STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 complaint investigation survey was conducted 2/03/25 through 2/06/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Z8WM11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 2/03/25 to conduct a recertification survey and exited on 2/06/25. Additional information was obtained on 2/12/25. Therefore, the exit date was changed to 2/12/25. Event ID# Z8WM11. The following intakes were investigated NC00220079, NC00214817, NC00223605, NC00224535, NC00212995, NC00225671, NC00222693, NC00222686, and NC00220718. 2 of the 27 complaint allegations resulted in a deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		2/13/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to develop a person-centered care plan for 1 of 1 resident reviewed for hearing impairment (Resident #75). The findings included:	F 656	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On February 6, 2025 it was identified that Resident #75 did not have a care plan for the use of hearing aids.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 656	Continued From page 2 Resident #75 was admitted to the facility on 8/01/24. Resident #75 was hospitalized on 1/04/25 and returned to the facility on 1/13/25. Review of the Minimum Data Set (MDS) admission assessment dated 1/20/25 revealed Resident #75 had moderate cognitive impairment and was coded for minimal hearing difficulty with the use of hearing aids. Review of the care plan revealed no care plan related to Resident #75's hearing impairment and use of hearing aids. An interview and observation were conducted on 2/03/25 at 2:15 pm with Resident #75. This surveyor had to move close and speak loudly within one to three inches of the right ear for Resident #75 to hear questions. Resident #75 reported she was very hard of hearing, and she did not have her hearing aids today. Resident #75's hearing aids were observed charging on the bedside table. An interview was conducted on 2/05/25 at 3:33 pm with MDS Nurse #1 who revealed the Social Worker was responsible to implement Resident #75's hearing impairment care plan because she completed that portion of the MDS assessment. MDS Nurse #1 stated she would not have reviewed Resident #75's care plan to make sure care plans were implemented in the areas of the assessments she did not complete. During an interview on 2/05/25 at 3:38 pm with the Social Worker she revealed she was responsible for implementing Resident #75's hearing impairment care plan. The Social Worker stated she normally implemented the	F 656	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On February 6, 2025 the Social Worker completed a 100% audit of all in-house residents who use hearing impairment devices to ensure each resident had a care plan in place. On February 6, 2025 an ad hoc QAPI meeting was held to discuss the deficient practice and create a plan of correction. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On February 6, 2025 the Administrator completed education with the Social Worker to include within seven days of admission every resident will be assessed by the Social Worker for hearing impairments and devices and a care plan must be put in place. Every new admission will be assessed using the new Social Worker Assessment Form. On February 6, 2025 the Administrator informed the Staff Development Nurse the education would be added to the Social Worker new hire education and any new Social Worker would not be allowed to work until the education has been completed. Indicate how the facility plans to monitor its performance to make sure solutions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 656	Continued From page 3 care plan after she completed the MDS assessment, but she must have missed Resident #75's hearing impairment care plan. An interview was conducted with the Administrator on 2/06/25 at 3:39 pm who revealed the Social Worker or the MDS Nurses were responsible for implementing resident care plans. The Administrator stated care plans were reviewed in the daily clinical meetings, but she was unable to recall if Resident #75's hearing impairment care plan was reviewed.	F 656	are sustained: The Social Worker will audit all new admissions for initiation of hearing impairment care plan if resident qualifies weekly for four weeks, five new admissions weekly for four weeks, followed by three new admissions weekly for four weeks. Results of the audit will be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained, ongoing, and determine the need for further auditing beyond the three months. The Quality Assurance Committee can modify this plan to ensure the facility remains in substantial compliance. Date of Compliance February 13, 2025	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		2/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 690	Continued From page 4 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to secure indwelling urinary catheter tubing to prevent tugging or pulling for 1 of 2 residents reviewed for indwelling urinary catheters (Resident #53). The findings included: Resident #53 was admitted to the facility on 12/4/24 with diagnoses that included neurogenic bladder (a condition that occurs when the nervous system connection to the bladder is	F 690	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On February 6, 2025, it was identified that resident #53 did not have indwelling catheter securement device on three out of four survey days. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 690	Continued From page 5 disrupted) with urinary retention. Review of a physician's order dated 12/4/24 read in part; "Check placement of catheter securement every shift." Resident #53's Admission Minimum Data Set (MDS) Assessment dated 12/11/24 revealed she had moderate cognitive impairment. She was coded as having an indwelling urinary catheter. An interview was conducted with Resident #53 on 02/03/25 at 11:35 AM. Resident #53 stated she had experienced pain from her urinary catheter when she was up in the chair. Resident #53 stated a leg strap was placed to secure the catheter tubing which helped with the pain. Resident #53 pulled back the sheet to expose catheter tubing that was not secure. Resident #53 denied any pain from the catheter tubing at that time. An observation of Resident #53's catheter tubing was conducted on 02/04/25 at 03:08 PM that revealed the urinary catheter tubing was not secured. An interview was conducted with Resident #53 on 02/05/25 at 01:31 PM. Resident #53 stated staff did not consistently secure the catheter tubing. Resident #53 pulled back her cover to expose catheter tubing that was not secured. There was no leg strap observed in the room. An interview was conducted on 02/05/25 at 01:37 PM with Nurse Aide #1. NA #1 stated she was assigned to Resident #53 and had provided care for this resident. NA #1 stated the nurse caring for the resident was responsible for making sure that	F 690	On February 6, 2025, the Director of Nursing completed an audit of all residents with indwelling catheters to ensure all had securement devices in place. All residents had securement devices. On February 6, 2025, an ad hoc QAPI meeting was held to discuss deficient practice and create a plan of correction. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On February 6, 2025, the Director of Nursing and Staff Development Nurse educated all nurses, CNAs and Med aides on importance of placing securement devices on all residents with indwelling catheters and instructions on how to apply. The Staff Development Nurse will be responsible for ensuring all direct care staff have received the education before working their next shift. On February 6, 2025, the Director of Nursing informed the Staff Development Nurse the education was to be added to the direct care staff new hire education and new staff cannot work until the education has been completed. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Director of Nursing or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 690	Continued From page 6 the indwelling catheter had a securement device. An interview was conducted with Nurse #1 on 02/06/25 at 09:23 AM. Nurse #1 stated nurses were responsible for making sure indwelling catheter tubing was secured. Nurse #1 stated she had forgotten to place the urinary catheter securement device on Resident #53 that morning. An interview was conducted with Unit Manager #1 on 2/12/25. Unit Manager #1 stated she expected that the nurse assigned to the resident would check each shift to make sure the urinary catheter securement device was in place. An interview was conducted on 2/12/25 at 10:45 AM with the Administrator. The Administrator stated she expected staff to follow the physician order and make sure the urinary catheter securement device was in place each shift.	F 690	audit all residents with indwelling catheters 5 times per week for four weeks, then three times per week for four weeks, then one time per week for four weeks to ensure securement device is in place. The Director of Nursing will take the results of the audit to be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained, ongoing, and determine the need for further auditing beyond the three months. The Quality Assurance Committee can modify this plan to ensure the facility remains in substantial compliance. The date of compliance is February 13, 2025	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Nurse Practitioner and Medical Director interviews, the facility failed to clarify a physician order for phenytoin (a medication used to treat epilepsy and manage seizures) for a resident with a diagnosis of generalized epilepsy (a brain	F 760	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 760	Continued From page 7	F 760		

disorder that causes seizures) which resulted in the phenytoin not being administered for 19 days. This deficient practice was identified for 1 of 1 residents reviewed for significant medication error (Resident #287).

The findings included:

Resident #287 was admitted to the facility on 4/11/24 with diagnoses which included generalized epilepsy and stroke.

Resident #287 had a physician order dated 4/11/24 for phenytoin sodium extended 100 milligram (mg) capsule. Give 100 mg by mouth twice a day on Monday, Tuesday, Wednesday, Friday, Saturday, and Sunday for generalized epilepsy.

The Minimum Data Set (MDS) quarterly assessment dated 9/18/24 revealed Resident #287 had moderate cognitive impairment.

Resident #287 had a care plan in place, last reviewed 10/24/24, for risk for injury related to seizure disorder and history of phenytoin toxicity (high levels of phenytoin in body which can cause slurred speech, vomiting, or lethargy). The care plan had Interventions in place which included to monitor for adverse effects of medications.

Review of Resident #287's laboratory results dated 10/30/24 revealed a phenytoin level of 8.7 micromole/liter. The therapeutic level of phenytoin is 10-20 micromole/liter.

Resident #287 had a physician order dated 10/30/24 at 12:15 pm to discontinue phenytoin 100 mg twice a day for generalized epilepsy. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 760	Continued From page 8	F 760		

discontinued order was verified by Unit Manager #1 on 10/30/24 at 2:00 pm.

Resident #287 had a physician order entered into electronic medical record by NP #1 on 10/30/24 at 12:16 pm for phenytoin 100 mg tablet three times a day on Monday, Tuesday, Wednesday, Friday, Saturday, and Sunday for generalized epilepsy. Resident #287's phenytoin order was verified and discontinued by Unit Manger #1 on 10/30/24 at 2:00 pm.

Review of the end-of-day communication email dated 10/30/24 sent from NP #1 to members of the facility management team which included the Administrator, Director of Nursing, and Unit Manager #1 revealed the notification that Resident #287's phenytoin medication was increased due to a low therapeutic level.

A telephone interview was conducted on 2/06/25 at 9:43 am with Nurse Practitioner #1 who revealed she wrote an order on 10/30/24 to increase Resident #287's phenytoin medication from twice a day to three times a day due to the therapeutic level of the medication being low. She stated Resident #287 was hospitalized for an unrelated incident on 11/19/24 and she was not aware Resident #287's phenytoin medication had been discontinued by facility staff or that the medication was not administered from 10/30/24 through 11/19/24. NP #1 stated she had a facility visit with Resident #287 on 11/18/24 and no acute issues or concerns were identified or reported. NP #1 stated Resident #287 did not have any seizure activity noted at the facility.

An interview was conducted on 2/06/25 at 8:40 am with Unit Manager #1 who revealed she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 760	Continued From page 9	F 760		

accidentally discontinued Resident #287's new phenytoin order written by NP #1 on 10/30/24 because she thought it was a duplicate order or may not have clicked to discontinue the medication when the order first showed to be verified. She was unable to state exactly what happened but stated she did discontinue both orders. Unit Manager #1 stated she did not speak to NP #1 regarding the change in Resident #287's phenytoin medication on 10/30/24. She confirmed she received the end of day communication emails from NP #1, but she was unable to recall if the email was reviewed on 10/30/24. Unit Manager #1 stated the normal process was to review all physician orders, which included discontinued orders, the next day during the clinical meeting, but she stated she did not recall if Resident #287's phenytoin orders were discussed. Unit Manager #1 stated she was responsible to ensure Resident #287's medication orders were reviewed, accurate, and verified.
Review of Resident #287's electronic medical record from 10/30/24 through 11/19/24 revealed no observations or reports of seizure activity noted.

The nursing progress note dated 11/19/24 at 10:18 pm written by Nurse #1 revealed Resident #287 was difficult to arouse and reported she did not feel good. Resident #287's vital signs were noted as follows: blood pressure 112/64 mm/Hg (millimeters of mercury), heart rated 59 beats per minute, respiratory rate of 16, and blood sugar of 164 mmol/L (millimoles per liter). Nurse #1 notified the provider via telemedicine regarding the observed change in condition and received an order for Resident #287 to be transferred to the hospital for further evaluation. Resident #287's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 760	Continued From page 10	F 760		

Responsible Party (RP) was notified, and Resident #287 left the facility at approximately 10:30 pm.

During an interview on 2/05/25 at 2:38 pm with Nurse #1 she revealed she was assigned to Resident #287 for both the 7:00 am-3:00 pm and 3:00 pm-11:00 pm shifts on 11/19/24. Nurse #1 stated Resident #1 had been hard to arouse during the end of 3:00 pm -11:00 pm shift, she notified the on-call provider and received the order to send Resident #287 to the hospital. Nurse #1 stated she did notice that the phenytoin medication was no longer listed to be administered to Resident #287, but she was not sure why the medication was discontinued. She stated she did not discontinue or verify Resident #287's phenytoin orders on 10/30/24. Nurse #1 stated she was normally assigned to Resident #287 and had not witnessed any seizure activity during the time she was at the facility.

Review of the hospital summary dated 11/19/24 through 11/22/24 revealed Resident #287 was sent to the hospital for change in mental status and unresponsiveness and was admitted to the hospital for altered mental status, metabolic acidosis (a condition when the body accumulates too much acid with symptoms which included lethargy, nausea, and vomiting), vomiting, and pneumonia. An electroencephalography (EEG, a test that measures electrical activity in the brain) was completed on 11/20/24 and showed no seizure activity. Resident #287 was discharged from the hospital to another facility on 11/22/24 with a discharge diagnosis of pneumonia.

A telephone interview was conducted with the Medical Director #2 on 2/06/25 at 2:08 pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 760	Continued From page 11	F 760		

Medical Director #2 confirmed she was responsible for the medical care provided by the facility at the time Resident #287's phenytoin medication was discontinued. Medical Director #2 stated she was not aware at the time the medication was discontinued but she was notified of the error when the facility determined what had occurred. Medical Director #2 stated that Resident #287's hospitalization on 11/19/24 was not related to the phenytoin medication being discontinued. Medical Director #2 stated the concern when discontinuing phenytoin would be breakthrough seizures that were continuous, but she stated Resident #287 had no seizure activity at the facility.

An interview with the DON was conducted on 2/06/25 at 10:25 am who revealed she was not aware Resident #287's phenytoin medication was discontinued by Unit Manager #1 until after Resident #287 was hospitalized on 11/19/24. The DON stated Unit Manager #1 was responsible for reviewing all resident orders for the unit she was assigned to manage. She stated she did not confirm, nor did she verify, that the Unit Manager #1 reviewed the end-of-day communication sent by NP #1 to ensure that all orders were reviewed and in place. The DON stated the normal process was that the provider would see a resident, enter any orders relevant to the resident, and the Unit Manager was then responsible for verifying the orders so they would be active. The DON stated although orders were normally reviewed in the morning clinical meeting, she stated they did not discuss each individual medication order during the meeting. The DON stated she did not recall talking about Resident #287's phenytoin orders during the clinical meetings. The DON stated Unit Manager #1 discontinued the new order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 760	Continued From page 12	F 760		

Resident #287's phenytoin medication accidentally because she thought it was a duplicate order.

During an interview on 2/06/25 at 11:41 am with the Administrator she revealed that Unit Manager #1 was responsible for making sure Resident #287's physician orders were in place as written by the providers. She stated that normally during the stand-down meeting, which was held at the end of the day, physician orders were verbally reviewed to ensure they were in place. The Administrator stated she was unable to recall Resident #287's phenytoin orders were discussed at the meeting on 10/30/24. The Administrator confirmed she did receive the end-of-day summary from NP #1, but she did not review the information because she had managers in place to make sure the orders were followed. The Administrator stated the facility did not have a triple check process in place to make sure all orders were in place and correct at that time, but she stated the facility had since implemented that process.

The facility provided the following corrective action plan with a completion date of 11/21/2024.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Resident #287 no longer resides in the facility.

On 11/20/24 a root cause analysis was completed by the Director of Nursing (DON) and the Administrator regarding omission of seizure medication administration for Resident #287. It was determined that Unit Manager #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 760	Continued From page 13	F 760		

misunderstood the NP order to increase Resident #287's seizure medication and discontinued the order without a physician order to discontinue.

On 11/20/24 the DON provided education to Unit Manager #1 on not discontinuing medication orders without a written or verbal order from the Nurse Practitioner or physician.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

An audit was conducted on 11/20/24 of all new orders for the past 30 days by the Director of Nursing and Staff Development Coordinator (SDC) Nurse to ensure all new orders were verified and administered as per physician orders. Any errors were corrected at the time of the audit.

On 11/20/24 an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held to discuss deficient practice and implement a plan of correction.

3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur.

On 11/20/24 the Director of Regulatory Compliance provided education to the Administrator and the DON on the new process of ensuring the Nurse Practitioner/Physician discuss any new orders with the nurse, Unit Manager, or DON before leaving the building to ensure the orders are entered correctly and understood by staff. They were also educated that upon receiving new medication orders they are to be verified with the provider for accuracy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 760	Continued From page 14	F 760		

The nurse will then repeat the order back to the provider and enter the order into the electronic medical record (EMR). The receiving nurse will then write a progress noted into the EMR stating the order was received from the provider for the specific medication, state the order was read back to the provider for accuracy, order entered into EMR, and the Responsible Party was notified with all questions answered.

On 11/20/24 the DON and Staff Development Coordinator provided education to all nurses regarding the new process of the NP/Medical Doctor to discuss any new orders with he nurse, Unit Manager, or DON before leaving the building to ensure they are entered correctly and understood by staff. They (nurses) were also educated that upon receiving new medication orders they are to be verified with the provider for accuracy. The nurse will then repeat the order back to the provider and enter the order into the electronic medical record (EMR). The receiving nurse will then write a progress noted into the EMR stating the order was received from the provider for the specific medication, state the order was read back to the provider for accuracy, order entered into EMR, and the Responsible Party was notified with all questions answered.

The DON will be responsible for ensuring nursing staff will not be allowed to work until education has been completed. On 11/20/24 the SDC was informed by the Administrator that the education would be added to the new hire orientation, and she will be responsible for ensuring new staff do not work until the education has been completed.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 760	Continued From page 15 sustained. To prevent this from recurring, the DON, SDC Nurse, or designee will audit new orders daily for four weeks, then 3 days weekly for four weeks, then weekly for four weeks to ensure no medication errors are made. The findings of these audits will be reported to the QAPI committed by the Administrator for further review or need to continue audits. The corrective action plan completion date was 11/21/24. The facility's corrective action plan was verified on 2/06/25 by the following: A record review was conducted of the facility education provided to all licensed nursing staff which included regularly scheduled agency staff and was noted to be completed on 11/20/24. Licensed nursing staff were interviewed and confirmed education had been received which included review of physician orders with the provider prior to the provider leaving the facility to make sure understanding of the order and that it was accurate, entering orders into the electronic medical record when applicable, and documentation of the new order and Responsible Party notification in the medical record. Record reviews of the physician order audits, end-of-day summary, and nursing progress notes were conducted and confirmed that auditing was completed as noted and was ongoing at the of the review. The compliance date of 11/21/24 was validated.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		2/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 812	Continued From page 16 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean seven of nine baking sheets. These practices had the potential to affect food served to residents. The findings included: During an observation of the kitchen dish drying rack on 2/05/25 at 11:37 AM, seven stacked baking sheets with dark dried grease built up under the rim. A second observation on 2/06/25 at 10:35 AM revealed 7 baking sheets stacked ready for use	F 812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On February 5, 2025, it was identified that the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On February 6, 2025, the Dietary Manager completed a 100% audit of all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 812	Continued From page 17 on the rolling food preparation rack were in the same condition. In an interview with the Dietary Manager on 2/06/25 at 10:42 AM he revealed staff should have cleaned and gotten all the grease built up off the baking sheets. In an interview on 2/06/25 at 10:53 AM the Administrator stated that dietary should maintain their cleaning schedule and deep clean the baking sheets.	F 812	baking sheets for dried or built-up grease and any findings were discarded. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On February 6, 2025, the Administrator completed education with the Dietary Manager on the importance of properly cleaning baking sheets to ensure grease is removed from trays post use. On February 6, 2025, the Dietary Manager completed education with all dietary staff members on the importance of properly cleaning baking sheets to ensure grease is removed from trays post use. The Dietary Manager will be responsible for ensuring no staff will work until education has been completed. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Dietary Manager or designee will audit all baking sheets for dried or built-up grease five times a week for four weeks, then three times a week for four weeks, followed by once weekly for four weeks. Results of the audit will be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 812	Continued From page 18	F 812	recommendations to ensure compliance is sustained, ongoing, and determine the need for further auditing beyond the three months. The Quality Assurance Committee can modify this plan to ensure the facility remains in substantial compliance. Date of Compliance February 13, 2025	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		2/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 19 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 20 Based on observations, record review, and staff interviews, the facility failed to implement their infection prevention program policies and procedures when 1) the Social Worker failed to remove her surgical mask after exiting a resident room that was on droplet precautions (Room #337), 2) when the Maintenance Director failed to wear a surgical mask in a resident room that was on droplet precautions (Room #314), and 3) Nurse Aide #1 failed to remove her surgical mask after exiting a resident room on droplet precautions (Room #318). This deficient practice was observed for 3 of 3 staff members (Social Worker, Maintenance Director, and NA #1) that failed to follow droplet precaution procedures for residents on isolation for influenza. The findings included: The facility's policy titled "Infection Prevention and Control Program" last revised June 2023 noted the program was a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The policy further noted the elements of the infection prevention and control program included the outbreak management process to manage affected residents and prevent the spread to other residents. The facility's Droplet Precautions policy and signage last revised 1/20/22 revealed the following instructions: everyone must clean their hands before entering and leaving room and wear surgical mask when entering the room and remove after exiting the room. The policy further stated common conditions for droplet precautions included influenza virus. The droplet precautions	F 880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to implement their infection prevention program policies and procedures when 1) the Social Worker (SW) failed to remove her surgical mask after exiting a resident room that was on droplet precautions (Room #337), 2) when the Maintenance Director failed to wear a surgical mask in a resident room that was on droplet precautions (Room #314), and 3) Nurse Aide #1 failed to remove her surgical mask after exiting a resident room on droplet precautions (Room #318). Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On February 6, 2025, the SW, Maintenance Director, and Nurse Aide (NA) #1 were educated by the Director of Nursing (DON) on the requirements for Enhanced Barrier Precautions (EBP) including the need to read the isolation sign on the door, wear the correct PPE and discard the PPE when leaving the isolation rooms with droplet precautions. On February 6, 2025, a walking round audit was completed by the DON to identify any additional infractions for EBP. There were no new findings as a result of this audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 21 signage with instructions were posted on each affected resident room for review prior to entering. 1. A continuous observation was conducted on 2/04/25 at 9:00 am through 9:03 am when the Social Worker was observed to perform hand hygiene and enter Room #337 with a surgical mask in place. The Social Worker was observed to exit Room #337, perform hand hygiene, and walk down the hall towards the nursing desk without removing the surgical mask. Room #337 had a droplet precaution sign on door frame due to influenza and a plastic drawer container of personal protective equipment (PPE) which included surgical masks. An immediate interview was conducted on 2/04/25 at 9:03 am with the Social Worker who confirmed the resident in Room #337 was on droplet precaution for influenza. She stated she had been educated on infection control measures for droplet precaution rooms which included performing hand hygiene and wearing an appropriate mask when entering and perform hand hygiene when you exited the room but that was all she was able to remember. This surveyor and the Social Worker reviewed the droplet precaution instructions posted outside Room #337. The Social Worker confirmed that she did not remove the surgical mask when she exited Room #337 because she was not aware that it was part of the education she received. During an interview on 2/04/25 at 9:05 am with the Infection Preventionist (IP) she revealed staff were to remove the surgical mask when they left a room that was on droplet precautions.	F 880	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On February 6, 2025, education was provided by the DON/designee for all staff on the requirements for EBP including the need to utilize PPE that includes the need to read the isolation sign on the door, wear the correct PPE and discard the PPE when leaving the isolation rooms with droplet precautions. The DON was informed by the Administrator it would be her responsibility to ensure staff were not allowed to work until the education had been completed. On February 6, 2025, the Staff Development Nurse was informed by the DON the education would be added to the new hire education and new staff could not work until completed. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: Beginning on February 6, 2025, the DON/designee will monitor this process by observing 2 resident encounters per day that require EBP. These audits will be done 5 x per week for 8 weeks to ensure that EBP guidance is followed. The findings of these audits will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee for 2 months. Audits will continue at the discretion of the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 22 An interview was conducted on 2/06/25 at 3:32 pm with the Administrator who revealed all staff had received education regarding the requirements for droplet precautions and the facility had initiated facility-wide education again on 2/04/25. 2. An observation was conducted on 2/05/24 at 8:26 am when the Maintenance Director was observed inside Room #314 without a surgical mask on and was observed to exit the room and proceed down the hall. Room #314 had a droplet precaution sign on door frame due to influenza and a plastic drawer container of personal protective equipment (PPE) which included surgical masks. An immediate interview was conducted with the Maintenance Director who stated he did not put on a surgical mask because he just went into the room to move the bedside table from the doorway so the table would be next to the resident bed in Room #314. The Maintenance Director confirmed Room #314 was on droplet precautions for influenza and he should have worn a surgical mask when he went into the room. An interview was conducted on 2/06/25 at 10:01 am with the Infection Preventionist (IP) who revealed all staff had received education regarding droplet precautions and the instructions were posted on each resident room that stated surgical masks were to be on before entering the room. An interview was conducted on 2/06/25 at 3:32 pm with the Administrator who revealed all staff had received education regarding the requirements for droplet precautions and the	F 880	Administrator is responsible for compliance. The date of compliance is 2/13/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 23	F 880		

facility had initiated facility-wide education again on 2/04/25.

3. An observation was conducted on 2/05/25 at 8:35 am when Nurse Aide (NA) #1 was observed to exit Room #318, perform hand hygiene and proceed to walk down the hall without removing the surgical mask. Room #318 had a precaution sign on door frame and a plastic drawer container of personal protective equipment (PPE) which included surgical masks.

An immediate interview was conducted with NA #1 reported Room #318 was on droplet precautions for influenza and stated she had received education when she arrived at work today (2/05/25) which included to remove the surgical mask when she exited the room. NA #1 stated she was going to tell the nurse that the resident in Room #318 wanted to talk to the nurse and she just forgot to take off the surgical mask.

An interview was conducted on 2/06/25 at 10:01 am with the Infection Preventionist (IP) who revealed all staff had received education regarding droplet precautions and the instructions were posted on each resident room that stated surgical masks were to be worn when in the room and removed when exiting the room. The IP stated that all residents and staff were offered and provided with the influenza vaccine in October 2024 and the facility continued to offer the vaccine to new residents and staff as needed. The IP stated that once a resident was identified to have influenza, the resident was placed on droplet precautions and oseltamivir (a medication to treat and prevent influenza) was started. She also stated that when a resident was exposed to either a positive staff member or positive resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 880	Continued From page 24 (such as a roommate), those residents were monitored for signs and symptoms of influenza and oseltamivir was offered. The IP stated the facility attempted to minimize the risk of spreading the influenza virus by education of staff and visitors on signs and symptoms of influenza, hand hygiene, minimized resident room changes, management of staff assignments to avoid staff movement from one unit to another, and communication with the local health department for additional guidance as needed. An interview was conducted on 2/06/25 at 3:32 pm with the Administrator who revealed all staff had received education regarding the requirements for droplet precautions and the facility had initiated facility-wide education again on 2/04/25.	F 880		