STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING ______ B. WING ______	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews, the facility failed to notify a resident ' s responsible party of a room change for 1 of 1	F 157	Roanoke River Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies	1/29/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 01/30/2016

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

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F 157	Continued From page 1 resident (Resident #62) reviewed for room transfers. The findings included: Resident # 62 was admitted to the facility on 6/1/2015 with diagnoses to include dementia with behavioral disturbances. His Minimum Data Set (MDS) assessment dated 10/13/2015 revealed his cognition to be severely impaired. He was independent with locomotion on and off the unit. He had verbal behavior directed toward others which occurred daily. A wandering assessment dated 11/26/2015 indicated the resident was at risk for wandering. A progress note dated 12/26/2015 at 1:10 PM revealed Resident #62 was " trying to find a way out " and was placed on the (Alzheimer ' s) unit as an intervention. This was at the direction of the Director of Nursing (DON), and was signed by Nurse #1. No additional notes were made for notification of resident ' s responsible party. An interview was conducted with the resident ' s family member on 1/4/2016 at 4:52 PM. The family member stated the resident had been moved from his room to a room on the locked Alzheimer ' s unit, but she had not been notified. She indicated she called the facility some days after that to talk to the nurse, and was informed at that time that he had been moved. On 1/6/2015 at 9:57 AM, an interview was conducted with Nurse #1. The nurse stated she was the nurse taking care of the resident when he was moved to the locked unit. She indicated the resident was going from exit door to exit door trying to leave the facility, and could not be redirected. She called the DON on the phone and was told to place the resident on the Alzheimer ' s unit. She was not sure why the family was not notified. She did not call the family and indicated the Social Worker (SW) usually	F 157	and proposes this place of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Roanoke River Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. 1. Resident #62 responsible party was notified of room change on 12/29/15 by the DON and documented in the resident’s medical record in a follow up note on 1/25/16. 2. 100% audit of all current residents’ progress notes will be reviewed for the past 30 days, to include resident #62, to ensure the MD/RP was notified of any resident identified with a change in condition or treatment, to include room changes. This audit will be completed by 1/29/2016 by the DON, ADON, QI nurse, and the UNIT MANAGER utilizing a RP/MD notification QI tool. Any areas of concerns will be addressed by the DON, ADON, QI, UNIT MANAGER at that time of the audit with MD/RP notification and documentation in the medical record.	

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F 157	Continued From page 2 called the family for room changes. An interview was conducted with the SW on 1/6/2015 at 10:35 AM. The SW stated that when a resident was moved to a different room because of a need, not a request, she or the DON would call the family and let them know why the resident needed to change rooms. She stated she did not call Resident #62 ' s family because she was on vacation at that time. An interview was conducted with the DON on 1/6/2015 at 10:54 AM. The DON stated the family was notified of the room change because she called the family, or the family called her. She couldn ' t remember who called first. She acknowledged that nothing was documented about the notification and she couldn ' t remember what the facts were. She stated her expectations were that the floor nurse would notify the family of the room change since it occurred on the weekend.	F 157	100% of all licensed nurses, to include nurse #1, will be inserviced to ensure all responsible parties are updated timely with any change in condition or treatment, to include room changes, and to ensure the notification is documented in the resident's medical record will be completed by 1/29/16. All newly hired licensed nurses will be inserviced to ensure all responsible parties are notified timely with any change in condition or treatment, to include room changes, and to ensure the notification is documented in the resident's medical record on orientation by the Staff Facilitator. 3. 100% of current resident's, to include resident #62, will be reviewed for change in condition or treatment using the 24 hour report, MD orders, progress notes and walking rounds with be conducted for room changes to ensure RP/MD notification by the ADON and QI nurse 3 X's a week for 4 weeks, then weekly X's 4 weeks and then monthly X's 1 month utilizing an RP/MD notification QI tool and addressing any areas of concerns at that time. The DON will review and initial the RP/MD notification QI tool to ensure all areas of concerns were addressed weekly X's 8 weeks and then monthly X's 1 month . 4. The Executive QI committee will meet monthly and review RP/MD Notification tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 166	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO	F 166		1/29/16

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F 166 SS=D — Continued From page 3 — F 166

RESOLVE GRIEVANCES

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews, the facility failed to resolve a grievance regarding missing clothing for 1 of 3 residents (Resident # 99) reviewed for missing property.

Findings include:

Resident #99 was admitted 6/21/13 with diagnoses which included hemiplegia and legally blind. Her most recent quarterly Minimum Data Set (MDS) of 10/12/15 indicated she was cognitively intact and she required supervision with eating and personal hygiene. She was independent with dressing requiring set up only.

An interview was conducted 01/04/2016 at 4:24 PM with Resident #99. She reported she had a suitcase full of clothes in her closet and someone had taken almost all of them. She added an overnight bag was unzipped and some of the clothes hanging in the closet were missing. The resident could not recall when she discovered the missing clothing. She stated she had spoken with the Administrator twice. She reported he said he would come back and go through the closet to see what was missing. She stated he told her he had not had time.

An interview was conducted 1/6/16 at 11:54 AM

Roanoke River Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this place of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.

Roanoke River Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

1. Resident #99 concerns on the issue of missing clothing was written on a Resident Grievance form and the Social Worker and the Administrator addressed the Resident concern on 1/6/16 with resolution with the concerned person at

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F 166	Continued From page 4 with NA #1. She stated the resident had talked about the missing clothes every day for the past 3 weeks. She said the resident indicated someone had taken her church clothes. She stated she reported this to Nurse #1 and Nurse #2. An interview was conducted 1/6/16 at 9:01 AM with Nurse #1. She stated the resident had not said anything to her about the missing clothes. She did not recall staff reporting the missing clothes to her. An interview was conducted 1/6/16 at 1:47 PM with Nurse #2. He stated the resident had not said anything to him about the missing clothes but he had heard about them. He stated if missing clothes were reported, he would have given that information to the DON. An interview was conducted 1/6/16 at 2:05 PM with the DON. She stated she was aware Resident #99 reported missing clothing but was not aware of when the items went missing. She stated the Administrator investigated missing items in the facility. An interview was conducted on 1/6/16 at 2:08 PM with the Administrator. He stated he was aware Resident #99 had missing items but could not recall when they were reported missing. He stated it was the facility ' s practice to write up missing clothing in a grievance notice. A second interview was conducted on 01/07/2016 at 12:02 PM with the Administrator. He stated he thought the missing clothing items had been reported approximately a week ago. He reported he told the resident he would come back with the social worker and see what was missing. He	F 166	that time. 2. 100% audit of all resident concerns for the past 30 days, to include any for resident #99, will be reviewed by the Social Worker to ensure all resident concerns were completed and resolved timely using a Grievance Resolution QI tool by 1/29/2016. Any concerns identified will be corrected and documented at the time of the audit by the social Worker. 100% in-service will be conducted by the staff facilitator with all licensed nurses to include Nurse #1 and nurse #2, and CNAs, to include NA#1, regarding the facility Grievance process to include ensuring all Resident Concerns are completed on the appropriate sheets and appropriate department managers are notified immediately of the concern by 1/29/2016. Also the facility Grievance process will be reviewed with department managers to include the Activities director, Administrator, Director of Nursing (DON), Maintenance, Dietary manager, Social Worker (SW), A/R bookkeeper, Admissions coordinator and Therapy manager regarding ensuring the grievance procedure is being followed appropriately per policy and procedure on 1/26/16 by the Facility Consultant. All newly hired license nurses, CNAs, maintenance, dietary, housekeeping, therapy, bookkeeping or activities will be inserviced on the Grievance process during orientation by the staff facilitator or the DON. 3. All residents□ concerns, to include resident #99, will be reviewed to ensure all concerns were completed timely and	

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F 166	Continued From page 5 stated he had not yet had an opportunity to do so. He was shown the grievance logs from December and January. He added he thought he had written up the missing clothing but it was not on the logs.	F 166	resolved with follow up documentation using a Grievance Resolution QI tool and any issues will be addressed at that time by the Social Worker 3X□s a week X□s 4 weeks, then weekly X□s 4 weeks and then monthly X□s 1 month. The Administrator will review and initial the Grievance Resolution QI form weekly X□s 8 weeks and then monthly X□s 1 month to ensure all concerns were resolved timely and with follow up documentation completed and any areas of concerns were addressed. 4. The Executive QI committee will meet monthly and review audits the Grievances Resolution tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain walls, leaking faucets, toilets, paper towel dispensers, air conditioner seals, cabinets, and a portable toilet seat in good repair on 4 of 4 halls in the facility. The findings included: A tour was conducted of Resident rooms and bathrooms on the Skilled, Martin, Peel, and Locked Units on 1/05/16 beginning at 8:30 AM	F 253	Roanoke River Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this place of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written	2/4/16

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F 253	Continued From page 6 and ending at 10:15 AM. Observations of resident rooms and bathrooms on the Skilled Hall revealed the following: a. Resident room #40 had a sink that was rusted around the sink faucet. The caulking around the toilet in the shared bathroom between room # 40 and room #42 had broken pieces falling off and was not providing a secure seal of the toilet base to the floor. The caulking around the air conditioning unit on the room ' s outer wall was breaking away from the wall and did not provide a secure seal around the entire unit. b. Resident room #43 had a sink that was rusted around the sink faucet. The caulking around the toilet in the shared bathroom between room # 43 and room #45 had broken pieces falling off and was not providing a secure seal of the toilet base to the floor. c. Resident room # 46 sink faucet leaked when the cold water was turned on. The wood at the base of the bathroom door frame was rotted for about two inches on the side near the sink. The caulking around the air conditioning unit on the room ' s outer wall was breaking away from the wall and did not provide a secure seal around the entire unit. d. Resident room #47 caulking around the toilet in the shared bathroom between room # 47 and room #49 had broken pieces falling off and was not providing a secure seal of the toilet base to the floor. The baseboard in the shared bathroom was not affixed securely to the bathroom wall on the wall that separated the bathroom and room #47. The caulking around the air conditioning unit on the room ' s outer wall was breaking away from the wall and did not provide a secure seal around the entire unit. e. Resident room # 311 had 13 open holes ranging from ¼ inch to ½ inch in radius on the	F 253	allegation of compliance. Roanoke River Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. 1. Maintenance issues noted in rooms #40, 42, 43, 45, 46, 47, 311, 4, 10, 11 18, 104, 110, 25, 27, 55, 57, 58 are to be addressed with all issues corrected by 2/4/2016. All corrections will be recorded on the initial correction QI tool. 2. 100% audit of all resident care areas will be conducted by the Maintenance Director to identify any of the noted issues located in other areas. This is to be completed by 2/2/2016. If areas are identified, the location and specification of issue will be recorded on the Maintenance Audit QI tool. Identified issues will be placed on a maintenance improvement schedule to address all issues and make necessary repairs and order required equipment. The maintenance department will be in-serviced by the Administrator by 2/2/2016 that all issues identified via the audit or work orders are the responsibility of the maintenance depart to address in a timely manner, and all areas identified via this POC are to be appropriately addressed by the Maintenance Department in the time frame depicted in	

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F 253	Continued From page 7 wall below the toilet dispenser. The portable raised toilet seat in the room was rusted and the hand rails on both sides were cracked. Observations of resident rooms and bathrooms on the Martin Hall revealed the following: a. Resident room # 4D wardrobe cabinet had a jagged broken corner on the door. The plastic trash can under the sink used by the residents in 4D and 4W was cracked. b. Resident room # 10 caulking around the air conditioning unit on the room ' s outer wall was breaking away from the wall and did not provide a secure seal around the entire unit. c. Resident room # 11 caulking around the air conditioning unit on the room ' s outer wall was breaking away from the wall and did not provide a secure seal around the entire unit. The bedside table for resident in room # 11W was in disrepair with the veneer around the dresser surface pulled away from the dresser. d. Resident room# 18W wardrobe cabinet had a jagged broken corner on the door. e. Resident room # 104W large build in cabinet was scraped and needed painting. The middle dresser drawer in the unit did not open and close properly. f. Resident room # 110 had a broken tray table which did not roll properly and had an uneven tray surface where the laminate was damaged. The caulking around the sink was breaking away and did not provide a secure seal to the wall. Observations of resident rooms and bathrooms on the Peel Hall revealed the following: a. Resident room # 25 had a broken toilet paper holder which. b. Resident room # 27D had a bedside dresser with one broken drawer which did not open and close properly. Observations of resident rooms and bathrooms	F 253	the maintenance improvement plan. 3. The Maintenance Director will conduct routine inspections of the facility to note monitor the physical condition of the interior of the facility. During these inspections, the building will be checked to ensure the interior is to remain in good repair, and any needed actions are to be documented on the Maintenance Weekly Inspection QI tool. These inspections will be conducted weekly and turn into the Administrator weekly X4 weeks, then monthly X2 months. 4. The executive QI committee will meet monthly and review all audits and inspections and address any issues, concerns, or complication in completing this correctional plan and make changes as necessary. The committee will monitor this monthly x3 months.	

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on the Locked Unit revealed the following:
a. Resident room # 55 paper towel dispenser beside the sink was rusted.
b. Resident room # 57 paper towel dispenser beside the sink was rusted. The caulking around the air conditioning unit on the room ' s outer wall was breaking away from the wall and did not provide a secure seal around the entire unit.
c. Resident room # 58 bathroom baseboard was not was not affixed securely to the bathroom wall in multiple areas of all four walls. The bathroom toilet paper holder was broken and unusable. The room had 20 open holes ranging in size from ¼ inch to ½ inch in radius on the wall near the paper towel dispenser. The paper towel dispenser beside the sink was rusted.
Review of the facility maintenance requests from August, 2015 to present revealed there were no requests in regards to the identified areas observed on 11/05/16.
In an interview on 1/05/16 at 2:30 PM with the Maintenance Supervisor it was revealed he had worked at the facility as Maintenance Supervisor for the past eight months. He stated that during that time he had been unable to establish an effective room audit program to identify maintenance issues due to being involved in major electrical rework in the facility required by the Life Safety Division. He also stated he had a maintenance assistant who had been out on family medical leave for the past 3 months. This absence had further complicated his ability to maintain the facility equipment in good working function. The Maintenance Supervisor stated he became aware of maintenance needs from maintenance requests submitted by staff and by auditing rooms on a weekly basis to observe for maintenance issues. He stated that neither of these systems had been working properly to the

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F 253	Continued From page 9 overload of maintenance demands he had faced since beginning work at the facility. He stated he tried to " stay on top of issues like broken wheelchairs, beds, and recliners that directly impacted the residents. " In an interview on 1/06/15 at 11:00 AM with the facility administrator it was revealed his expectation was for the resident living environment to be maintained in proper working order. When the administrator was shown the above mentioned maintenance issues he agreed the facility was not being maintained " to proper standards " and that " the residents deserved a better environment. "	F 253		
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	F 278		1/29/16

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F 278	Continued From page 10 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to correctly code the Minimum Data Set (MDS) for 10 of 10 residents identified as being Preadmission Screening and Resident Review (PASRR) level 2 (residents identified as having a serious mental illness or mental retardation as defined by state and federal guidelines) (Residents #16, #34, #40, #41, #43, #49, #53, #61, #98 and #99) and failed to correctly code the use of diuretic medication on the MDS for 1 of 5 residents reviewed for unnecessary medications (resident #4). Findings included: 1. On 1/04/2015 the facility provided the survey team with an entrance conference worksheet with PASRR level 2 residents listed. a. Resident #16 had been identified as being a PASRR level 2. Resident #16's most recent annual assessment dated 10/14/2015 did not include PASRR level 2 information. b. Resident #34 had been identified as being a PASRR level 2. Resident #34's most recent annual assessment dated 6/17/2015 did not include PASRR level 2 information. c. Resident #40 had been identified as being a PASRR level 2. Resident #40's most recent comprehensive assessment dated 4/18/2015 did not include PASRR level 2 information. d. Resident #41 had been identified as being a	F 278	Roanoke River Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this place of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Roanoke River Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. 1. Resident #16, #34, #40, #41, #43, #49, #53, #61, #98 and #99 with Level II PASSAR numbers had MDS modifications completed on 1/6/16 for the information needed for the Level II PASSAR by the MDS nurses. The MDS for Resident #4	

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	345145	A. BUILDING ______ B. WING ______	01/07/2016

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F 278 (summary statement, continued)

PASRR level 2. Resident #41's most recent annual assessment dated 5/20/2015 did not include PASRR level 2 information.
e. Resident #43 had been identified as being a PASRR level 2. Resident #43's most recent comprehensive assessment dated 11/15/2015 did not include PASRR level 2 information.
f. Resident #49 had been identified as being a PASRR level 2. Resident #49's most recent annual assessment dated 10/29/2015 did not include PASRR level 2 information.
g. Resident #53 had been identified as being a PASRR level 2. Resident #53's most recent annual assessment dated 7/28/2015 did not include PASRR level 2 information.
h. Resident #61 had been identified as being a PASRR level 2. Resident #61's most recent annual assessment dated 7/13/2015 did not include PASRR level 2 information.
i. Resident #98 had been identified as being a PASRR level 2. Resident #98's most recent annual assessment dated 10/01/2015 did not include PASRR level 2 information.
j. Resident #99 had been identified as being a PASRR level 2. Resident #99's most recent annual assessment dated 6/04/2015 did not include PASRR level 2 information.
An interview with MDS nurse #1 was conducted on 1/06/2016 at 3:54 PM. The nurse stated prior this survey she had been unaware of any PASRR level 2 residents residing in the facility. The nurse stated the MDS comprehensive assessments included an area to indicate PASRR level 2 conditions. The nurse stated MDS assessments needed to be accurate and needed to reflect the residents ' conditions.

An interview with the admissions coordinator (AC) was conducted on 1/06/2016 at 4:39 PM. The AC

F 278 (provider's plan of correction, continued)

was modified on 1/6/16 for the addition of the use of the diuretic by the MDS nurses.
2. 100% audit of all current resident most current MDS will be reviewed, to include residents #16, #34, #40, #41, #43, #49, #53, #61, #98, #99 and #4, by the DON and ADON to ensure all MDS's completed are accurate to include all diagnosis, medications, and correct PASSAR levels II and are coded correctly, was completed on 1/25/16 using a MDS Accuracy QI tool. Any issues will be addressed and documented at that time. 100% in-service was conducted with all MDS nurses to ensure all MDS assessments are completed accurately to include all diagnosis, medications, and PASSAR level II and are coded correctly on the MDS was completed on 1/25/16 by the MDS consultant.
3. 10% of completed MDS's, to include resident's #16, #34, #40, #41, #43, #49, #53, #61, #98, #99 and #4, will be reviewed to ensure all areas of the MDS are accurate to include diagnosis, medications and PASSAR levels by the ADON 3 X's a week X's 4 weeks, then weekly X's 4 weeks and then monthly X's 1 utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the ADON by retraining appropriate staff making the coding error and the MDS nurse will make modifications to the MDS with oversight by the ADON. The DON will review and initial the MDS Accuracy QI tool weekly X's 8 weeks and then monthly X's 1 to ensure any areas of concerns have been addressed.

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F 278	Continued From page 12 indicated before residents were admitted to the facility, each residents PASRR status is obtained. The AC stated she was not aware PASRR level 2 information was part of the MDS assessment. An interview with MDS nurse #2 was conducted on 1/07/2016 at 9:50 AM. The nurse stated she had been unaware of any residents residing in the facility who had been classified as PASRR level 2. The nurse stated it was important for the MDS to be accurate and correct and include PASRR level 2 information when these residents were identified. An interview with the Social Worker (SW) was conducted on 1/07/2016 at 10:39AM. The SW stated she obtained PASRR level 2 information from the admissions coordinator and kept this information on file should questions about any PASRR level 2 residents come up. The SW stated she had been unaware PASRR level 2 information was part of the MDS assessment. An interview with the Administrator and Assistant Director of Nursing (ADON) was conducted on 1/07/2015 at 11:59 AM. The Administrator stated he was aware of several PASRR level 2 residents residing in the facility but was unsure of who they were. The ADON stated she was unaware of any PASRR level 2 residents residing in the facility. The Administrator stated prior to this survey he had been unaware MDS needed this information for completion of the comprehensive assessment. The Administrator stated is was his expectation of the different departments to communicate information, problems and concerns with other departments. The Administrator and the ADON stated it was their expectation that the MDS should be accurate, complete and correct and if there were any	F 278	4. The Executive QI committee will meet monthly and review audits of MDS Accuracy tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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F 278	Continued From page 13 questions, staff should clarify the information. 2. Resident #4 was admitted to the facility on 8/7/2009 with diagnoses to include congestive heart failure and hypertension. Physician orders dated 10/1/2015 through 10/31/2015 included an order for Lasix (a diuretic) 20 mg (milligrams) daily. The Medication Administration Record (MAR) dated 10/1/2015 through 10/31/2015 revealed documentation of Lasix administered each day for the month. The Minimum Data Set (MDS) quarterly assessment dated 10/7/2015 did not indicate Resident #4 received a diuretic daily. Physician orders dated 12/1/2015 through 12/31/2015 included the order for Lasix 20 mg daily. The MAR dated 12/1/2015 thru 12/31/2015 revealed documentation of Lasix administration daily throughout the month. The quarterly MDS assessment dated 12/4/2015 did not indicate Resident #4 received a diuretic daily. An interview was conducted on 1/6/2015 at 11:07 AM with the MDS nurse (MDS #1). She stated the resident was on a diuretic and it was a typographical error that she had not included it on both of the last 2 assessments. She indicated she would have to do a modification on those assessments.	F 278		
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	F 520		1/29/16

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F 520 Continued From page 14

nursing services; a physician designated by the facility; and at least 3 other members of the 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 record review and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitoring practices to address interventions put into effect after the 2/26/15 recertification survey. During the survey of 2/26/15 the facility was cited at F 278 for inaccurate assessments. During the recertification survey of 1/7/16, the facility was recited for accuracy of assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program.
The findings included:

F 520

Roanoke River Nursing and Rehabilitation Center’s response to this Statement of Deficiencies does not denote agreement with Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

1. Resident #16, #34, #40, #41, #43, #49, #53, #61, #98 and #99 with Level II

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F 520

Continued From page 15

This tag is cross referenced to:
F 278 on the current survey of 1/7/16-Based on record reviews and staff interviews, the facility failed to correctly code the Minimum Data Set (MDS) for 10 of 10 residents identified as being Preadmission Screening and Resident Review (PASRR) level 2 (Resident #16, #34, #40, #41, #43, #49, #53, #61, #98, #99) and failed to correctly code the use of diuretic medication on the MDS for 1 of 5 residents reviewed for unnecessary medications (Resident #4).

During the recertification survey of 2/26/15, the facility was cited a deficiency at F278 for incorrectly coding the use of a diuretic medication on the MDS for 1 or 5 residents (Resident #138).

On 1/7/16 at 12:02 PM, an interview was conducted with the Administrator. He stated he had provided oversight for the MDS inaccuracies by reviewing the Care Area Assessments (CAA) to make sure they were more specific.

F 520

PASSAR numbers had MDS modifications completed on 1/6/16 for the information needed for the Level II PASSAR by the MDS nurses. Resident #4 had MDS modification completed on 1/6/16 for the addition of the use of the diuretic by the MDS nurses.
2. 100% audit of all current resident MDS's will be reviewed, to include residents #16, #34, #40, #41, #43, #49, #53, #61, #98, #99 and #4, by the DON and ADON within the last 30 days to ensure all MDS's completed are accurate to include all diagnosis, medications, and correct PASSAR levels to be completed on 1/25/16 using a MDS Accuracy QI tool. Any issues will be addressed and documented at that time. 100% in-service of the MDS nurses, administrator, DON and ADON to ensure all MDS assessments are completed appropriately to include all diagnosis, medications, and correct PASSAR level will be completed on 1/25/16 by the MDS consultant. The Administrator and DON were inserviced on 1/26/16 by the Facility Consultant that through the Use of the Quality Improvement Program, the facility will:
- Recognize concerns in the resident care or environmental issues
- Develop a plan of action for the resolution of those concerns
- Train staff member on the plan.
- Put the plan into effect and evaluate the plan to ensure that the concerns are resolved and do not reoccur
- Measure outcomes in the plan of action if positive outcomes are not noted.

Review of the last 3 months of QA

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F 520	Continued From page 16	F 520	committee meeting minutes were completed on 1/26/16 by the Facility Consultant with no issues noted on review. 3. 10% of completed MDS's, to include resident's #16, #34, #40, #41, #43, #49, #53, #61, #98, #99 and #4, will be reviewed to ensure MDS accuracy for all diagnosis, medications and PASSAR levels by the ADON 3 X's a week X's 4 weeks, then weekly X's 4 weeks and then monthly X's 1 utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the ADON by retraining appropriate staff making the coding error and the MDS nurse will make modifications to the MDS. The DON will review and initial the MDS Accuracy QI tool weekly X's 8 weeks and then monthly X's 1 to ensure any areas of concerns have been addressed. QA committee monthly meeting minutes will be reviewed and initialed by the Facility Consultant to ensure implemented procedures and monitoring practices to address interventions, to include MDS, are followed and maintained monthly X3 months. 4. The Executive QI committee will meet monthly and review audits and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly X3 months.	