working day shift (7 AM - 3PM). Daily posting also indicated 2 Licensed Practical Nurse (LPN) and 2 NA working night shift (11PM - 7 AM). Review of the nursing staff assignment sheet for 8/24/24 indicated the RN, Nurse #9, working from 7 AM - 7 PM. The RN, Nurse #9, was also assigned to work as a Nurse Aide from 11 PM to 7 AM. Review of the staff clock-in sheet revealed no RN working from 7 AM - 3 PM shift. Further review revealed there was no RN working for the period of 3 PM -11 PM. An RN, Nurse #9, had clocked in at 11:00 PM. There was only one NA clocked in at 11 PM. During an interview on 9/19/24 at 3:15 PM, Nurse #9 indicated she was a Registered Nurse and worked as an NA when needed. She indicated on 8/24/24 she had worked on the floor as an NA and not as an RN. She indicated her assignment was indicated in the assignment sheet. She stated she was not in the facility from 7 AM - 7 PM on 8/24/24. B. On 8/25/24 the daily staff posting indicated 1 RN working day shift (7 AM- 3 PM) and 2 LPNs working evening (3 PM - 11 PM) and night shift (11 PM- 7 AM). Review of the staff clock-in sheet revealed no RN working from 7 AM - 7 PM shift. Review of the nursing assignment sheet did not indicate an RN working the 7 AM -7 PM shift. During an interview on 9/19/24 at 3:44 PM, the scheduler indicated the facility did not have any agency Nurse aides. They however had contract with an agency for nurses. The scheduler stated on days when there was an NA call out and the slot was unable to be filled by another NA then a	F 727	works with HR and Corporate recruiters to obtain staff to meet the requirements and services levels. Facility stives to meet the PPD for resident care labor hours. Adm DON DSD reviewed the monthly schedule for the October 2024 on 9/26/24. Review of unfilled shifts and potential challenges with coverage were reviewed and discussion on current staff request and the onboarding of new staff for October. . Advertisements are posted on the parent company LifePoint web site along with external sites for open needs of all nursing levels and staff. Interviews are conducted and offers made to candidates. Acceptance of offers are dependent on the acceptance of the candidate to the employment offer. Facility has FT scheduler who builds relationship along with the Admin and DON to work with the current employee to cover shifts and take extra day when available. Admin/ DON offer incentive to nurses to pick up other shift and wages are paid at overtime as per labor codes. Facility offers shift differential for evening and night nurses. Adm/DON also work to ask nurses to cover shifts. Attempts to obtain staff and call-offs are monitored by Admin and DON. DSD daily and when report of potential labor challenges. Licensed Nurses are part of the care-team and are encouraged to work at all levels of care services in a team effort to service the residents. Admin and other dept heads have come in also to support care by doing non-direct care services task to ensure care to residents Weekend staffing is reviewed with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 30 nurse was called into fill the slot. The scheduler indicated as there was a RN in the building, the regulations for RN for 8 hours a day was met, During an interview on 9/19/24 at 4:34 PM, the Administrator indicated the call out policy was for staff to call the management 2 hours prior to their shift. The scheduler ensures that the call out slots were filled by staff who were willing to work overtime or by another staff not on assignment that day. The Administrator further indicated the facility had no NAs who were from agency. They however had agency nurses working for them. The Administrator stated nurses (both Registered nurse and License Practical Nurse) were called to fill in assigned NA shifts when needed. These Nurses worked as NAs and helped with patient care. The Administrator further stated when there was only one RN in the building and was assigned NA duty, the RN was also responsible to complete her duties as both a Nurse and Nurse Aide. The Administrator stated the requirement for RN for 8 hours was met, when the RN was in the facility and was working a NA.	F 727	scheduler by Admin and DON prior to the weekend. Management nurses are also asked to come in and cover nursing labor needs. The DON has come in and covered shifts as needed and available along with the MDS and DSD RNs. Adm has a weekly Recruitment meeting with HR and Senior management to monitor the applications, recruitment needs and direct hiring process along with temporary labor needs. A new Direct hire FT DON accepted and offer and potentially is schedule 10/7/24 to start the position. Admin, DON, and HR will continue to monitor staffing and will ensure all nurse staffing needs are posted with HR recruiter by 10/17/24. To continue to be monitored daily at Daily Management Meeting and via phone when weekend challenges arise to obtain staff by scheduler, Admin. DON, DSD To continue to be reviewed with QAPI process an at monthly QAPI meeting x3 and on going as needed.	
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		10/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 31 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post the daily nurse staffing information for residents and visitors on 1 of the 4 days of the survey period. The facility also failed to update the daily staffing information to reflect actual staffing changes for 6 of 33 days reviewed for posted nurse staffing information. Finding included: 1. On 9/15/24 (Sunday) during the facility initial	F 732	It is the policy of the Facility to post nurse staffing information. Staff projection sheets are posted for daily staffing projections on the side wall by the back public elevator. Charge Nurse Adm, DON DSD Schedule, Medical records are to check and monitor daily posting is up. Staff were in-services on the importance of the posting be up and correct for the day. Charge Nurse were reminded of the responsibility to correct the numbers on	

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 32 tour at 9:20 AM and for multiple observations throughout the day including 1:30 PM and 3 PM, the daily nurse staffing sheet posted near the facility elevator was dated 9/13/24 (Friday). The posting was not updated to reflect the current date, census, and staffing information. During an interview on 9/17/24 at 8:09 AM, the scheduler stated she was responsible for posting the daily staff posting during the weekdays. The scheduler stated she completed the staffing form for the weekend and left the posting sheet in a folder near the nurse's station. She explained the weekend nurses were responsible for posting and updating the daily staffing sheets on the weekend. During an interview on 9/17/24 at 9:49 AM, the Minimum Data Set (MDS) Nurse stated she was the nurse working on 9/15/24. She indicated all nurses over the weekend were responsible for ensuring the staff posting was updated near the elevator. The MDS Nurse stated she forgot to look at the posting and post an updated staff posting. During an interview on 9/17/24 at 1:59 PM, Nurse #3 stated she was hired 3 weeks ago and worked on 9/15/24. She added she was not aware that as a weekend nurse she was responsible for changing the staff posting over the weekend. During an interview on 9/19/24 at 1:14 PM, Nurse #1 stated she was the charge nurse over the weekend of 9/14/24 and 9/15/24. She added she was not aware she was responsible for changing the staff posting over the weekend. 2. Review of the daily nursing staff postings from	F 732	date of posting. Admin provided in service 9/21/24 and DSD/ DON will ensure training of Licensed assigned charge nurse on Rehab cart to review and correct labor hours and post the projection.in holder in the morning after day staff arrival. By 10/17/24 Staff call outs will be monitored by DON/DSD and reviewed by Admin for further action. DON, DSD and Admin will work to ensure correct labor and staffing are scheduled daily and on site to care for resident taking steps to offer incentive and bonus for staff to come in an or take on extra shift and or hours to meet the requires staffing ratios. In-service on 9/21 and 9/27 also included education and reminded to be on time for work and to complete full time scheduled for shift. Staffing hours to be monitored by DON/DSD, payroll and Admin daily per time records system. Staffing Post Sheets will be scanned into a electrocic file for safe keeping by scheduler or medical records along with the Facility daily assignment sheets. Scheduler will report by print out by month the scanned sheets at monthly QAPI meeting, on going. To be reviewed/monitored x3 months at QAPI to ensure the posting calculation and process are done as assigned by Licensed Nurse on schedule To be monitored and reviewed at monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	**615 RIDGE ROAD** **ROXBORO, NC 27573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 33 8/17/24 through 9/18/24 and staff clock in sheets for the same period was conducted on 9/19/24. The daily posted staffing indicated the facility did not update the posting to reflect staffing changes for the following: - On 8/24/24 the daily staff posting indicated 1 Registered Nurse (RN) and 3 Licensed practical Nurses (LPN) for day shift (7 AM-3 PM). Review of the staff clock in sheets revealed no RN and 2 LPNs were working for day shift. - On 8/25/24 the daily staff posting indicated 1 RN and 3 LPNs for day shift. Night shift (11 PM - 7 AM) indicated 4 Nurse Aides (NA). Review of the staff clock in sheets revealed no RN and 2 LPNs working for day shift. There were only 2 NAs working for the night shift. - On 8/30/24 the daily staff posting indicated 4 NAs working the evening shift (3PM - 11PM). Review of the staff clock in sheet revealed only 3 NAs working. - On 8/31/24 the staff posting indicated 2 RNs working the day shift. Review of the staff clock in sheet revealed only 1 RN working for the day shift. - On 9/1/24 the daily staff posting indicated 4 NAs for day shift, 5 NAs for evening shift and 3 NAs for night shift. Review of the staff clock in sheets revealed 3 NAs working for both day and evening shift. The night shift had only 2 NAs working. - On 9/14/24, the daily staff posting indicated 2 LPNs working the day shift. Review of the staff clock-in sheets revealed only 1 LPN working for	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 34 the day shift. During an interview on 9/19/24 at 3:44 PM, the scheduler stated the staff schedule was made a month ahead. If any staff had a call out, then the staff posting needed to be updated. She indicated if she was in the facility, she would try to make the changes. During an interview on 9/19/24 at 5:00 PM, the Administrator stated posting should be checked by the charge nurse, scheduler or MDS clerk were responsible for oversight for posted during the weekday. The charge nurse was responsible over the weekend for ensuring that the daily nurse staffing sheet was accurately and was posted daily The Administrator stated the daily staffing sheet should be updated by the scheduler or the charge nurse to reflect the accurate staff working in the facility.	F 732		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		10/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 35 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to remove an expired multi-dose vial of insulin for 1 of 3 medication administration carts, failed to date opened multi-dose vials of insulin medication for 2 of 3 medication administration carts, and discard loose pills in the medication cart drawer for 2 of 3 medication administration carts (rehabilitation hall, short and long halls). Findings Included: 1a. On 9/15/24 at 9:15 AM, an observation of the medication administration Rehabilitation Hall cart with Nurse #1 revealed one opened and undated multi-dose vial of Insulin Glargine. A review of the manufacturer's literature indicated to discard Glargine multi-dose vial 28 days after opening. 9/15/24 at 9:40 AM, during an interview, Nurse #1 indicated that the nurses, who worked on the medication carts, were responsible to discard expired multi-dose vials. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse did not administer expired insulin this shift.	F 761	It is the policy of the facility to Label and Store Drug and biologicals as required by standards and protocols and remove expired medication as needed. DON and DSD educated the nursed on-shift immediately when made aware of the situation of the medication labeling issue and then check the carts further for other medication system issue on 9/16/24. DON DSD in-serviced nurses on shift during survey and will provide nurse education to licensed nurse by 10/17/24 on proper handling, labeling and cleanliness of cart and medication misses that occur and the documentation of such med pass occurrences. The reported error will be reviewed by the DON/DSD and education will be provided to the nurse per the occurrence as needed. DON created a weekly med cart audit check sheet on 10/4/24. Education and system process will be established an monitored weekly by DON and DSD/assigned by 10/17/24. Facility will continue with monthly medication pass audit and cart check from the contracted Pharmacy. DON/DSD	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 761

Continued From page 36

b. 9/15/24 at 9:40 AM, an observation of the Long Hall medication administration cart with Nurse #2 revealed one, opened undated, half-empty multi-dose vial of Novolog insulin, one expired Basaglar Kwik Pen Insulin, opened on 8/15/24, one expired Humalog Pen (insulin), opened on 8/3/24, and one expired Insulin Aspart Flex pen, opened on 9/1/24. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening.

On 9/15/24 at 9:40 AM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible to discard expired multi-dose vials. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse did not administer expired insulin this shift.

On 9/16/24 at 9:30 AM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible for putting the date of opening on multi-dose medication containers, checking all the medications in medication administration carts for expiration date and remove expired medications every shift. He expected that no expired items or loose pills be left in the medication carts.

2a. On 9/15/24 at 9:15 AM, an observation of the medication administration Rehabilitation Hall cart with Nurse #1 revealed in the second draw of the medication cart there were noted two white loose capsules and one pink round shape loose pills.

On 9/15/24 at 9:20 AM, during an interview, Nurse #1 indicated that she could not identify

F 761

will monitor the monthly Pharmacy reports when received and take any corrective actions. Pharmacy Nurse Consultant conducted a cart and med pass audit 9/30/24 corrective actions were taken to ensure compliance with medication storage. DON/DSD will ensure licensed nurses provided education who was on cart by 10/17/24 regarding noted med storage non- compliance. Admin will request Pharmacy Nurse Consultant to provide training to licensed nurses on next monthly visit.
Medication cart audit by Facility will be monitored by DON/DSD or assigned weekly and reported monthly at QAPI X3 or on going to meet standard of medication cart labeling storage and cleanliness,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 37	F 761		

what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #1 did not clean the cart before her shift.

b. On 9/15/24 at 9:25 AM, an observation of the medication administration Short Hall cart with Nurse #3 revealed in the first draw of the medication cart there was one white and three pink round shape loose pills.

On 9/15/24 at 9:25 AM during an interview, Nurse #3 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #3 did not clean the cart before her shift.

On 9/16/24 at 9:30 AM, during an interview, the Director of Nursing (DON) expected that no loose pills be left in the medication carts.

On 9/16/24 at 10:50 AM, during an interview, the Administrator indicated that all the nurses were responsible for putting the date of opening on multi-dose medication containers, checking all the medications in medication administration carts for expiration date and remove expired medications every shift. He expected that no expired items or loose pills be left in the medication carts.