STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide activities according to activity preferences for 2 of 2 severely cognitively impaired residents (#134 and #96), reviewed for activities. The findings included: 1. Resident #134 was admitted to the facility on 5/13/2015 with diagnoses to included Alzheimer's disease. An "Initial Quality of Life lifestyle review", dated 5/18/2015, revealed the resident enjoyed music and inspirational/religious services or events. The document included an initial activity plan to provide 1 to 1 visits, and encourage resident. Activity Progress Notes included documentation of resident visits for dates of 5/18/2015 and 6/26/2015, and was signed by the Activity Director (AD). The admission Minimum Data Set (MDS) assessment dated 5/20/2015 revealed resident #134 was severely cognitively impaired, and required extensive assistance from staff for activities of daily living (ADL's). Her preferences for activities indicated it was very important to listen to music and participate in religious services. Her activity care plan was last updated on 9/22/2015 and included a goal to participate in 1:1	F 248	The Plan of Correction is this facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. 1) Residents # 134 & #96 were reevaluated for activity preferences with updates added to care plan if needed on 12/22/2014 by facility Activity Director. Residents #134 & #96 will be offered and attend activities that meet their interest with participation documented. 2) Current facility residents will be provided activities, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of each resident. An audit of activity preferences of severely cognitively impaired residents was completed on 12/23/2014 by facility Activity Department staff. Resident	12/31/15

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

Electronically Signed | 12/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 248	Continued From page 1 visits as desired at least 2 times per week through next review date of 12/21/2015. The approaches included provide 1:1 visits, invite to scheduled activities, offer variety of activity types and locations, and offer to assist resident to activity functions. The activity calendar for November 2015 included Sunday services at 10am, and devotions Tuesday at 10am, each week. An interview was conducted on 11/30/2015 at 3:08 PM with the resident's family member, who stated the resident did not go to activities, she usually stayed in bed. The resident, who was in attendance during the interview, was in her bed, but did not speak. On 11/30/2015 at 3:30 PM a musician was playing music in the dining room. The resident was not in attendance. On 12/1/2015 at 10:45 AM, a singer was preforming in the dining room. The resident was not in attendance. An observation on 12/1/2015 at 4 PM, found the resident sitting up in her bed staring. She did not speak when spoken to. On 12/2/2015 at 8:49 AM the resident was sitting up in the recliner chair in her room. She answered yes when asked if she wanted to go to an activity today. An interview was conducted with the nurse (nurse #6), on 12/2/2015 at 10:10 AM. The nurse stated the resident was alert today and up in the chair. She stated that sometimes she will sit in the hallway. On 12/2/2015 at 10:50 AM an interview was conducted with the nursing assistant (NA #4), who stated she got the resident up in a chair twice per week. She did not have an answer why the resident did not go to hear the music on 11/30/2015, and stated she did not have the	F 248	preferences were updated as needed and added to care plans. 3) Activity Department employees were re-educated on 12/22/2015 & 12/23/2015 by SHCLearn partners regarding evaluating residents with severe cognitive impairment to ensure activities are provided that meet their interest and the physical, mental, and psychosocial well-being as well as properly documenting resident evaluations and participation. Current facility employees and new hires will be educated by the Administrator, Administrative Staff, and Activity staff regarding inviting & assisting residents, especially residents with severe cognitive impairment, to scheduled activities starting 12/22/2015. 4) Activity Director and/or Activity Assistant will conduct random audits of 5 residents with severe cognitive impairment to ensure they are being provided activities, in accordance with their individual comprehensive assessment, that meet their interest and their physical, mental, and psychosocial well-being . Audits will be conducted weekly for 4 weeks then monthly for 3 months. Audits will be documented on an audit tool and findings will be presented to facility Quality Assessment & Assurance (QAA) Committee monthly. Any negative issues or trends will be corrected and addressed by the committee to ensure compliance. Any issues or trends identified will be addressed by the QAA committee as they arise and the plan will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 248	Continued From page 2	F 248		

resident on 12/1/2015, so she did not know why the resident did not go to the activity.
On 12/2/2015 at 11:49 AM, an interview was conducted with the Activities Director (AD), who stated the facility had offered to take her to activities in the past, but she didn't offer yesterday. She indicated that she knew she needed to get some activities for the residents that couldn't participate fully, and she was going to get that started.
An interview was conducted with NA #5 on 12/3/2015 at 10:30 AM, who stated she had not taken the resident to activities before.
An interview was conducted with the AD on 12/3/2015 at 10:42 AM, who stated the resident had not been receptive to activities. The AD indicated she offered to take the resident to the devotion activity a couple of weeks ago, but the resident just looked at her and moved her head, so she took that to mean a refusal. She did not have documentation of refusals. The AD stated she usually stayed 10 to 15 minutes with the resident on a 1 to 1 visit and talked to the resident about her family, but that was probably a couple of months ago. She had no documentation of dates for 1 to 1 visits, after the 6/26/2015 visit.
An interview was conducted with the Administrator on 12/3/2015 at 10:42AM, who stated it was her expectation that an assessment for cognitive level would be done and activities would be geared for what the resident was able to do. She indicated that if a resident consistently refused activities, it should be documented by the AD or her assistant.
An interview was conducted with the assistant director for activities on 12/3/2015 at 11:20 AM. The assistant stated she stopped by to visit the resident yesterday, but does not know if the resident refused activities or not, because she

be revised to ensure continued compliance. The QAA committee consists of the Administrator, Director Of Nursing, RN MDS Coordinator, Activity Director, Social Service Director, Human Resource Coordinator, Physician Medical Director, and other members assigned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 248	Continued From page 3	F 248		

doesn't speak. She indicated she did not have any documentation or dates for visits with the resident.

#2. Resident # 96 was admitted to the facility on 6/25/2014 with diagnoses to include intellectual disability, below the knee amputation and difficulty walking.
A daily participation log dated 4/2015 listed Active Participation (A) on date 4/6/2015 for Independent activity and family visit; and 4/15/2015 for music program. Daily participation log dated 10/2015 listed "A" on 10/6/2015 for Religious service.
His annual Minimum Data Set assessment (MDS) dated 5/15/2015, revealed severe cognitive impairment, with extensive assistance from staff for activities of daily living (ADL's). His preferences for activities indicated it was very important to listen to music and participate in religious services.
The resident's care plan, last updated on 5/21/2015 listed as a problem impaired cognitive skills related to impaired intellectual abilities. Included in the interventions were invite, encourage, remind and escort to activity programs consistent with resident's interests.
An interview with the resident was conducted on 11/30/2015 at 2:52 PM. The resident was lying in bed, and stated he liked to watch any kind of games and sports.
On 11/30/2015 at 3:30 PM a musician was playing music in the dining room. The resident was not in attendance.
On 12/1/2015 at 10:45 AM, a singer was preforming in the dining room. The resident was not in attendance.
An interview was conducted with resident #96 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 248	Continued From page 4	F 248		

12/2/2015 at 8:44 AM, who stated he liked to go to activities. The resident was in his bed eating breakfast.
On 12/2/2015 at 10:53AM, an interview was conducted with the nursing assistant (NA #4), who stated the resident's family took him out to church on some Sundays. She indicated the resident was mobile once he was in his wheelchair, and he liked to go to activities and could take himself.
An interview was conducted with the Activity Director (AD) on 12/2/2015 at 12:01 PM, who stated the resident was not at the music activity the last 2 days, and did not know if anyone asked him. She stated she did not ask him. She indicated he went the dining room about a month ago and listened to the music, but it was an impromptu thing and she did not document anything. She indicated she talked to the resident and tried to ask him questions, but did not document when she had visits with him. She stated she had no way to make sure someone was conducting 1 on 1 visits regularly.
On 12/2/2015 at 12:09 PM an interview was conducted with NA #6, who stated she got the resident up in the wheelchair twice per week. He could propel himself to the dining room with verbal cues. She indicated he sometimes refused to get up out of bed.
An interview was conducted with the resident on 12/3/2015 at 10:19 AM, who stated he would go to activity today if the lady came and got him. He indicated he was heavy and they were light and they needed help to get him in the chair.
An interview was conducted with the Administrator on 12/3/2015 at 10:42AM, who stated it was her expectation that an assessment for cognitive level would be done and activities would be geared for what the resident was able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 248	Continued From page 5 do. She indicated that if a resident consistently refused activities, it should be documented by the AD or her assistant. An interview was conducted by the assistant for activities on 12/3/2015 at 11:20 AM, who stated the resident would come to devotion activities on Tuesdays if he was up. She stated he had come to devotions not that long ago, about 6 weeks, but she did not have any documentation of his attendance at activities.	F 248		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		12/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 278	Continued From page 6 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to code the MDS accurately for 2 of 18 residents (#83 and #104), reviewed for MDS accuracy. The findings included: 1. Resident #83 was re-admitted to the facility on 8/12/2015 with diagnosis of pulmonary embolism. The most recent minimum data set (MDS) assessment dated 10/20/2015 revealed his cognitive status to be intact. He was independent with dressing and toileting, but frequently incontinent. On 12/2/2015 at 12:27 PM, an interview was conducted with the Nursing Assistant (NA #1), who stated the resident was alert and oriented and was always continent. She indicated if he was coded on the assessment as incontinent, then it was miscoded. An interview was conducted on 12/2/2015 at 1:59 PM with the nurse (nurse #1), who stated the resident was alert and oriented. She indicated he had not been incontinent. On 12/2/2015 at 3:04 PM, an interview was conducted with Resident #83, who stated that he could take care of himself. He indicated he did most of his care himself, and had never had an accident with toileting. On 12/3/2015 at 7:57 AM, an interview was conducted with the NA (NA #2). She indicated he was alert and oriented and would tell her when he needed assistance. She stated he could take himself to the bathroom, and had not been incontinent with toileting.	F 278	The Plan of Correction is this facility s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. 1. A) The Minimum Data Set (MDS) for Resident # 83 was modified on 12/4/2015 by RN MDS Coordinator to accurately reflect continent status. RN MDS Coordinator on 12/21/2014 printed incontinent sheets for upcoming ARDs. The RN MDS Coordinator reviewed the incontinent sheets for coding inconsistencies and interviewed aides involved for accuracy. Coding was changed in electronic system with documentation added to the incontinent sheets. B) The MDS for Resident # 104 was modified on 12/4/2015 by RN MDS Coordinator to accurately reflect indwelling urinary catheter and significant weight loss. 2. Current facility residents will receive assessments that accurately reflect their status. An audit was started on 12/4/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 278	Continued From page 7 An interview was conducted on 12/3/2015 at 8:02 AM with the nurse (nurse #2). The nurse stated the resident got up and went to the bathroom himself, he was not incontinent. An interview was conducted with the MDS nurse on 12/3/2015 at 9:14 AM, who stated she coded what the NA's charted in the activities of daily living (ADL) tracker. She indicated she generally just looked at the number of times a resident was incontinent and coded it according to that, and took no steps to question or verify the accuracy of the data in the tracker. The MDS nurse then printed the ADL data for bladder incontinence during the MDS look back period of 10/14/2015 to 10/20/2015. It was noted that one NA who worked the night shift had coded Resident # 83 for the same number of incontinent episodes and continent episodes at the same time each night she had worked. The MDS nurse stated that the coding did not look accurate. The MDS nurse indicated she did not know what she could do to ensure the accuracy of the MDS coding. On 12/3/2015 at 9:51PM, an interview was conducted with the Director of Nursing (DON), who stated she expected that if the MDS nurse found discrepancy with the ADL's she should talk to the resident and do an assessment to make sure the MDS was correct. Additionally, if a NA was identified as making errors, the MDS should let the DON know, so that additional training could be done. 2a. Resident #104 was readmitted to the facility on 10/21/15. Diagnoses included neurogenic bladder and enlarged prostate. Physician orders on readmission included an indwelling urinary catheter to be changed monthly and as needed for occlusion, leakage or removal.	F 278	and completed on 12/22/2015 by RN MDS Coordinators & DON of current facility residents reviewing coding of Bowel and Bladder function, indwelling urinary catheters, and significant weight loss to ensure accurate coding. Modifications were submitted on any resident found to have a discrepancy. 3. Facility Interdisciplinary Team to include Director of Nursing (DON), Dietary Manager, RN MDS Coordinators, and Administrator received education from the Clinical Reimbursement Specialist on 12/18/2015 regarding accurate MDS coding with emphasis on bowel and bladder function, indwelling urinary catheter, and significant weight loss. Training also included coding resident cognitive status and making self understood in addition to reviewing Certified Nursing Assistant coding with employee interview as needed for residents in reference window as it relates to accuracy verification. IDT Team will review Certified Nursing Assistant coding sheets for Bowel & Bladder function, dietary progress notes and weight sheets for patients with significant weight loss, and nursing notes of patient with indwelling catheters to verify accuracy of documentation for patients in assessment reference window Monday through Friday during morning clinical review. Needed updates to patient assessment will be noted in electronic system and documented on Certified Nursing Assistant coding sheets for Bowel & Bladder function, dietary progress notes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 278	Continued From page 8 The quarterly Minimum Data Set (MDS) dated 10/28/15 was not coded for a catheter. During an interview on 12/3/15 at 8:45 AM, the MDS Nurse indicated the resident should have been coded as having a catheter. 2b. Resident #104 was admitted to the facility on 6/11/15 and last readmitted 10/21/15. The admission nursing assessment dated 6/11/15 revealed the resident weighed 178.8 pounds. The admission Minimum Data Set (MDS) dated 6/18/15 revealed a weight of 179 pounds. A significant change in condition MDS dated 7/30/15 revealed a weight of 166 pounds, reflecting a weight loss of 7.3%. The MDS of 7/30/15 was not coded to reflect a significant weight loss in the last month. The quarterly MDS dated 9/6/15 revealed the resident weighed 134 pounds, reflecting a 19% weight loss since the significant change MDS of 7/30/15. The MDS of 9/6/15 was not coded to reflect a significant weight loss in the last month. During an interview on 12/3/15 at 11:47 AM, the registered dietician indicated that the MDSs dated 7/30/15 and 9/6/15 should have been coded for weight loss. During an interview on 12/3/15 at 12:01 PM, the Dietary Manager (DM) stated she was responsible for coding the Swallowing/Nutrition section of the MDS. The DM explained that for the MDS of 7/30/15 she did not check the weight on the admission record but used the first weight recorded in the "Weight" section of the computer. This weight was 169.5 pounds and dated 6/18/15.	F 278	and weight sheets for patients with significant weight loss, and nursing notes of patient with indwelling catheters to show accuracy was verified. Certified Nursing Assistants were re-educated by RN MDS Coordinators regarding accurate Bowel and Bladder continence/incontinence, indwelling urinary catheter, and ostomy documentation completed on 12/15/2015. Newly hired Certified Nursing Assistants will receive accurate Bowel and Bladder continence/incontinence, indwelling urinary catheter, and ostomy documentation training in orientation. Certified Nursing Assistants with identified coding discrepancies will have one on one session with RN MDS Coordinators to verify coding accuracy and make changes as needed. Change will be documented in the electronic system as well as on the Certified Nursing Assistant coding sheets showing accuracy verification. 4. Random audits will be conducted of 10 MDS assessments each week prior to submission by RN MDS Coordinators reviewing coding of Bowel and Bladder function, indwelling urinary catheters, and significant weight loss. These audits will be conducted weekly for four weeks, then monthly for three months. Results of Audits will be presented to facility Quality Assessment & Assurance (QAA) Committee monthly by the RN MDS Coordinator. Any issues or trends identified will be addressed by the QAA committee as they arise and the plan will be revised to ensure continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 278	Continued From page 9 The DM speculated that for the MDS of 9/6/15 she had misread the weight report and missed the significant weight loss. The DM indicated that the MDSs should have been coded for weight loss.	F 278	compliance. The QAA committee consists of the Administrator, DON, RN MDS Coordinator, Activity Director, Social Service Director, Human Resource Coordinator, Medical Director, and other members assigned.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews the facility failed to administer medication as the doctor ordered for 1 of 5 residents (# 17), reviewed for unnecessary medication. The findings included: Resident # 17 was re-admitted to the facility on 5/20/2015, with diagnoses to included neuropathy. Her quarterly Minimum Data Set (MDS) assessment dated 9/9/2015 revealed her cognition to be moderately impaired. She had no behaviors, and required extensive assistance from staff for activities of daily living (ADL). Physician orders dated 11/1/2015 thru 11/30/2015 included an order for fentanyl (a pain medicine) 25 micrograms (mcg) per hour patch every 3 days, and Lortab (a pain medication) 10-325 milligrams (mg) 1 tablet every 6 hours as needed for pain. The Medication Administration Record (MAR), dated 11/1/2015 thru 11/30/2015 revealed the patch was administered on 11/2, 11/5, 11/8,	F 333	1. The Plan of Correction is this facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. 12/2/15 Director of Nursing (DON) verified Resident #17 fentanyl 25 micrograms per hour patch every 3 days order was correct and being administered per physician order. MD and responsible party notified on 12/2/15. 12/2/15 Nurse #1, #4, #5, and #6 were re-educated by the DON on the five rights of medication administration to include verification of analgesic patch placement as well as date of application of patch for each shift. Also educated prior to administering analgesic patch verify last	12/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 333	Continued From page 10 11/10, 11/11, 11/22, 11/28. "Dose not due" was recorded on 11/16, 11/19, and 11/25. The MAR contained a treatment /procedure for "check patch placement every shift", which was documented as completed every shift for November 2015. An interview was conducted with the resident on 12/2/2015 at 8:26 AM. The resident stated she had pain all the time in her feet and legs. She indicated her pain was relieved when she received pain medication and she asked for the pain medication when she needed it. An interview was conducted with the nursing assistant (NA #1) on 12/2/2015 at 12:24 PM, who stated the resident had reported pain in her legs and feet at times, and she would relay that information to the floor nurse. On 12/2/2015 at 3:45 PM an interview was conducted with the Director of Nursing (DON), who stated there was a glitch in the electronic MAR. She indicated when medications were ordered on a schedule other than daily, the system did not populate the MAR correctly, for the medicine to be given as ordered. She indicated the nurse should put the date on the patch when she was placing it, and it was the responsibility of the nurses each shift to check the patch. She stated she would expect the nurse to have checked the date, when removing the previous patch, before putting another one on. On 12/2/2015 at 4:55 PM an interview was conducted with the nurse (nurse #4). The nurse stated when she checked the pain patch, she checked it for placement and not the date of application. On 12/3/2015 at 9:38 AM, an interview was conducted with the DON. She stated she had identified the inaccuracy with the electronic MAR on 9/18/2015 and produced an email of this date	F 333	date the analgesic patch was signed on the narcotic sign out sheet, to the application date of the patch on the resident, to the date on the medication administration record (MAR); if administration of the fentanyl patch is off schedule discontinue the order and rewrite with the correct next administration date and immediately notify Director of Nursing of discrepancy. 2. Upon completion of 100% audit of resident's receiving fentanyl patches on 12/2/15 no other residents were found to be affected. The Director of Nursing (DON) reviewed the Electronic Medication Administration Record to verify administration compliance to physician orders. 12/8/15 the DON completed a 100% resident audit to identify 2 receiving other analgesic transdermal patch that all medications were being administered per physician orders. No issues were identified. The DON Conducted audits of 2 Licenses Nurses administering medications to 3 residents on 12/22/15 to identify nurse following five rights of medication administration as ordered by the physician including fentanyl patch. Any issues identified was immediately reported to the physician. 3. On 12/2/15 – 12/22 /15 the DON provided education to all licensed nurses regarding five (5) rights of medication administration to include verification of patch placement and date of application to be checked by Licensed Nurse each shift. Licensed Nurses were educated to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 333	Continued From page 11 she had sent to the information technology (IT) department of the makers of the MAR. She received a reply email from their IT department on 9/19/2015 that everything had been fixed. The DON indicated she reviewed the facility's MARs for the month of October 2015 and all medicines were populated correctly. She did not take the problem to the Quality Assurance meeting because she thought everything had been fixed. The current narcotics book was reviewed with the DON, and fentanyl had been checked out for the resident on 11/11/15, 11/18, 11/21, 11/28, and 12/1/2015. On 12/3/2015 at 12:45 PM, an interview was conducted with nurse #1 who worked with the resident on 11/14 and 11/15. The nurse stated she checked the placement of the patch and documented placement on those 2 days. She didn't notice if there was a date written on the patch or not. She did not have an answer for why the patch was not given on the 11/14/2015 when it was due. She stated the MAR will populate when a medicine is due and if the MAR did not populate when the medicine was due, she would not have thought to give it. A phone interview was conducted on 12/3/2015 at 2:18 PM with nurse #5. She stated the resident's pain patch schedule was every 3 days. She indicated the MAR populated on 11/10/2015 to give the resident a new patch, but that was a day early, as she could tell by the narcotics sign out sheet. She mistakenly documented that she gave the patch and forgot to go back into the system and correct it. She signed out a patch in the narcotics book on 11/11/15 and noted in the MAR on 11/11 that she gave the patch, which was when the patch was due. She stated that by putting the information about when the patch was given in the MAR, she thought the electronic MAR	F 333	verify the last date the analgesic patch was signed on the narcotic sign out sheet, to the application date of the patch on the resident, to the date on the medication administration record (MAR) to ensure the medication is being administered per physician order. If administration of analgesic patch is off schedule on the electronic MAR, discontinue the order on the electronic MAR and enter the correct next administration date and notify the DON immediately of discrepancy. This education will also be provided to all licensed nurses upon hire during orientation and at least annually through a skills review. 4. DON, Assistant Director Of Nursing (ADON) , SDC, MDS Nurse to monitor nurses during medication administration to validate the right resident, right time, preparing and giving medication in the prescribed dose, route, frequency; in addition verify the last date the analgesic patch was signed on the narcotic sign out sheet, to the application date of the patch on the resident, to the date on the medication administration record (MAR) (when indicated) for 3 residents weekly x 3 months to ensure professional standards of care that medications are given per physician orders. DON, ADON, SDC, will audit patches for application date with corresponding MAR and narcotic sheet sign out twice weekly for 1 month then once a week for 2 months. All data will be summarized and presented to the facility Quality Assessment & Assurance (QAA) committee meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 333	Continued From page 12 system would correct itself and populate the future entries on time. She indicated she did not notify the DON of the discrepancy, or document in the resident medical record about the discrepancy. She stated that she gave the patches every 3 days when she came back to work on 11/18/15. She stated the MAR populated on the dates of 11/16 and 11/19 which were not the correct dates for the patch, and that was why she had coded the MAR with medication not due. She did not make any notation in the medical record about the discrepancies in the dates, or notify the DON because she knew when the patch was to be given. She did not have an answer for failure to notify other staff that would be responsible for the medication in her absence. An interview was conducted with nurse #6 on 12/3/2015 at 2:37 PM who stated she remembered putting a patch on the resident. She stated she put the patch on the resident on 11/22/2015, and made an error when she signed out the patch from the narcotics book by writing the date of 11/21/2015. She indicated the MAR was the correct date, and the sign out sheet was an incorrect date. She stated she knew the facility had error problems with the electronic MAR system. She indicated when she checked for patch placement, she was looking to see if the patch was on, and did not usually check the date written on the patch.	F 333	monthly by the DON, SDC, or ADON. Any area or trends will be addressed by the QAA committee as they arise and the plan will be revised to ensure continued compliance. The QAA committee consists of the Administrator, DON, SDC, ADON, Environmental Service Director, Medical Director, Social Services Director, Plant Operator, and Dietary Services. Other members may be assigned as the need arises.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		12/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 431	Continued From page 13 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 observation, staff interview, facility policy and record review, the facility failed to maintain the temperature in 1 of 2 medication refrigerators (Unit 3) within a 36 - 46 degree Fahrenheit (F) range. The findings included: The facility policy dated 2007 and entitled "Storage of Medications" read in part,	F 431	The Plan of Correction is this facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 431	Continued From page 14 "Medications requiring 'refrigeration' or 'temperatures between 2 degrees Centigrade (C) (36 degrees F) and 8 degrees C (46 degrees F)' are kept in a refrigerator with a thermometer to allow temperature monitoring." A form entitled "Refrigerator Temp Log" was observed on 12/2/15 at 11:30 posted on the door of the facility's Unit #3 medication refrigerator. Directly under the title read, "Attention nurses please check the temps on the refrigerators at the beginning of your shift. The acceptable temp is 36 - 46 degrees. If the range is outside of these parameters, please remove everything and place it in another refrigerator and notify maintenance in writing so it can be fixed." The Log was dated 11/1/15 - 12/2/15. Temperatures were recorded daily. Temperatures from 11/1/15 - 11/21/15 were within the 36 - 46 degrees F range. On 11/22/15 the temperature was 34. From 11/23 - 11/27/15 the temperatures were within the acceptable range. On 11/28/15 the temperature was 25 degrees F; on 11/29/15, 22 degrees F; on 11/30/15 it was back in range at 36 degrees F. 12/1/15 and 12/2/15 both had recorded temperatures of 30 degrees F. On 12/2/15 at 11:30 AM, the thermometer inside the medication refrigerator on Unit 3 was observed, with Nurse # 1 in attendance, to read 30 degrees F. Unopened vials of insulin were observed in the refrigerator. The nurse stated the temperature should be between 36 - 46 degrees F and she was observed to adjust the refrigerator's thermostat at this time. Nurse #1 was observed to recheck the temperature at 12:00 PM. The thermometer continued to read 30 degrees F. The nurse adjusted the thermostat again. The insulin remained in the refrigerator. During an interview on 12/2/15 at 5:18 PM, the Director of Nursing (DON) stated medication	F 431	executed solely because it is required by the provisions of Federal and State Law. 1. Education was started on 12/2/15 with Licensed Nurses that are employed by the center on appropriate medication storage. This education was provided by the Director of Nursing (DON). Medications noted in unit 3 refrigerator unopened vials of insulin were immediately removed, sent back to pharmacy/or discarded and reordered on 12/2/15. Education was provided to Nurse #1 on Medication storage on 12/2/15. 2. Medication refrigerators, temperature logs, thermometers and storage areas have been inspected and reviewed by the DON and Assistant Director of Nurses on 12/3/15 to ensure all medications are stored within appropriate temperature range as well as proper storage, no other issues were identified. The DON, ADON's, Staff Development Coordinator (SDC), Wound Nurse or other Licensed Nurse will audit two medication refrigerators, one medication storage area and four medication carts at various times on all shifts to ensure medication storage compliance is met. One audit per shift will be completed. 3. Licensed Nurses will be educated by the Director of Nursing regarding proper medication storage, as well as appropriate temperatures for medication requiring refrigeration per policy. This education will be completed by 12/23/15. This training will be provided to all Licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 431	Continued From page 15 refrigerator temperatures should be between 36 - 46 degrees F. If the temperatures were outside this range medications should be moved to another refrigerator, the temperature should be adjusted and maintenance should be notified.	F 431	Nurses upon hire during orientation and at least annually through a skills review. 4. Ongoing audits will be performed by the DON, SDC, ADON's, Wound Nurse, or other Licensed Nurse to ensure all medications are within appropriate temperature range and stored properly per policy. Two medication refrigerators, one medication storage area and four medication carts will be audited weekly for three months , then monthly for eight months at various times on all shifts to ensure medication storage compliance is met. All data will be summarized and presented to the facility Quality Assessment & Assurance (QAA) committee meeting monthly by the DON, SDC, or ADON. Any area or trends will be addressed by the QAA committee as they arise and the plan will be revised to ensure continued compliance. The QAA committee consists of the Administrator, DON, SDC, ADON, Environmental Service Director, Medical Director, Social Services Director, Plant Operator, and Dietary Services. Other members may be assigned as the need arises.	
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 456		12/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 456	Continued From page 16 Based on observations and staff interviews, the facility failed to keep the walk in cooler free of water leaks and also failed to keep the freezer free of water leaks that refroze leaving an accumulation of ice on food products. Findings included: An observation was made during the initial tour of the kitchen on 11/30/15 beginning at 10:00 AM of a water leak in the walk in cooler. Upon further inspection, it was revealed the area in the ceiling that was leaking had a brown circle drawn around the leak. In the freezer area, the pipe running along the ceiling had icicles hanging that indicated water had leaked, dripped and refrozen. Observation also revealed under the hanging ice was 1-3 gallon container of ice cream with a 1-2 inch layer of ice on top and sides, 1 case of chocolate cream pies with 1-2 inches of solid ice build-up on the top and sides and 1 case of muffins with 1-2 inches of ice build-up on the top and sides. The Dietary Manager (DM) tried to brush the ice off the food products, but was unable to move the ice. The DM stated there was obvious thawing and refreezing evident in the freezer. The DM was interviewed at this time. She stated a few months back, the freezer had leaked in another place. She had reported it to the previous maintenance director (MD), but the freezer had not been repaired. The DM added the walk in cooler and the freezer only seemed to leak when it rained. The DM reported at approximately 3:00 PM on 11/30/15 that she had thrown out the iced over foods. The MD was interviewed on 12/02/15 at 10:46 AM. He stated he had known about the leak in the walk in cooler for a couple of weeks; adding it does not leak unless it is raining. The MD added when the DM reported the leaking cooler, he had	F 456	The Plan of Correction is this facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. 1. Walk in cooler and walk in freezer received service to include sealing joints to prevent leaks on 12/1/2015 by AB Robinson Heating & Air. 2. Walk in cooler and walk in freezer was re-inspected on 12/22/2015 by facility Maintenance Director and Dietary Manager to ensure proper function. Any identified function concerns will be corrected. 3. The Dietary Staff was educated on 12/22/2015 by the Maintenance Director regarding completing facility work order for identified maintenance concerns. The Maintenance Director will place a work order log book in the kitchen to be used by the Dietary employees as needed. The Maintenance Director and/or Maintenance Assistance will include checking the Dietary work order log book in his daily preventative maintenance rounds to ensure concerns are addressed timely. 4. The Maintenance Director and/or Maintenance Assistant will conduct weekly visual inspections of the walk in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 456	Continued From page 17 checked the leak and he was the person that had drawn the circle around the leak. He stated he had called a local company last week and they were supposed to check the cooler on 12/2/15. He added another vender that had been in the facility had looked at the leak, but had not given the facility a written assessment of the inside structure. He stated he had only been aware of the freezer leaking and refreezing when it was reported to him on 11/30/15 by the DM. The MD stated he had not assessed the leak in the freezer. Another interview was held with the DM on 12/3/15 at 9:40 AM. The DM acknowledged the ice build-up on the items in the freezer had been at least 1 inch or more. She stated the first time the freezer leaked was prior to the current MD starting and she had reported the leak to the former MD. The DM stated she thought enough time had passed that there had been enough time for the leak in the cooler and the freezer to be evaluated. The MD was again interviewed on 12/3/15 at 9:53 AM. He stated any maintenance issues were relayed via maintenance logs and verbally during morning meeting. The MD stated he had found out about the walk in cooler on a rainy day when someone (kitchen staff), pointed it out to him. The MD stated he could not recall the name of the staff person or the exact date, but thought it was about 2 weeks ago. He stated he made a mark around the leak in the cooler and even climbed on the roof to see if he could see a leak. He added he thought it may be water collecting around the drains, but the drains seemed to be draining properly. He stated he had not called any outside vendor to check the leak. He added about 3 days later, he called multiple vendors, but could not get anyone to	F 456	refrigerator and walk in cooler for four weeks, then monthly for three months. The results of the inspections will be presented to the facility Quality Assessment & Assurance (QAA) Committee monthly by the Maintenance Director. Any issues or trends identified will be addressed by the QAA committee as they arise and the plan will be revised to ensure continued compliance. The QAA committee consists of the Administrator, Director Of Nursing, RN MDS Coordinator, Activity Director, Social Service Director, Human Resource Coordinator, Physician Medical Director, and other members assigned.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 456	Continued From page 18 come into the area. The MD added while one vendor was in the facility running wires for the dishwasher, he got the repairman to walk into the cooler. The man had not given him a written assessment of the leak or any idea on how to fix the leak. The MD added after speaking with the surveyor yesterday, he was able to locate a company that agreed to come to the facility on 12/4/15 to check the walk in cooler and the freezer. The MD stated he had been unaware of the leaking and refreezing water in the freezer until the DM had notified him on 11/30/15 after the surveyor's initial tour of the kitchen. He stated while the freezer had not been involved in the leaking 2 weeks prior, he thought the leaking in the cooler and freezer had been all connected on Monday. He added he thought over time, the rain water could build up and affect the freezer too. He stated yesterday, after talking with the surveyor, he thought it was an emergency situation and had found a company to evaluate the leaks. The MD stated he had been unaware the freezer had leaked and refrozen prior to Monday. The MD was asked to provide documentation the initial freezer issues were reported. He relayed information back and stated there was no maintenance log that addressed the freezer leaking a couple of months ago.	F 456		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520		12/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 520	Continued From page 19 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility's Quality Assessment and Assurance Committee failed to implement, monitor and revise as needed the action plan developed to correct deficient practice in the area of medication storage (F431) cited during the recertification survey of 1/9/15. As a result, deficient practice in the area of medication storage was again cited on the current recertification survey. The findings included: This tag is cross referenced to: F431: Based on observation, staff interview, facility policy and record review, the facility failed to maintain the temperature in 1 of 2 medication refrigerators (Unit 3) within a 36 - 46 degree Fahrenheit (F) range.	F 520	The Plan of Correction is this facility□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. 1. Administrative team members consisting of the Director Of Nursing (DON), Assistant Director of Nursing (ADON), Dietary Manager, Housekeeping Supervisor, Maintenance Director, Chaplain, Quality of Life Director, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 520	Continued From page 20 During the recertification survey of 1/9/15 the facility was cited for failing to discard expired medications and failing to verify the presence of an expiration date on bottles of acetaminophen. On 12/3/15 at 2:04 PM an interview was held with the Director of Nursing (DON). She stated that after the last recertification survey the facility put a plan of correction in place to ensure expired medications were not on the medication carts and stock medication bottles had expiration dates. She said the QA committee determined the issues with medication storage were resolved on 5/18/15 since no problems had been found during the monitoring period. The DON indicated the QA measures were focused on the specific issues cited and did not review all the requirements of the regulation.	F 520	MDS Coordinator, Medical Records, Human Resource Manager, and Social Service Director were educated on 12/23/2015 by the Administrator regarding facility Quality Assessment & Assurance procedures to include: 1) Committee membership consisting of the Director of Nursing, Physician Medical Director and three other members of the facility staff; 2) Committee meeting times being monthly and no less than quarterly; and 3) Committee purpose of identifying quality issues then developing, implementing, and revising as needed appropriate plans of action to correct identified issues. Medications noted in unit 3 refrigerator unopened vials of insulin were immediately removed, sent back to pharmacy/or discarded and reordered on 12/2/15. Education was provided to Nurse #1 on Medication storage on 12/2/15 by the DON. 2. Current facility residents have the potential to be affected by the alleged deficient practice. Medication refrigerators, temperature logs, thermometers and storage areas have been inspected and reviewed by the DON and Assistant Director of Nurses on 12/3/15 to ensure all medications are stored within appropriate temperature range as well as proper storage, no other issues were identified. The DON, ADON's, Staff Development Coordinator (SDC), Wound Nurse or other Licensed Nurse will audit two medication refrigerators, one medication storage area and four medication carts at various times	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 520	Continued From page 21	F 520	on all shifts to ensure medication storage compliance is met. One audit per shift will be completed. Facility Quality Assessment & Assurance Committee has added audits to the monthly agenda to ensure corrective action plan oversight, implementation, and revision as needed. 3. Administrative team members consisting of the Director Of Nursing (DON), Assistant Director of Nursing (ADON), Dietary Manager, Housekeeping Supervisor, Maintenance Director, Chaplain, Quality of Life Director, RN MDS Coordinator, Medical Records, Human Resource Manager, and Social Service Director were educated on 12/23/2015 by the Administrator regarding facility Quality Assessment & Assurance procedures to include: 1) Committee membership consisting of the Director of Nursing, Physician Medical Director and three other members of the facility staff; 2) Committee meeting times being monthly and no less than quarterly; and 3) Committee purpose of identifying quality issues then developing, implementing, and revising as needed appropriate plans of action to correct identified issues. RN Signature Care Consultant educated the Director of Nursing on 12/22/2015 regarding proper medication labeling and storage to include: 1) Medications and biologicals in medication rooms, carts, boxes, and refrigerators were maintained within secured (locked) locations, accessible only by designated staff with clean and sanitary conditions and proper temperatures in accordance with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 520	Continued From page 22	F 520	manufacturer specifications; 2) Schedule II controlled medications (excluding single-unit packaging in minimal quantities that can readily be detected if missing) were maintained within separately locked permanently affixed compartment; 3) Sufficiently detailed records of receipt and disposition of controlled medications were maintained to enable an accurate reconciliation; 4) All medications records were in order and an account of all controlled mediations was maintained and periodically reconciled; and 5) Medications and biologicals labeled in accordance with currently accepted professional principles, to include appropriate accessory and cautionary instructions as well as expiration date, when applicable. Education was started on 12/2/15 with Licensed Nurses that are employed by the center on appropriate medication storage. Licensed Nurses will be educated by the Director of Nursing regarding proper medication storage, as well as appropriate temperatures for medication requiring refrigeration per policy. This education will be completed by 12/23/15. This training will be provided to all Licensed Nurses upon hire during orientation and at least annually through a skills review. 4. Ongoing audits will be performed by the DON, SDC, ADON's, Wound Nurse, or other Licensed Nurse to ensure all medications are within appropriate temperature range and stored properly per policy. Two medication refrigerators, one medication storage area and four	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 520	Continued From page 23	F 520	medication carts will be audited weekly for three months , then monthly for eight months at various times on all shifts to ensure medication storage compliance is met. All data will be summarized and presented to the facility Quality Assessment & Assurance committee meeting monthly by the DON, SDC, or ADON. Any issues or trends identified will be addressed by the QAA committee as they arise and the plan will be revised to ensure continued compliance. The QAA committee consists of the Administrator, DON, RN MDS Coordinator, Activity Director, Social Service Director, Human Resource Coordinator, Physician Medical Director, and other members assigned. RN Signature Care Consultant will review facility QAA committee meeting minutes monthly to ensure committee continues corrective action plan oversight, implementation, and revision as needed with regard to complete medication and biological labeling and storage regulations.	