STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted 3/22/21 through 3/26/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# G7N611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted 3/22/21 through 3/26/21. Immediate Jeopardy was identified at CFR 483.25 at F689 scope and severity of K. The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 9/8/19 and was removed on 3/25/21. An extended survey was conducted. Four of the 11 complaint allegation were substantiated and 1 Facility Reported Incident was substantiated without a deficiency. See #G7N611. Addendum: On 4/19/21 the survey was reopened to correct example 11 of citation F 641. The correct resident number is #75. See #G7N611.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		5/5/21

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

Electronically Signed | 04/19/2021

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to treat residents with dignity and respect by enforcing a facility protocol that required all residents who smoked to be supervised, smoke at designated times between 9:00 AM and 9:00 PM, and wear a smoking apron. This was for 1 of 3 residents (Resident #28) reviewed for smoking. The findings included:	F 550	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because	

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F 550	Continued From page 2 Resident #28 was admitted to the facility on 5/6/20 with multiple diagnoses that included heart failure. The admission Minimum Data Set (MDS) assessment dated 5/9/20 indicated Resident #28 ' s cognition was intact, and he had no behaviors or rejection of care. He was assessed as independent with no assistance needed for transfers, walking in room, locomotion on unit, and locomotion off unit. He required supervision of 1 for bed mobility. Resident #28 was assessed as steady at all times, he had no functional impairment with range of motion, and he utilized a wheelchair. A hard copy Smoking Observation Form dated 5/19/20 completed by the Director of Nursing (DON) for Resident #28 indicated the following questions and answers: - Is there a physician ' s order prohibiting the resident to smoke? No - Does the resident have any cognitive impairment? No - Is the resident physically unable to hold a cigarette? No - Is the resident unable to light his/her own cigarette? No - Is the resident unable to extinguish his/her own cigarette? No - Is the resident unable to extinguish a lit cigarette which has fallen on his/her person, others, or any potentially flammable object? No - Is the resident unable to call for help if a lit cigarette or ash falls on his/her persons, others, or any potentially flammable object? No - Is the resident unable to independently get out of a chair? Yes	F 550	it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. 1)On 3/29/21 Resident #28 went out to designated area for smoking activity. Resident #28 was reassessed for safe smoking on 4/19/21 by facility Charge Nurse indicating resident as a safe smoker. Resident #28 was educated by the facility Administrator on 4/19/21 about the results of the assessment and no longer needing supervision to smoke or an apron. 2)On 4/19/21 residents grandfathered in for smoking activity according to the facility policy were re-assessed by the MDS Coordinator and Charge Nurses. 4 of 16 residents were found to be safe smokers and did not require supervision or an apron. These residents were educated about their safe smoking status and no longer needing supervision or to wear an apron. 3)Facility employees were educated starting 4/19/21 by the Facility Administrator about residents deemed as safe smokers. Education included resident□s ability to smoke unsupervised, not having to wear an apron while smoking, as well as where residents will retrieve smoking materials when they are ready to smoke. Residents grandfathered in will be reassessed by Charge Nurse for	

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F 550	Continued From page 3 - Is the resident unable to independently move to and from designated smoking areas? No - Does the resident have any medical diagnosis/conditions that would make unsupervised smoking a danger to him/her? No - Is the resident on any medication that has the potential to create a hazard for themselves or others when smoking? No - Does the resident have a past history of poor judgement/non-compliance regarding safety for him/her others? No - Is there a physician order for the resident to use oxygen? No This form indicated that Supervision was required for smoking if any of the above questions were answered "Yes". Resident #28 was assessed by the DON to require supervision for smoking because he was not able to get up out of a chair independently. On 6/9/20 a care plan was initiated for Resident #28 with problem area of "Resident needs supervision with smoking". The interventions initiated on 6/9/20 were as follows: - Resident will have screen completed to determine the need to be supervised - Resident will be provided with the designated places to smoke - Supervision to be provided for residents that need supervision - Resident to wear smoking apron as needed - Resident will be educated with a verbal understanding of the smoking policy A hard copy Smoking Observation Form dated 9/18/20 completed by the DON for Resident #28 was reviewed. The DON assessed Resident #28 with identical answers to the 5/19/20 Smoking Observation Form indicating that Resident #28	F 550	safe smoking quarterly and upon change in condition. Outcome of smoking assessment will be reported to Interdisciplinary team by facility MDS Coordinator to ensure corrective action is taken if needed. 4)Facility Administrative team (Financial Counselor, Human Resources, Housekeeping Supervisor, Activity Director, Maintenance Director, Medical Records Coordinator, Social Worker, Dietary Manager, and/or Administrator) will monitor designated resident smoking area daily for 7 days, weekly for 3 weeks, then monthly for 3 months to ensure residents deemed as safe smokers are able to smoke without supervision or an apron. Monitoring results will be reported at facility QAPI meeting by facility Administrator for 3 months. 5)May 5, 2021	

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F 550	Continued From page 4	F 550		

required supervision for smoking because he was unable to independently get out of a chair.

An electronic Smoking Observation Form dated 10/5/20 completed by Nurse #2 for Resident #28 included identical questions to the hard copy Smoking Observation form. Nurse #5 assessed Resident #28 to require no supervision with smoking. She provided conflicting information with the DON ' s 5/19/20 and 9/18/20 Smoking Observation form indicating that Resident #28 was able to independently get out of a chair.

The annual Minimum Data Set (MDS) assessment dated 12/11/20 indicated Resident #28 ' s cognition was intact, and he had no behaviors and no rejection of care. Resident #28 was assessed as independent with set up help only for transfers, walk in room, walk in corridor, locomotion on unit, and locomotion off unit. He required supervision with set up help only for bed mobility. Resident #28 was assessed as steady at all times, he had no functional impairment with range of motion, and he utilized a wheelchair.

A hard copy Smoking Observation Form dated 1/15/21 completed by the DON for Resident #28 was reviewed. The DON assessed Resident #28 with identical answers to the 5/19/20 and 9/18/20 Smoking Observation Forms indicating that Resident #28 required supervision for smoking because he was unable to independently get out of a chair.

The quarterly MDS assessment dated 1/25/21 indicated Resident #28 ' s cognition was intact, and he had no behaviors and no rejection of care. Resident #28 was assessed as independent with set up help only for bed mobility, transfers, walk in

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F 550	Continued From page 5	F 550		

room, and locomotion on unit. He was coded with locomotion off unit occurring only once or twice with no set up or physical help and walking in corridor had not occurred. Resident #28 was assessed as steady at all times, he had no functional impairment with range of motion, and he utilized a wheelchair.

An electronic Smoking Observation Form dated 3/24/21 completed by the DON for Resident #28 included identical questions to the hard copy Smoking Observation Form. The answers to this assessment conflicted with her previous assessments on 5/19/20, 9/18/20, and 1/15/21. The following questions were answered with opposite responses as on the previous 3 assessments completed by the DON:
- Is the resident unable to independently get out of chair? No
- Does the resident have any medical diagnosis/conditions that would make unsupervised smoking a danger to him/her? Yes
- Is the resident on any medication that has the potential to create a hazard for themselves or others when smoking? Yes

During an interview with the Administrator on 3/24/21 at 12:10 PM she stated that all residents who smoked were supervised, had to smoke at designated times between 9:00 AM and 9:00 AM, and had to wear a smoking apron.
She indicated that these were requirements for residents assessed as safe smokers in addition to the residents assessed as unsafe smokers. When asked why this was the protocol for all residents, she stated that this protocol had been in place since she began working at the facility in 2017 and it remained in place ever since.

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F 550	Continued From page 6 An interview was conducted with Resident #28 on 3/24/21 at 12:20 PM. He stated that he was an approved smoker at the facility. He reported that all approved smokers were supervised by staff, were required to smoke at designated times, and they had to wear a smoking apron. He indicated the designated times were every two hours beginning at 9:00 AM and 9:00 PM. Resident #28 stated that he was a safe smoker, but he was still required to be supervised. He indicated he would much rather have been able to independently decide when he smoked rather than being restricted to the designated smoking times. He explained that if he woke up early in the morning and wanted to smoke, he was not able to do so as he had to wait until the smoking hours started. He further indicated that he would also rather not wear a smoking apron, but he was a rule follower, so he complied with the facility ' s rules. An interview as conducted with Nurse #6 on 3/25/21 at 10:10 AM. Nurse #6 stated that she worked regularly with Resident #28. She reported that he was cognitively intact and independent with most Activities of Daily Living (ADLs) including the ability to independently get out of a chair. She was asked if Resident #28 was a supervised or unsupervised smoker and she stated that all of the residents at the facility were supervised when smoking. Nurse #6 explained that all residents who smoked were only able to smoke during designated smoking times, there had to be a staff member present, and they had to wear aprons. She stated she had always wondered why every resident who smoked had to be supervised. She reported that in her assessment of Resident #28 he was a safe smoker and had not required supervision.	F 550		

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F 550	Continued From page 7 A phone interview was conducted with Nurse #2. The electronic Smoking Observation Form completed on 10/5/20 was reviewed with Nurse #2. She confirmed she completed this form and assessed Resident #28 as a safe smoker. She had not known why Resident #28 was not able to smoke unsupervised. An interview was conducted with the DON on 3/25/21 a1 10:15 AM. The DON reported that the facility utilized both hard copy and electronic Smoking Observation Forms. She confirmed the Administrator ' s interview that indicated all residents at the facility were supervised smokers. She reported that the facility utilized the Smoking Observation Form as their smoking assessment and that this form had so many questions on it that it was difficult for anyone to be assessed as an unsupervised smoker. The following information was reviewed with reviewed with the DON: - The Smoking Observation Form dated 5/19/20 completed by the DON that indicated Resident #28 was unable to get out of a chair independently and the 5/9/20 MDS that provided conflicting information assessing Resident #28 as independent with no assistance needed for transfers, walking in room, locomotion on unit, and locomotion off unit were reviewed. The DON stated that Resident #28 may have been weak that day she completed her observation. - The Smoking Observation Form dated 9/18/20 completed by the DON that indicated Resident #28 was unable to get out of a chair independently and the 10/5/20 Smoking Observation Form completed by Nurse #2 that provided conflicting information by indicating Resident #28 was able to get out of a chair	F 550		

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F 550	Continued From page 8	F 550		

independently were reviewed. The DON stated that Resident #28 may have been weak that day she completed her observation.
- The 1/15/21 Smoking Observation Form completed by the DON that indicated Resident #28 was unable to get out of a chair independently and the 1/25/21 MDS that provided conflicting information by assessing Resident #28 as independent with set up help only for transfers, walk in room, and locomotion on unit were reviewed. The DON stated that Resident #28 may have been weak on the day she completed her observation.
- The Smoking Observation Form dated 3/24/21 completed by the DON that provided conflicting answers to her 3 previous assessments (5/19/20, 9/18/20, and 1/15/21) of Resident #28 were reviewed. This assessment indicated Resident #28 had a medical diagnosis/condition that would make unsupervised smoking a danger to himself. The DON was asked what new diagnosis/conditions Resident #28 developed since his previous assessments. She revealed there were no new diagnoses/conditions for Resident #28. This 3/24/21 assessment also indicated that Resident #28 was on medication that had the potential to create a hazard for himself or others while smoking. The DON revealed that she had not known if Resident #28 was on any new medications since his 1/15/21 smoking assessment.
After the completion of this review the DON was asked why she assessed Resident #28 as a supervised smoker on each of her assessments. She revealed that she was following the facility protocol of all residents being supervised smokers by answering at least 1 of the questions on the Smoking Observation Form "Yes". She explained that she had not agreed with the

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F 550	Continued From page 9 protocol that required supervision for all smokers, but she enforced the protocol as part of her job responsibilities. The DON revealed that in her opinion Resident #28 was a safe smoker and should not have required supervision. During an interview with the Administrator and DON on 3/26/21 at 2:30 PM they both indicated that they expected residents to be treated with dignity and respect.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to assess and obtain a Physician order for the self-administration of an inhaler found in Resident #35's possession. This was for 1 of 1 residents reviewed for self-administration of medications. The findings included: Review of the policy titled Self-Administration of Medication by Residents revised 1/28/20 read as follows: The medication provided to the resident for bedside storage are to be kept in the packing that was dispensed by the provider pharmacy. A Physician order was required and any medications found at the bedside were to be removed and given to the responsible party or family. The policy made no mention of completing a self-medication administration assessment.	F 554	1)On April 16, 2021 Resident #35 was assessed by the facility RN MDS Coordinator for self- administration of medication related to his inhaler use. Resident #35 was provided a lock box with key on April 16, 2021 by Facility Administrator and the medication will be kept in this box. On April 16, 2021 An order was obtained from the attending physician of Resident #35 to keep medication at bedside and self-administer two puffs every six hours as needed for shortness of breath. Resident #35 was provided education by Charge Nurse on April 19, 2021 regarding self-administration of inhaler to include communication with Charge Nurse for the purpose of documenting and monitoring frequency of use. Resident #35	5/5/21

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F 554	Continued From page 10 Resident #35 was admitted on 4/20/20 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). A Self-Determination Self-Medication assessment was last completed on 4/20/20. The assessment indicated Resident #35 was not appropriate for any self-administration of medications. Review of Resident #35's quarterly Minimum Data Set dated 1/22/21 indicated he was cognitive intact and exhibited no behaviors. He was coded independent to supervision with his activities of daily living and no impairment to his bilateral upper extremities. Review of Resident #35's care plan last revised on 1/14/21 did not include a care plan for self-administration of his medications. Review of a Physician order dated 1/14/21 read Resident #35 was ordered Albuterol (bronchodilator) aerosol inhaler 2 puffs every 6 hours for wheezing, cough, and shortness of breath (SOB) as needed. In an observation and interview on 3/22/21 at 12:40 PM, there was an unlabeled blue inhaler lying on his bed. Resident #35 stated he used the inhaler as needed for coughing, SOB, or wheezing. In another interview with Resident #35 on 3/24/21 at 9:18 AM, he stated he brought the inhaler from home, kept it inside his nightstand drawer and nobody was going to take it from him. In an interview on 3/24 at 4:30 PM, Nurse #2	F 554	2)On April 19, 2021 facility residents were audited by Director of Health Services, RN MDS Coordinator, RN Infection Preventionist, and RN Charge Nurses related to ability to self-administer medication. 3 residents were found with desire and ability to self-administer medication. This resident was provided education by Charge Nurse on April 19, 2021 regarding self-administration of inhaler to include communication with Charge Nurse for the purpose of documenting and monitoring frequency of use. An order was obtained by the resident□s Charge Nurse from the attending physician on April 19, 2021. 3)Facility licensed nurses were educated starting April 19, 2021 by the Director of Nursing, Infection Preventionist, and/or RN MDS Coordinators regarding resident assessment for medication self-administration and communication of assessment results. Residents will be assessed upon admission and quarterly by Charge Nurse and/or Nurse Manager for self- administration of medication. Residents deemed as safe for self-administration will be provided a lock box for medication by facility Administrator, Maintenance Director, and/or Director of Health Services to store medication. 4)Facility Director of Health Services, Infection Preventionist, RN MDS Coordinators, and/or Charge Nurses will audit residents deemed as safe for	

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F 554	Continued From page 11 stated she was not aware that Resident #35 had an inhaler in his possession. She stated there needed to be a Physician order and self-administration assessment in order for him to be allowed to keep and self-administer his inhaler. In an interview on 3/25/21 at 10:00 AM, Nurse #5 stated Resident #35 came into the facility with an inhaler. She stated attempts to confiscate his inhaler were unsuccessful. She stated there was no Physician order for him to keep and self-administer his inhaler and she was not aware of any assessment for him to self-administer his inhaler. Nurse #5 stated this was an ongoing issue and management was aware. In an interview on 3/26/21 at 2:30 PM, the Director of Nursing stated she was not aware that Resident #35 had an inhaler in his possession. She stated her expectation was the inhaler be removed until an assessment for self-administration and a Physician order was completed.	F 554	self-administration of medication daily for 7 days, then weekly for 3 weeks, then monthly for three months. Results of these audits will be brought to facility QAPI committee to ensure compliance monthly. 5)May 5, 2021	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests,	F 561		5/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 561	Continued From page 12 assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with resident, staff, Occupational Therapist, and Physical Therapist, the facility failed to honor resident choices related to smoking, going outside for leisure, and for showers. This was for 8 of 9 residents reviewed (Residents #3, #27, #28, #35, #41, #43, #46, and #55) and the members of the Resident Council. The findings included: 1. Resident #28 was admitted to the facility on 5/6/20 with multiple diagnoses that included heart failure. The facility ' s smoking policy, titled "Smoke Free Policy", last revised on 10/12/19 indicated that smoking was only to be allowed in outdoor designated areas for residents who were	F 561	1)On 3/26/2021 Residents #27, #28, #35, #41, and #46 returned to designated area and participated in resident smoking activity. Residents #55 received a shower and nail care on April 1, 2016. Resident #43 received a shower and nail care on April 19, 2021. Resident #3 was interviewed by facility Activity Director regarding activity preferences on April 15, 2021. MDS Coordinator and Activity Director updated above mentioned resident care plans on April 19, 2021 with activity, smoking, and shower preferences. 2)On April 15, 2021 facility residents were audited by Activity Director related to outside activity preferences. 43 of 77 residents stated they would like to participate in outside activities. Activity	

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 561	Continued From page 13 "grandfathered" in prior to January 1, 2015. The annual Minimum Data Set (MDS) assessment dated 12/11/20 indicated Resident #28 ' s cognition was fully intact. He had no behaviors, no rejection of care, and he utilized tobacco. He was assessed with tobacco use. Resident #28 ' s care plan included, in part, a problem area related to smoking that was initiated on 6/9/20 and last revised on 1/26/21. The interventions included, in part, Resident #28 would be educated with a verbal understanding of the smoking policy. An interview was conducted with Resident #28 on 3/22/21 at 2:05 PM. He stated that he was transferred to this facility from another facility within the same corporation and that because of this he was "grandfathered" in and was permitted to smoke upon admission to this facility in May 2020. He reported that he smoked 6 times daily up until the time that the facility stopped permitting residents to smoke. He explained that sometime near the end of December 2020 the residents were told that smoking was no longer permitted due to an outbreak of COVID with residents and staff. Resident #28 reported that he had to stop "cold turkey". He explained that he was an easy going guy so he had not complained at all when this change occurred because he thought the facility had no choice during the outbreak, but that the COVID outbreak had been over for about a month and the smoking privileges had not been restarted. When asked if he wanted to smoke again, he stated, "Oh yeah!". On 3/23/21 at 4:07 PM the Administrator provided	F 561	Director, Financial Coordinator, Housekeeping Supervisor, and Medical Records Coordinator conducted audit on April 19, 2021 asking facility residents about bathing preferences related to showers or bed baths. 37 of 75 residents stated they would like to receive showers. Care plans were updated by Activity Director by April with resident preferences. On 3/26/2021 residents grandfather in under facility smoking policy participated in outside smoking activity and continue to do so on a daily basis. Care plans of these residents were updated by May 5, 2021 facility MDS Coordinator. 3)Facility employees received education starting April 19, 2021 by the Activity Director and /or Administrator regarding assisting residents to activities of their choice to include smoking. On April 19, 2021 Activity Director started educating facility employees on honoring the smoking choice of residents grandfather in under smoking policy. Facility employees were educated by Nurse Management regarding resident shower preferences starting April 19, 2021. Employees on leave of absence will be educated upon return and newly hired employees will be educated during orientation prior to regarding honoring resident choice for showers, activity participation, and grandfathered in smoking choices by the Activity Director. Newly admitted residents will be assessed by Charge Nurse and/or Activity Director related to shower and activity preferences with updates to the interim care plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 561	Continued From page 14 a policy titled "COVID 19 Smoking" dated 12/31/20. The policy read, in part: "[The facility] will stop resident smoking while facility is in outbreak status. Whereas it has been found that 7 of 14 COVID 19 positive patients have been identified as smokers with 2 more identified as roommates or having close contact via in hall visitation or communal dining (prior to outbreak). Once the outbreak is over and the facility has had a few weeks (2 or less) of no new positive cases (resident or partner) the facility will phase resident smoking back into place." On 3/24/21 at 12:10 PM an interview was conducted with the Administrator. She stated that as of 12/27/20 the facility stopped permitting residents to smoke due to a COVID-19 outbreak in the facility. She indicated that a policy was implemented on 12/31/20 that indicated residents were no longer permitted to smoke. The Administrator revealed the outbreak ended on 2/25/21, but that smoking privileges had not been reimplemented. When asked why smoking privileges had not been reimplemented she stated that they were planning on making this change within the next few weeks. During an interview with the Director of Nursing (DON) on 3/24/21 at 2:35 PM she confirmed that Resident #28 was an approved smoker and he smoked multiple times per day from admission (5/6/20) until resident smoking was banned (12/27/20). In a telephone interview on 3/26/21 at 12:45 PM,	F 561	4)Facility Administrative team members will audit 10 residents for adherence to activity, shower, and grandfather in smoking preferences daily for 7 days, then weekly for 3 weeks, then monthly for three months. Results of these audits will be brought to facility QAPI committee by facility Administrator to ensure compliance monthly. 5)May 5, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 561	Continued From page 15	F 561		

the Medical Director stated he was not aware that the smoking residents weren ' t allowed to smoke. He stated that residents ' psychosocial needs were very important, and he expected the facility to provide opportunities to improve or maintain their psychosocial well-being by allowing the residents who were approved for smoking at the facility to take part in this activity.

In a follow up interview on 3/26/21 at 2:30 PM, the Administrator and DON stated it was their expectation that resident choices and preferences be honored. They reported that smoking was going to be reimplemented, but they had no specific date for this change.

2. A review of Resident Council minutes dated 2/26/21 indicated the residents stated that they were ready to go outside and get some fresh air.

A review of Resident Council minutes dated 3/23/21 indicated the residents asked about smoking and when they would be permitted to start smoking again.

On 3/24/21 at 11:30 AM a meeting was conducted with 12 members of the Resident Council. The residents reported two current concerns: 1) They wanted to know when the approved smokers would be permitted to smoke again. 2)They wanted to know when they could go outside to get fresh air again. The Resident Council members reported that sometime near the end of 2020 they were informed that there was a COVID-19 outbreak in the facility and that the approved smokers were no longer permitted to smoke until the outbreak

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 561	Continued From page 16	F 561		

was over. The residents indicated that around the same time the residents were no longer permitted to go outside to get fresh air due to the outbreak. They reported that the outbreak was over, but they still were not permitted to smoke or to go outside for leisure, and they wanted to know when both of these activities would be reinstated.

On 3/24/21 at 12:10 PM an interview was conducted with the Administrator. She stated that as of 12/27/20 the facility stopped permitting residents to smoke due to a COVID-19 outbreak in the facility. She indicated that a policy was implemented on 12/31/20 that stated residents were no longer permitted to smoke. The Administrator revealed the outbreak ended on 2/25/21, but that smoking privileges had not been reimplemented. When asked why smoking privileges had not been reimplemented she stated that they were planning on making this change within the next few weeks.

In an interview on 3/25/21 at 10:55 AM, the Activity Director (AD) stated that residents had voiced a desire to go outside to smoke and/or to get fresh air, but as of yet, the smoking area had not been reopened. She explained that the smoking area was also the area where residents were able to go outside.

In an interview on 3/26/21 at 2:30 PM, the Administrator and DON stated it was their expectation that resident choices and preferences be honored. The Resident Council ' s report that they wanted to be able to go outside and get fresh air as well as the Activity Director ' s interview that indicated the residents had not been able to go outside since smoking privileges were ceased (12/27/20) was reviewed with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 561	Continued From page 17	F 561		

Administrator and DON. They confirmed that residents had used the smoking area as a place to go outside for fresh air, but they indicated they had not realized that because the smoking area was not in use that this resulted in the residents not being able to go outside. The Resident Council ' s report that the approved smokers wanted their smoking privileges reinstated was reviewed with the Administrator and DON. They reported that smoking was going to be reimplemented, but they had no specific date for this change.

In a phone interview on 3/26/21 at 12:45 PM, the Medical Director stated he was not aware that residents weren ' t allowed to go outside or to smoke. He stated that residents ' psychosocial needs were very important, and he expected the facility to provide opportunities to improve and/or maintain their psychosocial well-being by allowing the residents to smoke and go outside for fresh air.

3. Resident #55 was admitted to the facility on 10/3/19 and most recently readmitted to the facility on 2/4/21 with diagnoses that included orthopedic aftercare.
A nursing note dated 2/4/21 indicated Resident #55 was readmitted to the facility from the hospital with a right femur fracture.

The significant change MDS assessment dated 2/10/21 indicated Resident #55 had clear speech, was usually understood, and usually understands others. She was noted with short-term and long-term memory problems and modified independence for daily decision making. Resident #55 had no behaviors or rejection of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 18	F 561		

care. She required the extensive assistance of 1 for dressing and the extensive assistance of 2 or more for bed mobility. Resident #55 was dependent on 1 for personal hygiene and dependent on 2 or more for toileting. Transfers, locomotion, and walking had not occurred. Resident #55 was dependent on 1 for bathing.

Resident #55 ' s care plan included, in part, the problem area of assistance with personal hygiene. The intervention was for Resident #55 to receive a shower and nail care every Tuesday, Thursday, and Saturday during the 1st shift. This care plan was last reviewed on 2/18/21.

A review of Resident #55 ' s Nursing Assistant (NA) bathing/shower documentation from 2/5/21 through 3/22/21 indicated Resident #55 had no showers. The documentation indicated that she received either a partial bed bath or complete bed bath in place of a shower.

An interview was conducted with Resident #55 on 3/22/21 at 9:50 AM. She stated that she had not gotten a shower since she was admitted to the facility and she would like to receive one soon. She reported that she always got a bed bath instead of a shower. Resident #55 indicated that she thought the reason she had not gotten a shower was because she was not able to walk to the shower.

An interview was conducted with NA #5 on 3/25/21 at 1:55 PM. She indicated that she worked with Resident #55 regularly during the 1st shift. She reported that Resident #55 was provided with bed baths rather than showers. She stated that she recalled Occupational Therapist (OT) #1 and Physical Therapist (PT) #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 561	Continued From page 19	F 561		

informing her that Resident #55 was not able to receive showers due to being non-weight bearing. She was unable to recall when she was informed of this information.

An interview was conducted with PT #1 on 3/25/21 at 2:50 PM. She stated that she was familiar with Resident #55. She indicated that Resident #55 was able to receive showers. She reported that there was no point in time during 2021 when Resident #55 was restricted from showers. PT #1 indicated that showers would only have been restricted if there was a physician ' s order for this. PT #1 reviewed the physician ' s orders for Resient #55 and stated that there were no orders indicating she was restricted from showers. She indicated that she had not informed NA #5 that Resident #55 could not be showered. PT #1 was unable to explain why NA #5 thought Resident #55 was not permitted to receive showers.

An interview was conducted with OT #1 on 3/25/21 at 2:52 PM. OT #1 reiterated PT #1 ' s interview stating that she was familiar with Resident #55 and that the resident was able to receive showers. She indicated that she had not informed NA #5 that Resident #55 could not be showered. OT #1 was unable to explain why NA #5 thought Resident #55 was not permitted to receive showers.

During an interview with the Director of Nursing (DON) on 3/25/21 at 2:15 PM she indicated that there were no shower restrictions for Resident #55. She reported that she expected the residents to be provided with the bathing method of their choice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 20	F 561		

4) Resident #3 was admitted to the facility on 8/21/20 with diagnoses that included left hip fracture, chronic obstructive pulmonary disease (COPD) and type 2 diabetes.

The admission Minimum Data Set (MDS) assessment dated 8/28/20 indicated Resident #3 was cognitively intact. The section for Preferences for Customary Routine and Activities was marked as very important to her to go outside to get fresh air when the weather is good.

The most recent MDS coded as a quarterly assessment and dated 12/18/20 indicated Resident #3 was cognitively intact. There were no behaviors present. Resident #3 required supervision for transfers, locomotion on and off the unit.

Review of a Patient/Resident Council Minutes/Report Form dated 2/26/21 revealed residents were ready to go out and get some fresh air.

An interview occurred with the Activity Director (AD) on 3/25/21 at 10:55 AM, who stated that residents had voiced a desire to go to get fresh air, but as of yet, the smoking area had not been reopened. She explained that the smoking area was also the area where residents were able to go outside.

On 3/25/21 at 11:01 AM, an interview occurred with Resident #3 who stated since her admission to the facility she had only been outside for the purpose of doctor appointments. She reported not being permitted to go outside for fresh air due to the COVID-19 outbreak, however, the outbreak was over, and she was still not permitted to go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 21	F 561		

outside for leisure.

In an interview on 3/26/21 at 2:30 PM, the Administrator and Director of Nursing (DON) stated it was their expectation that resident choices and preferences be honored. The Resident Council's report that they wanted to be able to go outside and get fresh air as well as the Activity Director's interview that indicated the residents had not been able to go outside was reviewed with the Administrator and DON. They confirmed residents had used the smoking area as a place to go outside for fresh air, but they indicated they had not realized that because the smoking area was not in use that this resulted in the residents not being able to go outside.

5) Resident #27 was originally admitted to the facility on 5/6/20 with a recent readmission date of 3/12/21. His diagnoses included quadriplegia, anxiety, and depression.

The facility's smoking policy, titled "Smoke Free Policy", last revised on 10/12/19 indicated smoking was only to be allowed in outdoor designated areas for residents who were "grandfathered" in prior to January 1, 2015.

The admission Minimum Data Set (MDS) assessment dated 5/9/20 indicated Resident #27's cognition was fully intact. He had no behaviors or rejection of care and he utilized tobacco.

Resident #27's active care plan included, in part, a problem area related to smoking that was initiated on 6/9/20 and last reviewed 3/17/21. The approaches included:

- Assist with smoking materials as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 561	Continued From page 22 - Provide resident with a designated place to smoke. - Resident will be educated with a verbal understanding of the smoking policy. On 3/23/21 at 4:07 PM, the Administrator provided a policy titled, "COVID-19 Smoking" dated 12/31/20. The policy read, in part: "(The facility) will stop resident smoking while facility is in outbreak status. Whereas it has been found that 7 of 14 COVID-19 positive patients have been identified as smokers with 2 more identified as roommates or having close contact via in hall visitation or communal dining (prior to outbreak). Once the outbreak is over and the facility has had a few weeks (2 or less) of no new positive cases (resident or partner), the facility will phase resident smoking back into place" An interview occurred with Resident #27 on 3/24/21 at 9:21 AM. He stated he was transferred to this facility from another facility within the same corporation. Because of this he was "grandfathered" in and was permitted to smoke upon admission to this facility in May 2020. He reported he smoked 5 to 6 times per day up until the time the facility stopped permitting residents to smoke. He explained sometime near the end of December 2020, the residents were told smoking was no longer permitted due to the COVID-19 outbreak with residents and staff and he had to stop "cold turkey". Resident #27 further stated he was easy going so he had not complained when the change occurred because he thought the facility had no choice during the outbreak. He added the COVID outbreak had been over for about a month and smoking privileges had not restarted.	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 23 On 3/24/21 at 12:10 PM, an interview was conducted with the Administrator. She stated that as of 12/27/20, the facility stopped permitting residents to smoke due to a COVID-19 outbreak in the facility. She indicated a policy was implemented on 12/31/20 stating residents were no longer permitted to smoke. The Administrator revealed the outbreak ended on 2/25/21, but smoking privileges had not been reimplemented. When asked why smoking privileges had not been reimplemented she stated they were planning on making this change within the next few weeks. In an interview on 3/25/21 at 10:55 AM, the Activity Director (AD) stated that residents had voiced a desire to go outside to smoke, but as of yet, the smoking area had not been reopened. On 3/26/21 at 2:30 PM, the Administrator and Director of Nursing (DON) stated it was their expectation that resident choices and preferences be honored. They reported that smoking was going to be reimplemented, but they had no specific date for this change. 6) Resident #43 was originally admitted to the facility on 1/21/20 with a recent readmission date of 1/27/21. His diagnoses included cerebral infarction affecting the left non-dominant side, aphasia, contracture of the left knee and type 2 diabetes. A review of Resident #43's medical record revealed he was hospitalized from 1/18/21 through 1/27/21. The quarterly Minimum Data Set (MDS)	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 24	F 561		

assessment dated 1/31/21 indicated Resident #43 had impaired cognition. He had no behaviors or rejection of care and required extensive to total assistance from staff for Activities of Daily Living (ADL's).

The review of Resident #43's active care plan, last reviewed on 2/4/21 revealed the following problem areas:

- Personal hygiene. The approach stated to provide shower, nail and oral care on Monday, Wednesday, and Friday on the 3:00 PM to 11:00 PM shift (2nd shift).
- ADL decline related to CVA (cerebrovascular accident-a stroke). The approaches included to set up resident for ADL's.

A nursing progress note dated 2/26/21 indicated Resident #43 was alert and able to make his needs known to staff.

A review of the nursing progress notes from 3/1/21 through 3/24/21 did not indicate Resident #43 had refused baths or attempts to shower.

A review of Resident #43's Nursing Assistant (NA) bathing/shower documentation from 3/1/21 through 3/24/21 indicated Resident #34 had received either a partial bed bath or complete bed bath in place of showers.

An interview was conducted with NA #4 on 3/25/21 at 1:00 PM, who stated she was familiar with Resident #43 and he was able to understand others and make self-understood through nods, gestures, and yes/no answers. She was unable to recall Resident #43 refusing a bath when offered. Resident #43's shower/bath documentation was reviewed and indicated NA #4 was assigned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 561	Continued From page 25	F 561		

the resident on 3/15/21, a scheduled shower day. She further stated Resident #43 normally received a complete bed bath on his shower days because he was too stiff to be transferred to a shower chair for a shower. NA #4 also stated she was unaware if the facility had a shower stretcher.

An interview was completed with Resident #43 on 3/25/21 at 2:45 PM. When asked if he received a shower on his scheduled days, he shook his head No. When asked if he would like to have a shower instead of a complete bed bath on his scheduled days he stated Yes and nodded his head.

During an interview with NA #6 on 3/25/21 at 3:10 PM she indicated she worked on the 2nd shift and was familiar with Resident #43. NA#6 stated the resident typically didn't refuse bathing assistance and usually received a complete bed bath instead of a shower as it was unsafe to use a shower chair due to his contracture. She was unaware if the facility had a shower stretcher available.

On 3/25/21 at 3:15 PM, an interview occurred with NA #7 who worked 2nd shift, was familiar with Resident #43 and was assigned to him on scheduled shower days of 3/3/21, 3/5/21, 3/17/21, 3/22/21 and 3/24/21. She indicated he was scheduled for showers on 2nd shift and typically received a complete bed bath instead of a shower due to his contracture and the shower chair caused him discomfort. NA #7 added she was aware the facility had a shower stretcher but did not utilize it.

An interview was completed with the Director of Nursing (DON) on 3/25/21 at 3:20 PM. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 26	F 561		

it was her expectation for showers to be provided on the scheduled days per the resident's choice. The DON added the facility had a shower stretcher and should be utilized when Resident #43 chose a shower. She further stated if a bed bath or partial bath was provided rather than a shower the NA's documentation should indicate which was provided and the nurse should be made aware so documentation would occur in the EMR as to the reason why.

7. Resident #46 was admitted 4/2/18 with a cumulative diagnosis of Chronic Obstructive Pulmonary Disease.

Resident #46's quarterly Minimum Data Set dated 2/5/21 indicated he was cognitively intact and exhibited no behaviors. He was coded for extensive assistance to supervision with his activities of daily living (ADLs) and coded for no impairment to his bilateral upper extremities. Resident #46 was not coded for the use of tobacco products.

Review of Resident #46's care plan dated 6/9/20 read he needed supervision with smoking. Interventions read Resident #46 required supervision when smoking, wear a smoking apron as needed, education of the smoking policy and screen Resident #46 to determine the need for supervised smoking.

Review of a smoking assessment dated 10/13/20 at 9:09 PM read Resident #46 was unable to hold a cigarette, light his own cigarette, extinguish his cigarette, unable to extinguish a lit cigarette or ash if it fell on him or another resident and he took medications potentially creating a hazard to him or others. Resident #46 was identified as a supervised smoker. This assessment was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 27	F 561		

completed by Nurse #2.

Review of Resident #46's smoking observation form dated 12/10/20 read that his identified risk was his medications potentially creating a hazard to him or others. Resident #46 was identified as a supervised smoker. The form was completed by the DON.

In an interview on 3/22/21 at 10:40 AM, Resident #46 was in his room sitting in his wheelchair. He stated he has not been able to go outside to smoke in months because of COVID-19. Resident #46 stated prior to COVID-19, smokers required a staff member to be outside with them at assigned times and he wore a smoking apron when smoking. He stated smoking was pleasurable to him and he wished they would reopen the smoking area.

In an interview on 3/24/21 at 8:40 AM, Nurse #6 stated that resident smoking ceased sometime last year when the facility had an COVID-19 outbreak. She was not aware of any policy change regarding smoking and confirmed she had no in-servicing about smoking cessation for the residents. Nurse #6 stated the staff were just told that resident smoking would cease until the COVID-19 outbreak was resolved. She stated the outbreak resolved sometime last month but resident smoking had not resumed and she was unsure why. Nurse #6 stated that the smoking area for residents was off the D hall and the C/D halls were utilized for COVID+ and quarantine units. She indicated there was nowhere else for the residents to smoke and it was her understanding that the facility did not want to bring COVID-19 negative residents onto the COVID unit and quarantine unit to get the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 561	Continued From page 28	F 561		

smoking area. She stated management decided where to house COVID-19 positive residents and quarantine residents and also decided to stop resident smoking. Nurse #6 stated she was not aware of residents having a difficult time with no longer smoking.

In another interview on 3/24/21 at 9:10 AM, Resident #46 stated the facility management told him yesterday that they were working on reopening the smoking area. Resident #46 stated he did not mind wearing a smoking apron.

In an interview on 3/24/21 at 9:15 AM, the DON stated resident smoking ceased on 12/27/20 when a COVID-19 outbreak was identified.

In an interview on 3/24/21 at 12:10 PM, the Administrator stated that as of 12/27/20 the facility stopped permitting residents to smoke due to a COVID-19 outbreak in the facility. She indicated that a policy was implemented on 12/31/20 that stated residents were no longer permitted to smoke. The Administrator revealed the outbreak ended on 2/25/21, but that smoking privileges had not been reimplemented. When asked why smoking privileges had not been reimplemented she stated that they were planning on making this change within the next few weeks.

In an interview on 3/25/21 at 10:55 AM, the Activity Director (AD) stated that residents had voiced a desire to go outside to smoke and/or to get fresh air, but as of yet, the smoking area had not been reopened. She explained that the smoking area was also the area where residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 29 were able to go outside. In a telephone interview on 3/26/21 at 12:45 PM, the Facility Physician stated he was not aware that residents weren't allowed to go outside or smoke. The Facility Physician stated residents' psychosocial needs were very important and expected the facility to provide opportunities to improve or maintain their psychosocial well-being by allowing the resident to smoke or go outside for fresh air. In an interview on 3/26/21 at 2:30 PM, the Administrator and DON stated it was their expectation that resident choices and preferences be honored. They confirmed that residents had used the smoking area as a place to go outside for fresh air, but they indicated they had not realized that because the smoking area was not in use that this resulted in the residents not being able to go outside. They reported that smoking was going to be reimplemented, but they had no specific date for this change. 8. Resident #35 was admitted on 4/20/20 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #35's quarterly Minimum Data Set dated 1/22/21 indicated he was cognitive intact and exhibited no behaviors. He was coded independent to supervision with his activities of daily living (ADLs) and no impairment to his bilateral upper extremities. Resident #35 was not coded for the use of tobacco products. Review of Resident #35's care plan dated 06/9/20 read he needed supervision with smoking.	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 30	F 561		

Interventions read Resident #35 required supervision when smoking, wear a smoking apron as needed, education of the smoking policy and screen Resident #35 to determine the need for supervised smoking.

Review of a smoking assessment dated 10/28/20 at 6:55 PM read Resident #35 was unable to hold a cigarette, light his own cigarette, extinguish his cigarette, unable to extinguish a lit cigarette or ash if it fell on him or another resident and he took medications potentially creating a hazard to him or others. Resident #46 was identified as a supervised smoker. This assessment was completed by Nurse #2.

Review of Resident #35's smoking observation form dated 1/14/21 read that his identified risk was his medications potentially creating a hazard to him or others and he had a loss of feeling in his fingers. Resident #35 was identified as a supervised smoker. The form was completed by the DON.

In an interview on 3/22/21 at 12:40 PM, Resident #35 stated his only concern with the facility was that management took away smoking privileges. He stated he has not been able to smoke from December 2020 to present.

In an interview on 3/24/21 at 8:40 AM, Nurse #6 stated that resident smoking ceased sometime last year when the facility had an COVID-19 outbreak. She was not aware of any policy change regarding smoking and confirmed she had no in-servicing about smoking cessation for the residents. Nurse #6 stated the staff were just told that resident smoking would cease until the COVID-19 outbreak was resolved. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 31	F 561		

the outbreak resolved sometime last month but resident smoking had not resumed and she was unsure why. Nurse #6 stated that the smoking area for residents was off the D hall and the C/D halls were utilized for COVID+ and quarantine units. She indicated there was nowhere else for the residents to smoke and it was her understanding that the facility did not want to bring COVID-19 negative residents onto the COVID unit and quarantine unit to get the smoking area. She stated management decided where to house COVID-19 positive residents and quarantine residents and also decided to stop resident smoking. Nurse #6 stated she was not aware of residents having a difficult time with no longer smoking.

In another interview with Resident #35 on 3/24/21 at 9:18 AM, he stated staff were not letting him and other residents' smoke. He stated he was not told the reason why smoking was no longer allowed.

In an interview on 3/24/21 at 12:10 PM, the Administrator stated that as of 12/27/20 the facility stopped permitting residents to smoke due to a COVID-19 outbreak in the facility. She indicated that a policy was implemented on 12/31/20 that stated residents were no longer permitted to smoke. The Administrator revealed the outbreak ended on 2/25/21, but that smoking privileges had not been reimplemented. When asked why smoking privileges had not been reimplemented she stated that they were planning on making this change within the next few weeks.

In an interview on 3/25/21 at 10:00 AM, Nurse #5 stated Resident #35 frequently complained about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 32 not being able to go outside to smoke In an interview on 3/25/21 at 10:55 AM, the Activity Director (AD) stated that residents had voiced a desire to go outside to smoke and/or to get fresh air, but as of yet, the smoking area had not been reopened. She explained that the smoking area was also the area where residents were able to go outside. In a telephone interview on 3/26/21 at 12:45 PM, the Facility Physician stated he was not aware that residents weren't allowed to go outside to smoke or get fresh air. The Facility Physician stated residents' psychosocial needs were very important and expected the facility to provide opportunities to improve or maintain their psychosocial well-being by allowing the resident to smoke and go outside. In an interview on 3/26/21 at 2:30 PM, the Administrator and DON stated it was their expectation that resident choices and preferences be honored. They confirmed that residents had used the smoking area as a place to go outside for fresh air, but they indicated they had not realized that because the smoking area was not in use that this resulted in the residents not being able to go outside. They reported that smoking was going to be reimplemented, but they had no specific date for this change. 9. Facility smoking policy review revealed it was initiated on 1/1/2015 and last revision was on 10/15/2019. The policy documented that "smoking was not allowed on the healthcare center premises by visitors, partners or patients/residents. Smoking will only be allowed	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 33	F 561		

in outdoor designated areas for those residents "grandfathered" in prior to January 1, 2015. The Admission Director or admitting licensed nurse will inform patient/residents and/or legal representative of the smoking policy upon admission." The policy also included the following:

· At no time should any fire igniting material (matches/lighters) and smoking materials to include cigarettes, smokeless, electronic cigarettes, vaping devices, cigars, snuff or loose tobacco be in a patient/resident ' s possession. Patient/resident igniting, and smoking materials will be maintained at the nurse ' s station for the safety of smokers.

A revised COVID smoking policy, dated 12/31/20 indicated that the facility stopped smoking while the facility was in outbreak status.

Resident #41 was admitted to the facility on 3/20/19 with diagnosis of dementia.

A review of Resident #41 ' s annual Minimum Data Set dated 2/2/2021 revealed that he was moderately cognitively impaired. The resident required extensive assistance of 1 staff for all activities of daily living (including personal care). His diagnosis was debility.

Resident #41 ' s care plan dated 1/12/20 revealed the resident chose to smoke. The resident was a supervised smoker.

A review of Resident #41 ' s last smoking assessment dated 3/24/2021 revealed he was a supervised smoker because he was unable to extinguish burning material.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 561	Continued From page 34 Resident #41 was observed on 3/25/2021 at 3:45 pm for a transfer to his bed by Nursing Assistant (NA) #2. During transfer the resident commented to the NA that "I want to smoke." The NA responded to the resident that smoking would be started again soon and when she knew the time she would let the resident know. The resident commented to the NA "it has been a long time" (since he was permitted to smoke at the facility). The NA agreed. On 3/25/2021 at 4:00 pm an interview was conducted with Resident #41. He stated that he has "not been able to smoke since this COVID thing" and that he "wanted to go outside and smoke with the guys." On 3/26/2021 at 1:30 pm the Director of Nursing participated in an interview. She stated that smoking was discontinued December of 2020 due to COVID breakout and had not been reinitiated since. Smoking was going to be started again for all smoking residents after smoking evaluation was completed and a process was set up.	F 561		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but	F 583		5/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 583	Continued From page 35 this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observation, family interview, and staff interview, the facility failed to provide a private environment for in person visitation for 2 of 2 residents (Resident #7 and #22) reviewed for privacy. The findings included: 1. Resident #22 was admitted to the facility on 11/9/20 with multiple diagnoses that included hypertensive encephalopathy. The quarterly Minimum Data Set (MDS)	F 583	1) Indoor visitation for residents was moved out of the front lobby to a room in the facility on March 31, 2021. Resident #22 had an indoor visit in the private room without employee supervision. The family of resident #7 has not rescheduled a visit. 2)Facility residents have the potential the potential to be affected by not having a private place to meet with friends and family. On March 29, 2021 resident visitation was moved to a room in the facility offering privacy. Family and friends	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 583	Continued From page 36 assessment dated 1/8/21 indicated Resident #22 ' s cognition was severely impaired. An interview was conducted with the Administrator on 3/24/21 at 9:55 AM. She spoke about the facility ' s current indoor visitation protocol. She stated that residents met with their visitor in the lobby area of the facility, they were seated 6 feet apart, and they wore the required Personal Protective Equipment (PPE). The Administrator indicated that the lobby connected the 2 units of the facility and a sign was placed on the double doors leading from the lobby to each unit informing staff that a visitation was in progress and not to disturb. She reported that there was another pathway through the dining area that the staff could use to get to the other unit in order to avoid the lobby area. She was asked if the screener was present in the lobby during the visitation and she revealed the screener was in the lobby as well as the receptionist. She reported that the current corporate policy was that a staff member must be present for the duration of the visit to ensure PPE was worn and social distancing was maintained. She acknowledged that with the screener and receptionist present they may be able to overhear the conversation between the resident and visitor. She further acknowledged that the resident was not provided with complete privacy for the visitation. On 3/24/21 at 3:05 PM Resident #22 was observed in the lobby visiting with a family member. A large plastic screen was placed as a barrier between the resident and the family member and they were seated 6 feet apart. There were no signs observed on either double doorway leading from the units to the lobby to	F 583	visit residents without being overheard or staff present in the room. An audit of visitation conducted on April 11, 20201 by facility Administrator revealed 2 of 2 indoor visits for the day were conducted in room providing privacy and without resident supervision 3)Facility employees started receiving education on April 1, 2021 concerning the new location of indoor visitation and ensuing privacy is maintained during the visit from facility Administrator and Activity Director. Residents and families are educated before each visit about the location providing privacy for the visit. 4)Facility Activity Director and/or Activity designee will monitor visits daily for 7 days, weekly for 3 weeks, then monthly for 3 months to ensure location of visits maintains privacy. Results of audits will be discussed at facility QAPI meeting for 6 months to ensure compliance 5)May 5, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 583	Continued From page 37 inform staff that a visitation was in progress. The screener (NA #3) was present in the lobby and staff were observed walking through the lobby from one unit to the other. An interview was conducted with Resident #22 ' s family member at 3:10 PM. He stated that meeting in the lobby area provided no privacy and that it was also difficult for Resident #22 to hear him with all of the noise from staff walking through the area. He reported that he visited with Resident #22 last week and the same thing occurred during that visit. An interview was conducted with NA #3 on 3/25/21 at 1:10 PM. She confirmed that she was the screener in the lobby area during Resident #22 ' s visitation with her family member on 3/24/21. She revealed that she was able to hear their whole conversation. She stated that the Administrator told her to try not to listen to the resident and visitor so that they had privacy. During an interview with the Administrator on 3/26/21 at 2:30 PM she stated that she expected residents to have privacy during visitation, but that she was required to follow the corporate policy. 2. Resident #7 was admitted to the facility on 6/12/17 with multiple diagnoses that included intellectual disabilities. The annual Minimum Data Set (MDS) assessment dated 12/7/20 indicated Resident #7 ' s cognition was severely impaired.	F 583		

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F 583	Continued From page 38 A phone interview was conducted with Resident #7 ' s family member on 3/22/21 at 1:43 PM. She stated that she came to the facility last week to visit with Resident #7. She reported that the facility had her meet with the resident in the lobby area with a 6 foot social distance between herself and Resident #7. She revealed that during this visit there was a screener sitting at a table in the lobby and staff members who were walking back and forth between units as the lobby area connected one unit to the other. Resident #7 ' s family member stated that she wished she was able to visit with Resident #7 in a private setting. An interview was conducted with the Administrator on 3/24/21 at 9:55 AM. She spoke about the facility ' s current indoor visitation protocol. She stated that residents met with their visitor in the lobby area of the facility, they were seated 6 feet apart, and they wore the required Personal Protective Equipment (PPE). The Administrator indicated that the lobby connected the 2 units of the facility and a sign was placed on the double doors leading from the lobby to each unit informing staff that a visitation was in progress and not to disturb. She reported that there was another pathway through the dining area that the staff could use to get to the other unit in order to avoid the lobby area. She was asked if the screener was present in the lobby during the visitation and she revealed the screener was in the lobby as well as the receptionist. She reported that the current corporate policy was that a staff member must be present for the duration of the visit to ensure PPE was worn and social distancing was maintained. She acknowledged that with the screener and receptionist present they may be able to overhear the conversation between the resident and visitor.	F 583		

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F 583	Continued From page 39 She further acknowledged that the resident was not provided with complete privacy for the visitation. During an interview with NA #3 on 3/25/21 at 1:10 PM she revealed she was present in the lobby area as the screener during resident visitations and that she was able to hear their whole conversation. She stated that the Administrator told her to try not to listen to the resident and visitor so that they had privacy. During an interview with the Administrator on 3/26/21 at 2:30 PM she stated that she expected residents to have privacy during visitation, but that she was required to follow the corporate policy.	F 583		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		5/5/21

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F 584	Continued From page 40 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record review, the facility failed to ensure resident rooms were in good repair. This was for 8 (Room #117, Room #119, Room #121, Room #127, Room #129, Room #131, Room #146, and Room #147) of 9 residents rooms reviewed for comfortable, clean, and homelike environment. The findings included: 1. Observation on room 119 was completed on 3/22/21 at 11:00 AM. The curtain was observed to be off the track on one side of the window. In an interview and observation on 3/25/21 at 11:10 AM, the Maintenance Director noted the	F 584	1. Window curtains in resident rooms 119,121,127,131, and 146 were repaired by the Maintenance Director by May 5, 2021. Painting and wall repairs were completed for rooms 117,121,129, and 147 by Maintenance Director by May 5, 2021. Tile and window repair for room 117 was completed by May 5, 2021 by the Maintenance Director 2.By April 19, 2021 the Financial Counselor, Housekeeping Supervisor, and Maintenance Director completed an audit of all resident rooms to ensure window curtains were on the track and no	

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F 584	Continued From page 41 curtain and stated most of the time, the housekeeping staff let him know about the need for curtain repairs. The administrator was interviewed on 3/26/21 at 2:19 PM, and stated it was important for the environment to be well repaired and homelike. 2. Observation on room 121 was completed on 3/22/21 at 11:04 AM. The curtain was observed to be off the track on one side of the window. Also observed was the wallpaper behind B bed hanging off the wall and the sheet rock on the side of B bed had multiple patched areas that were unpainted. In an interview and observation on 3/25/21 at 11:10 AM, the Maintenance Director stated room renovations were on hold and room 121 was one of the rooms to be renovated. He noted the curtain and stated most of the time, the housekeeping staff let him know about the need for curtain repairs. The administrator was interviewed on 3/26/21 at 2:19 PM, and stated it was important for the environment to be well repaired and homelike. 3. Observation on room 127 was completed on 3/22/21 at 2:50 PM. The curtain was observed to be off the track on one side of the window. In an interview and observation on 3/25/21 at 11:10 AM, the Maintenance Director noted the curtain and stated most of the time, the housekeeping staff let him know about the need for curtain repairs.	F 584	other repairs were needed for paint, wall coverings, or broken tile. Rooms found needing repair will be repaired by the Maintenance Director by May 5, 2021 3.Starting April 19, 2021 Facility Maintenance Director educated employees in the nursing, housekeeping, therapy, environmental, and administrative departments on entering work orders in facility electronic system to notify him a repair is needed. Maintenance Director and/or designee will review work orders Monday to Friday to ensure timely completion. 4.Facility Administrator will monitor work orders for timely completion daily for seven days, then weekly for three weeks, then monthly for six months. Findings of this monitoring will be brought to the facility QAPI committee monthly to ensure compliance 5.May 5, 2021	

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F 584	Continued From page 42 The administrator was interviewed on 3/26/21 at 2:19 PM, and stated it was important for the environment to be well repaired and homelike 4. Observation on room 131 was completed on 3/22/21 at 2:57 PM. The curtain was observed to be off the track on one side of the window. In an interview and observation on 3/25/21 at 11:10 AM, the Maintenance Director noted the curtain and stated most of the time, the housekeeping staff let him know about the need for curtain repairs. The administrator was interviewed on 3/26/21 at 2:19 PM, and stated it was important for the environment to be well repaired and homelike. 5) On 3/24/21 at 3:30 PM, an observation of room 146 revealed the front portion and back portion of the window curtain not attached to the rail system and was hanging loose. In addition, around the window was a white piece of insulation tap with the bottom 12 inches not attached to the window frame with a visible gap to the outside and wind causing the tape to flap. Observations were conducted during a round with the Maintenance Director on 3/25/21 at 10:50 AM. Upon entering the room, he observed the window curtain not properly hung at the window. The Maintenance Director observed the insulation tape present on the inside seam of the metal window frame with 12 inches at the bottom left, not attached and flapping due to wind from the outside. He removed the piece of tape exposing the bottom of the metal window frame that was bent creating the gap. He stated the opening was about three sixteenth in width and he was	F 584		

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F 584	Continued From page 43	F 584		

unaware of the gap at the window frame. He stated the areas did require attention and would be addressed.

The administrator was interviewed on 3/26/21 at 2:19 PM, and stated it was important for the environment to be well repaired and homelike.

6) On 3/24/21 at 3:40 PM, an observation of room 147 revealed damage to the plaster of the wall to the left side at the door entry, exposing the sheetrock.

Observations were conducted during a round with the Maintenance Director on 3/25/21 at 10:55 AM. He observed the area of exposed sheetrock and indicated wheelchairs coming through the door had caused the damage. He stated the area did require attention and would be addressed.

The administrator was interviewed on 3/26/21 at 2:19 PM, and stated it was important for the environment to be well repaired and homelike.

7) On 3/24/21 at 3:50 PM, an observation was made of room 129 revealing multiple scattered areas of plaster off the walls behind the headboards of Beds A and B.

Observations were conducted during a round with the Maintenance Director on 3/25/21 at 11:00 AM. He observed the multiple scattered areas of damage to the walls behind the headboards of the beds and indicated damage occurred when moving beds around. He further stated the areas did require attention and would be addressed.

The administrator was interviewed on 3/26/21 at 2:19 PM, and stated it was important for the

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F 584	Continued From page 44 environment to be well repaired and homelike. 8. On 3/24/21 at 12:00 PM, an observation of room 117 revealed: - 15 floor tiles, 1 foot by 1 foot, with cracks running through them - A dark horizontal line approximately 4 feet in length across the wall in which the resident beds were facing - 12 dark colored circles approximately 1/4 inch by 1/4 inch scattered about the wall in which the resident beds were facing - A section of wallpaper approximately 1.5 feet peeling off the wall behind the bed located nearest the doorway During a phone interview on 3/22/21 at 1:43 PM with the Responsible Party of a resident in room 117 she indicated that the resident was previously in another room that was in better condition than his current room. She reported that his current room was in disrepair with cracks on the floor and marks all over the walls. An observation of room 117 was conducted with the Maintenance Director on 3/25/21 at 11:00 AM. He revealed that he was aware of multiple items in this room that needed to be repaired which included the cracks throughout the floor tiles and the peeling wallpaper. He reported that the dark colored horizontal line approximately 4 feet in length was probably caused by chairs being moved across that wall. He indicated that the scattered dark colored circles appeared to be splatters from a liquid. The administrator was interviewed on 3/26/21 at 2:19 PM, and stated it was important for the environment to be well repaired and homelike.	F 584		

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F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medication (Resident #49), Preadmission Screening and Resident Review Level II (Resident #7), cognition (Residents #45, #50, #55, and #75), indwelling urinary catheter (Residents #4 and #127), skin conditions (Resident #13), tobacco use (Resident #28), bowel and bladder (Residents #27 and #43), and activities of daily living (Resident #43). This was for 12 of 27 residents reviewed. The findings included: 1. Resident #7 was admitted to the facility on 6/12/17 with multiple diagnoses that included intellectual disabilities. Resident #7 ' s profile in the Medical Record indicated he had a Preadmission Screening and Resident Review (PASRR) Level II with no expiration date in place during his entire stay at the facility (admitted 6/12/17). The annual Minimum Data Set (MDS) assessment dated 12/7/20 indicated Resident #7 ' s cognition was severely impaired. He was coded with no PASRR Level II. Resident #7 ' s active care plan, last reviewed on 12/23/20, included the problem area of a PASRR	F 641	1.Facility Registered Nurse Case Mix Coordinator completed MDS modification to correct section A Preadmission Screening and Resident Review (PASRR) Level II for Resident #7 on April 14, 2021. Facility Registered Nurse Case Mix Coordinator completed MDS modification to correct section N for Antipsychotic Medication received and reviewed for Resident #49 on April 14, 2021. MDS modification completed to correct Section H for Resident #4 on April 15,2021, Resident did not have indwelling urinary catheter and is always incontinent of bladder. MDS modification completed to correct Section H for Resident #127 on April 15,2021, Resident #127 has an indwelling urinary catheter and his continence is not rated. MDS modification completed to correct Section J for Resident # 28 on April 15,2021, Resident was current tobacco use. Resident #50 Section C (BIMS) interview completed per RAI guidelines and care plan updated to reflect current BIMS on April 16, 2021. Resident #55 Section C (BIMS) interview completed per RAI guidelines and care plan updated to reflect current BIMS on April 16, 2021. Resident MDS modification completed to correct Section H and for Resident #27 on April 15, 2021. Resident has suprapubic catheter and	5/5/21

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 46 Level II related to intellectual disabilities. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 3/25/21 at 3:57 PM. Resident #7 ' s profile and care plan that indicated he had a PASRR Level II were reviewed with the MDS Nurses. MDS Nurse #1 and MDS Nurse #2 revealed Resident #7 ' s 12/7/20 annual MDS was coded inaccurately for PASRR Level II. They both indicated his assessment should have been coded with PASRR Level II status. During an interview with the Director of Nursing (DON) on 3/5/21 at 4:30 PM she stated that she expected the MDS to be coded accurately. 2. Resident #49 was admitted to the facility on 5/7/20 and most recently readmitted on 1/25/21 with multiple diagnoses that included depression, anxiety, and metabolic encephalopathy. A physician ' s order dated 1/28/21 indicated aripiprazole (antipsychotic medication) 15 milligrams (mg) once daily for Resident #49. A review of Resident #49 ' s Medication Administration Record (MAR) from 1/29/21 through 2/4/21 indicated he received aripiprazole on 7 of 7 days. The annual Minimum Date Set (MDS) assessment dated 2/4/21 indicated Resident 49 ' s cognition was intact. This MDS indicated he received no antipsychotic medication during the 7-day look back period (1/29/21 through 2/4/21). An interview was conducted with MDS Nurse #2 on 3/26/21 at 12:05 PM. Resident #49 ' s 2/4/21	F 641	urinary continent is coded as not rated. MDS modification completed to correct Section G and H for Resident #43 on April 15, 2021. Resident had received extensive assist with bathing during MDS 7 day look back per staff interviews. Resident #45 Section C (BIMS) interview completed per RAI guidelines and care plan updated to reflect current BIMS on April 16, 2021. Resident #75 Section C (BIMS) interview completed per RAI guidelines and care plan updated to reflect current BIMS on April 16, 2021. MDS modification completed to correct Section M for Resident #13 on March 24, 2021. 2.Facility Registered Nurse Case Mix Coordinator to review recent completed comprehensive and quarterly assessments for accurate coding starting April 16, 2021 and to be completed no later than May 5,2021. The comprehensive assessments will capture accurate coding for section A related to level 2 PASRR and section J for smoking. Assessments with inaccurate coding will be corrected and retransmitted no later than May 5,2021. Director of Social Services will complete BIMS interviews per RAI guidelines for all current Residents in house and care plan will be updated to reflect current BIMS starting April 16, 2021 and to be completed by May 5, 2021. 3.Director of Social Service will complete an audit on residents with level 2 PASRR by April 20, 2021 with a list of these	

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PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 47 annual MDS that indicated he had not received antipsychotic medication during the 7-day look back period as well the MAR that revealed he received aripiprazole on 7 of 7 days during the look back period (1/29/21 through 2/4/21) were reviewed with MDS Nurse #2. MDS Nurse #2 revealed that Resident #49 ' s 2/4/21 MDS was coded inaccurately. She stated that this MDS should have been coded to indicate Resident #49 received antipsychotic medication on 7 of 7 days. During an interview with the Director of Nursing (DON) on 3/5/21 at 4:30 PM she stated that she expected the MDS to be coded accurately. 3. Resident #4 was admitted to the facility on 12/8/20 with multiple diagnoses that included diabetes mellitus with diabetic chronic kidney disease. A review of Resident #4 ' s physician ' s orders from 3/3/21 through 3/9/21 revealed no orders related to an indwelling urinary catheter. A review of Resident #4 ' s medical record from 3/3/21 through 3/9/21 revealed no indication that the resident had an indwelling urinary catheter. The quarterly Minimum Data Set (MDS) assessment dated 3/9/21 indicated Resident #4 ' s cognition was intact. She was coded with an indwelling urinary catheter. An observation and interview were conducted with Resident #4 on 3/22/21 at 2:00 PM. She was observed to have no indwelling urinary catheter. Resident #4 reported she had no indwelling urinary catheter during March 2021.	F 641	residents provided to Registered Nurse Case Mix Coordinator on the same day. Resident with level 2 PASRR list will be updated as needed by Director of Social Service as Residents discharged, expired and new admissions. Facility Registered Nurse Case Mix Coordinators will receive training from Regional Registered Nurse Case Mix Director regarding accurate coding of Resident assessments for Section A: A Preadmission Screening and Resident Review (PASRR) Level II, Section N: Indicate the number of days the resident received the following medications by pharmacological classification for antipsychotic medications, Section H: Urinary appliance and urinary continent, Section J: Current tobacco use, Section C: Should Brief Interview for Mental Status (C0200-C0500) be conducted? Attempt to conduct interview with all residents, Section G: How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair). Code for most dependent in self-performance and support, Section N: Determination of pressure ulcer/injury Risk and Current numbers of unhealed pressure ulcers/injuries at each stage. Starting April 19, 2021 and completed no later than May 5, 2021. Education will be provided to Nursing Assistant on documentation on care provided to Residents Related to Section G: Bathing and H: urinary continent, starting April 19, 2021 and to be completed no later than May 5, 2021. Education will be added to newly hired Case Mix Coordinators,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 48 An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 3/25/21 at 3:57 PM. Resident #4 ' s 3/9/21 quarterly MDS that indicated she had an indwelling urinary catheter as well as Resident #4 ' s medical record that indicated she had no indwelling urinary catheter were reviewed with the MDS Nurses. MDS Nurse #1 and MDS Nurse #2 revealed Resident #4 ' s 3/9/21 MDS was coded inaccurately for an indwelling urinary catheter. They both indicated this assessment should have been coded to indicate Resident #4 had no indwelling urinary catheter. During an interview with the Director of Nursing (DON) on 3/5/21 at 4:30 PM she stated that she expected the MDS to be coded accurately. 4. Resident #127 was admitted to the facility on 11/19/19 with multiple diagnoses that included heart failure and chronic kidney disease. A physician ' s order dated 1/16/20 indicated an indwelling urinary catheter was in place for Resident #127. A review of Resident #127 ' s physician ' s orders from 6/23/20 through 6/29/20 indicated the 1/16/20 order for an indwelling urinary catheter remained an active order. The quarterly Minimum Data Set (MDS) assessment dated 6/29/20 indicated Resident #127 ' s cognition was intact. He was coded with no indwelling urinary catheter.	F 641	Interdisciplinary Team Members and nursing assistants. 4.Pruitt Health Regional Registered Nurse Case Mix Director or her designee (Facility Director of Health Services) will audit eight transmitted assessments weekly for four weeks, then monthly for 6 months for coding accuracy in the areas of Section A: A Preadmission Screening and Resident Review (PASRR) Level II, Section N: Indicate the number of days the resident received the following medications by pharmacological classification for antipsychotic medications, Section H: Urinary appliance and urinary continent, Section J: Current tobacco use, Section C: Brief Interview for Mental Status (C0200-C0500), Section G: How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower. Section N: Determination of pressure ulcer/injury Risk and Current numbers of unhealed pressure ulcers/injuries at each stage. All findings will be reviewed at facility QAPI committee meeting by RN MDS Coordinators monthly for 6 months to ensure compliance. 5.May 5, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 49	F 641		

An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 3/25/21 at 3:57 PM. Resident 127 ' s 6/29/20 quarterly MDS that indicated he had no indwelling urinary catheter as well as Resident #127 ' s medical record that indicated he had an indwelling urinary catheter at the time of this 6/29/20 MDS were reviewed with the MDS Nurses. MDS Nurse #1 and MDS Nurse #2 revealed Resident #127 ' s 6/29/20 MDS was coded inaccurately for an indwelling urinary catheter. They both indicated this assessment should have been coded to indicate Resident #127 had an indwelling urinary catheter in use.

During an interview with the Director of Nursing (DON) on 3/5/21 at 4:30 PM she stated that she expected the MDS to be coded accurately.

5. Resident #28 was admitted to the facility on 5/6/20 with multiple diagnoses that included heart failure.

The admission Minimum Data Set (MDS) assessment dated 5/9/20 indicated Resident #28 ' s cognition was fully intact. He was coded with no tobacco use by a former MDS Nurse.

During an interview with Resident #28 on 3/22/21 at 2:05 PM he reported he was admitted to this facility in May of 2020 and was a smoker at that time. He stated he smoked multiple times every day during May 2020.

During an interview with the Director of Nursing (DON) on 3/24/21 at 2:35 PM she confirmed that Resident #28 utilized tobacco in the form of cigarettes daily when he was admitted to the facility (5/6/20).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 50 An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 3/25/21 at 3:57 PM. Resident #28 ' s 5/9/20 admission MDS that indicated he had no tobacco use as well as Resident #28 ' s interview and the DON interview that indicated the resident utilized tobacco daily at the time of this 5/9/20 MDS were reviewed with the MDS Nurses. MDS Nurse #1 and MDS Nurse #2 revealed that based on the information, Resident #28 ' s 5/9/20 admission MDS was coded inaccurately for tobacco use. They both indicated this assessment should have been coded to indicate Resident #28 utilized tobacco. During an interview with the DON on 3/5/21 at 4:30 PM she stated that she expected the MDS to be coded accurately. 6. Resident #50 was admitted to the facility on 10/9/18 with multiple diagnoses that included cerebral infarction and diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated 2/5/21 indicated Resident #50 had unclear speech, was sometimes understood, and usually understands. In the Cognitive Patterns section the first question asked if the Brief Interview for Mental Status (BIMS) was to be conducted and this was answered "No" indicating that Resident #50 was rarely/never understood. The BIMS was not conducted for Resident #50. In the Mood section, the first question asked if the resident mood interview was to be conducted and this was answered "Yes" indicating that Resident #50 was at least sometimes understood. The resident mood interview was conducted and completed for	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 51	F 641		

Resident #50. The Cognitive Patterns and Mood Sections were completed by the Social Worker (SW).

An interview was conducted with Resident #50 on 3/22/21 at 10:05 AM. Resident #50 had mumbled/unclear speech. He was able to answer some simple yes/no questions with answers that were distinguishable.

An interview was conducted with the SW on 3/25/21 at 2:40 PM. The 2/5/21 MDS for Resident #50 that indicated the BIMS was not completed due to the resident being rarely/never understood and the resident mood interview that indicated Resident #50 was at least sometimes understood were reviewed with the SW. The SW revealed that Resident #50 was sometimes understood. She explained that Resident #50 was not able to state specific words such as "blue" or "sock" which were asked during the BIMS, but he was able to give "yes" or "no" answers to questions in the resident mood interview. She stated that this was why she reported that Resident #50 was rarely/never understood for the cognition questions and conversely answered the mood questions to indicate that he was sometimes understood. The SW indicated she was unaware of the coding instructions specified in the Resident Assessment Instrument (RAI) manual regarding the completion of the resident interviews for the cognition and mood sections.

An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 3/25/21 at 3:57 PM. MDS Nurse #1 and MDS Nurse #2 indicated that the BIMS interview was to be conducted with all residents who had any form of verbal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 52 communication, written communication, or any other form of communication methods. MDS Nurse #1 and MDS Nurse #2 revealed that the cognitive patterns question that indicated Resident #50 was rarely/never understood was answered inaccurately as the resident was sometimes able to be understood as demonstrated in the completion of the resident mood interview. During an interview with the Director of Nursing (DON) on 3/5/21 at 4:30 PM she stated that she expected the MDS to be coded accurately. 7. Resident #55 was admitted to the facility on 10/3/19 and most recently readmitted to the facility on 2/4/21 with multiple diagnoses that included orthopedic aftercare. The quarterly Minimum Data Set (MDS) assessment dated 1/22/21 indicated Resident #55 ' s cognition was fully intact. A physician ' s note dated 2/5/21 indicated Resident #55 was alert and oriented with some forgetfulness. The significant change Minimum Data Set (MDS) assessment dated 2/10/21 indicated Resident #55 had clear speech, she was usually understood, and she usually understands others. The Cognitive Patterns Section indicated a Brief Interview for Mental Status (BIMS) was to be conducted with Resident #55. The BIMS resident interview questions were left unanswered. The question asking if the staff assessment for mental status should be	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 53	F 641		

conducted was answered "Yes" indicating that Resident #55 was unable to complete the BIMS.

An interview was conducted with Resident #55 on 3/22/21 at 9:05 AM. Her speech was clear, and she was alert and oriented to person, place, time, and situation.

An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 3/25/21 at 3:57 PM. Resident #55 ' s 2/10/21 significant change MDS indicated they had clear speech, was alert and oriented, and indicated the staff assessment for mental status was completed as she was unable to complete the BIMS was reviewed with the MDS Nurses. MDS Nurse #1 and MDS Nurse #2 stated the Resident Assessment Instrument (RAI) Manual indicated that the staff assessment for mental status was not to be conducted if the resident interview should have been conducted but was not done. Both MDS Nurses reported that the BIMS should have been conducted with Resident #55.

During an interview with the Director of Nursing (DON) on 3/5/21 at 4:30 PM she stated that she expected the MDS to be coded accurately.

8) Resident #27 was originally admitted to the facility on 5/6/20 with a recent readmission date of 3/12/21. His diagnoses included neuromuscular dysfunction of the bladder and quadriplegia.

The quarterly Minimum Data Set (MDS) assessment dated 1/18/21 indicated Resident #27 was able to understand others and make

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 54	F 641		

himself understood. He was coded with an indwelling catheter and always incontinent of bladder.

A review of the March 2021 physician orders revealed an order for Resident #27 to have the suprapubic catheter changed monthly.

On 3/25/21 at 4:00 PM, an interview occurred with MDS Nurses #1 and #2. The nurses reviewed the MDS dated 1/18/21 and indicated section H0300 was marked in error and should have been marked as not rated, since Resident #27 had urinary catheter during the MDS 7 day look back period.

An interview occurred with the Director of Nursing on 3/25/21 at 4:35 PM. She indicated it was her expectation for the MDS to be coded accurately.

9a) Resident #43 was originally admitted to the facility on 1/21/20 with a recent readmission date of 1/27/21. His diagnoses included cerebral infarction (a stroke) affecting the left non-dominant side and contracture of the left knee.

A review of the December 2020 and January 2021 nursing progress notes revealed Resident #43 required extensive to total assistance with Activities of Daily Living (ADLs). Resident #43 was in the hospital from 1/18/21 through 1/27/21.

A review of the daily charting detail for ADL's from 1/28/21 to 1/31/21 revealed the areas for bathing were not coded.

The most recent MDS dated 1/31/21 and coded

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 55	F 641		

as a quarterly assessment indicated Resident #43 had impaired cognition. He was coded as requiring extensive assistance for bed mobility, dressing, toileting and dependent on staff for eating and personal hygiene. The bathing section was coded as the activity did not occur during the seven day look back period.

An interview was completed on 3/25/21 at 12:42 PM, with Nurse Aide (NA) #2 who worked first shift and was familiar with Resident #43. She explained he received scheduled showers three times a week on the evening shift (3:00 PM through 11:00 PM). The NA further stated when she was providing his care, a sponge bath was provided in the mornings and he required total assistance with the task.

On 3/25/21 at 4:00 PM, an interview occurred with MDS Nurses #1 and #2. The nurses reviewed the MDS dated 1/31/21 and verified the bathing portion of the MDS was marked as the activity did not occur. They explained the ADL portion of the assessment was coded based on the ADL charting completed by the NA's for bathing and there should have been some observations and interviews completed with the resident and staff to determine the amount of assistance required for the bathing task.

An interview occurred with the Director of Nursing on 3/25/21 at 4:35 PM. She indicated it was her expectation for the MDS to be coded accurately.

9b) Resident #43 was originally admitted to the facility on 1/21/20 with a recent readmission date of 1/27/21. His diagnoses included cerebral infarction (a stroke) affecting the left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 56 non-dominant side and benign prostatic hyperplasia with obstruction. A quarterly MDS assessment dated 1/6/21 revealed Resident #43 had severely impaired cognition. He was coded with an indwelling urinary catheter. A physician order dated 1/28/21 revealed Resident #43 to have an indwelling urinary catheter. The most recent MDS dated 1/31/21 and coded as a quarterly assessment indicated Resident #43 had impaired cognition. He was coded with intermittent catheterization and the urinary continence section was coded as not rated, resident with a urinary catheter. On 3/25/21 at 4:00 PM, an interview occurred with MDS Nurses #1 and #2. The nurses reviewed the MDS dated 1/31/21 and indicated intermittent catheterization was marked in error and indwelling catheter should have been marked. An interview occurred with the Director of Nursing on 3/25/21 at 4:35 PM. She indicated it was her expectation for the MDS to be coded accurately. 10) Resident #45 was admitted to the facility on 3/2/18. His diagnoses included cerebral infarction with aphasia (a stroke with impairment of language) and major depressive disorder. The quarterly MDS assessment dated 2/4/21 indicated Resident #45 had slurred or mumbled speech, was sometimes able to make	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 57	F 641		

self-understood and always understood others. In the Cognitive Patterns section, the first question asked if the Brief Interview for Mental Status (BIMS) was to be conducted and this was marked "No", indicating Resident #45 was rarely/never understood. The BIMS was not conducted for Resident #45. In the Mood section, the first question asked if the resident mood interview was to be conducted and this was answered "Yes" indicating Resident #45 was at least sometimes understood. The resident's mood interview was conducted and completed for Resident #45. The Cognitive Patterns and Mood Sections were completed by the Social Worker (SW).

A review of the nursing progress notes dated 2/1/21 through 3/26/21 indicated Resident #45 was able to communicate with staff nonverbally using nods of his head and gestures.

An observation and interview was completed with Resident #45 on 3/26/21 at 10:45 AM. He had mumbled/unclear speech but was able to answer some simple yes/no questions that were distinguishable. Resident #45 also communicated with nodding his head and hand gestures.

An interview was conducted with the SW on 3/26/21 at 11:55 AM. The 2/4/21 MDS for Resident #45 that indicated the BIMS was not completed due to the resident being rarely /never understood and the resident mood interview that indicated Resident #45 was at least sometimes understood were reviewed with the SW. The SW revealed that Resident #45 was sometimes understood. She explained that Resident #45 was not able to state specific words such as "blue" or "sock" which were asked during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 58 BIMS, but he was able to give "yes" or "no" answers or nods of his head, to questions in the resident mood interview. She stated this was why she reported that Resident #45 was rarely/never understood for the cognition questions and conversely answered the mood questions to indicate that he was sometimes understood. On 3/26/21 at 12:10pm, an interview occurred with MDS Nurse #2, who indicated the BIMS interview was to be conducted with all residents who had any form of verbal communication, written communication, or any other form of communication methods. Resident #45's 2/4/21 quarterly MDS that indicated he was rarely/never understood in the Cognitive Patterns section but was sometimes understood in the Mood section was reviewed with the MDS Nurse #2. MDS Nurse #2 revealed the question which indicated Resident #45 was rarely/never understood was answered inaccurately as the resident was sometimes able to be understood as demonstrated in the completion of the resident mood interview. An interview occurred with the Director of Nursing on 3/26/21 at 12:30 PM. She indicated it was her expectation for the MDS to be coded accurately. 11. Resident #75 was admitted to the facility on 5/6/20 with diagnoses of stroke and hemiparesis. The care plan dated 5/6/20 documented for Resident #75 had sustained a cerebral vascular	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 641	Continued From page 59	F 641		

accident and had limited mobility. Her (communication ability was not mentioned).

The quarterly Minimum Data Set (MDS) dated 3/6/2021 revealed Resident #75 was sometimes understood and understands. In the Cognitive Patterns section, the first question asked if the Brief Interview for Mental Status (BIMS) was to be conducted and this was answered "No" indicating that Resident #75 was rarely/never understood. The resident ' s active diagnoses were stroke, hemiparesis, and diabetes. The resident received physical therapy.

On 3/24/2021 at 12:45 pm Resident #75 participated in an interview. The resident was able to state she wore a hand splint and held her right hand up with splint in place. The resident was able to communicate that her hand was cleaned, and her mother visited. The resident also answered multiple yes and no questions clearly during this interview.

An interview was conducted with Social Work (SW) on 3/25/21 at 2:40 pm. The 3/6/21 MDS for Resident #75 indicated the BIMS (brief interview for mental status) was not completed due to the resident being rarely/never understood. The resident mood interview that indicated residents were at least sometimes understood was reviewed with the SW. The SW revealed that Resident #75 was sometimes understood. She explained that residents who were not able to state specific words such as "blue" or "sock" asked during the BIMS but was able to give "yes" or "no" answers to questions in the resident mood interview were skipped. The SW indicated she was unaware of the coding instructions specified in the Resident Assessment Instrument (RAI)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 60 manual regarding the completion of the resident interviews for the cognition and mood sections if able to be understood. On 3/26/2021 at 1:30 pm the Director Nursing (DON) was interviewed and indicated that staff responsible were required to code the MDS accurately. 12. Resident #13 was admitted on 10/19/18 with cumulative diagnoses of Congestive Heart Failure and Diabetes. Resident #13's quarterly Minimum Data Set (MDS) dated 1/5/21 indicated he was cognitively intact and exhibited no behaviors. He was coded for supervision with transfers and one stage 2 pressure ulcer. A Physician progress note dated 3/1/21 read Resident #13 had a diabetic right foot ulcer. A Wound Physician progress note dated 3/18/21 read the area to his right foot was an abrasion. Resident #13's care plan revised on 3/22/21 indicated he had chronic abrasions to his bilateral lower extremities. There was no care plan for a pressure ulcer or diabetic ulcer. On 3/23/21 at 5:05 PM, the facility provided a Physician order that read the area to Resident #13's right foot was an abrasion. In an interview on 3/24/21 at 10:30 AM, the	F 641		

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 641	Continued From page 61 Treatment Nurse stated the area to his right foot was an abrasion and that he often hit his lower extremities when self-transferring resulting in chronic abrasions. She stated she wrapped his right foot and lower leg in gauze for protection. In an interview on 3/24/21 at 12:55 PM, MDS Nurse #1 stated she recently started at the facility. She said she did not complete Resident #13's quarterly MDS but section M (skin) should not have been coded for a pressure ulcer on the quarterly MDS dated 1/5/21. MDS Nurse #1 stated his MDS was coded incorrectly. In an interview on 3/25/21 at 4:35 PM, the Director of Nursing stated it was her expectation that Resident 13's MDS dated 1/5/21 be coded accurately in the area of skin conditions.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to provide nail care for 2 of 5 dependent residents for Activities of Daily Living (Residents #41 and #43). 1) Resident #43 was originally admitted to the facility on 1/21/20 with a recent readmission date of 1/27/21. His diagnoses included cerebral infarction affecting the left non-dominant side and type 2 diabetes.	F 677	1.On April 19, 2021 Charge Nurse provided nail care to resident #41 and resident #43. Electronic records of both residents were updated to include nail care completion with showers by facility MDS Coordinators 2.An audit of resident nails was completed by the facility Financial Counselor, Medical Records Coordinator, Activity Director, Social Worker, and	5/5/21

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 677	Continued From page 62 A quarterly Minimum Data Set (MDS) Assessment dated 1/31/21 indicated Resident #43 had impaired cognition. He was coded as requiring extensive assistance for bed mobility, dressing, toileting and was dependent on staff for eating and personal hygiene. Limited range of motion was present to 1 upper and lower extremity. A review of the nursing progress notes from 8/5/20 through 3/24/21 revealed no refusals of nail care documented. A review of the active care plan revealed the following problem areas: -Personal hygiene. The intervention included to provide shower, nail care and oral care on Monday, Wednesday, and Friday from 3:00 PM to 11:00 PM. During observations on 3/22/21 and 3/24/21 Resident #43 was observed to have medium length nails to the right hand and left contracted hand, as well as a dark substance under all 5 fingernails to the right hand. On 3/24/21 at 11:20 AM, an interview occurred with the Director of Nursing (DON) who explained nurse aides (NA's) completed nail care on scheduled shower days and during personal care tasks. They were to visualize the fingernails and clean/trim/file as needed. If the resident was a diabetic a nurse was to cut their nails. An interview was completed with NA #8 on 3/24/21 at 11:52 AM, who stated both the NA's and nurses completed nail care as needed. The NA explained during showers and personal care, aides were to observe nails and provide	F 677	Housekeeping Supervisor by April 19, 2021. Residents found needing nails cleaned or cut had their nails taken care of facility Charge Nurses and nursing assistants by April 21, 2021. 3.Facility employees (housekeeping, nursing, dietary, therapy, and administration) were educated by facility Director of Nursing and/or Administrator regarding residents nails remaining clean and cut starting April 19, 2021. Education included reporting nails in need of attention to resident Charge Nurse to ensure nails would be cut and trimmed. Facility Administrative Team (Activity Director, Financial Counselor, Human Resources, Medical Records, Social Worker, Dietary Manager, and Housekeeping Supervisor) will conduct rounds during the week days to ensure resident nails remain clean and trimmed. Nails in need of attention will be reported to resident Charge Nurse for care. 4.Facility Director of Nursing, Infection Preventionist, and/or Administrator will audit the nails of five residents daily for 7 days, then weekly for three weeks, then monthly for three months to ensure timely nail care is given. Results of these audits will be discussed in facility QAPI committee meeting monthly for three months to ensure compliance 5.May 5, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 677	Continued From page 63	F 677		

assistance to clean/trim nails or alert a nurse if the resident was a diabetic.

On 3/24/21 at 12:53 PM, an interview was conducted with the Treatment Nurse who stated during weekly skin assessments provided by herself or the floor nurses, nail care should be rendered if there was a need, however, the NA's provided nail care during personal care and showers unless the resident was a diabetic.

On 3/24/21 at 3:00 PM, the Treatment Nurse indicated she had rendered nail care to Resident #43, cleaning under his nails to the right hand and trimming nails to both hands. She denied any refusals from Resident #43.

The DON was interviewed on 3/25/21 at 3:20 PM and indicated NA's could clean under all resident's nails and cut fingernails for all residents except those with diabetes. Diabetic residents had their fingernails cut by the nurse or treatment nurse. She stated it was her expectation for the aides to monitor, clean and trim nails during personal care, retrieving a nurse for any diabetic nail care that was needed.

2. Resident #41 was admitted to the facility on 3/20/19 with diagnoses of dementia and protein calorie malnutrition.

A review of Resident #41 ' s annual Minimum Data Set dated 2/2/2021 revealed that he was moderately cognitively impaired. The resident required extensive assistance of 1 staff for all activities of daily living (including personal care). His diagnoses were debility, acute respiratory disease, and aphasia.

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F 677	Continued From page 64 Resident #41 ' s care plan dated 1/12/20 revealed the problem of self-care deficit and required assistance with nail cleaning and cutting. Shower/bath was scheduled for Tuesday and Thursday. On 3/22/2021 at 10:35 am an observation was done of Resident #41 in his room for incontinence and morning care. The resident was cared for by NA #1. It was noted that the resident ' s nails were long, jagged and dirty underneath. On 3/22/2021 at 4:10 pm another observation of Resident #41 ' s nails were done. The nails remained long and dirty (same). On 3/22/2021 at 4:10 pm an interview was conducted with Resident #41. He stated, when asked, "yes, I would like my nails cut." On 3/24/2021 at 10:25 am a third observation of Resident #41 ' s nails were done. The nails remained long and dirty (same). On 3/24/2021 9:45 am an interview was conducted with Nurse #7. She stated that NAs were responsible to cut the resident ' s nails when they had a shower and as needed. Nurse #7 was informed of the residents that were observed to have long nails.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of	F 679		5/5/21

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F 679	Continued From page 65 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, Physician interview and record review, the facility failed to maintain an ongoing activity program based on resident's preference for 2 (Resident #46 and Resident #3) of 2 residents reviewed for activities. The findings included: 1. Resident #46 was admitted 4/2/18 with a cumulative diagnosis of Chronic Obstructive Pulmonary Disease. Resident #46's annual Minimum Data Set (MDS) dated 1/7/21 indicated he was cognitively intact and exhibited no behaviors. Resident #46's Preferences for Activities (section F) indicated going outside to get fresh air when the weather was good was very important to him. Review of Resident #46's psychosocial well-being care plan dated 05/20/2020 read he was at risk for alteration in psychosocial well-being related to restriction on visitations secondary to COVID-19. Intervention included offering of activities. Review of an Activity Assessment Form dated 2/5/21 read Resident #46 enjoyed 1:1 in room visits. Due to COVID-19, he has been restricted to his room. The goal was for Resident #46 to continue with his 1:1 in-room visits until group activities started again. Review of Resident #46's medical record indicated he was diagnosed	F 679	1.Resident #46 was offered an outside activity to get fresh air on March 26,2021 by facility Activity Director. Resident #3 was offered an outside activity by Activity Director on April 15, 20201. Both resident #46 and Resident #3 were informed by facility Administrator on April 19, 20201 they are able to sit outside on front porch or patio off of D Hallway when they desired to get fresh air as long as social distance was maintained. 2.The procedure for identification of other potential residents that are affected by Activities Meet Interest/Needs Each Resident not met are as follows: Activity Director audited facility residents related to desire for outside activities. 43 of 77 residents stated they would like more outside activities. Facility resident activity preferences were updated by Activity Director and/or Medical Records Coordinator by April 20, 2021. Residents indicating they would like to have more outside activity were informed Activity Director and Medical Records Coordinator (at the time of activity preference update) of their ability to go outside and get fresh air independent of activity program as long as social distance was maintained.	

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F 679	Continued From page 66 with COVID-19 on 1/3/21. Review of Resident Council meeting minutes dated 2/26/21 read as follows: "Residents are ready to go out and get some fresh air." The minutes were signed by the Activities Director (AD). In an interview on 3/22/21 at 10:40 AM, Resident #46 was in his room sitting in his wheelchair. He stated it was a beautiful day outside and wished he could go outside for some fresh air. He stated he could not remember the last time the staff took him outside. In another interview on 3/25/21 at 10:00 AM, Resident #46 stated he wanted to go outside for fresh air and had not been outside except for Physician appointments in months. In an interview on 3/25/21 at 10:55 AM, the AD stated when COVID-19 started, she did not have a plan for the activities program but at present the activity program consisted of mostly video chats and in room visits. She stated she tried to do overhead bingo and doorway bingo, but it did not work out. The AD provided copies of the monthly activity calendars from March 2020 to present except for July, August, and September 2020. She stated she did not complete an activity calendar in July, August, or September 2020 due to illness and resumed the monthly calendar in October 2020. The AD stated she was not aware that Resident #46 wanted to go outside for fresh air and that it was coded as very important to him on his annual MDS. She stated the previous MDS Nurse completed section F of his annual MDS. The AD stated she had no documentation regarding in room visits or 1:1 activity with	F 679	3. The facility has implemented the following measures and systemic changes to ensure this citation does not occur again: Facility Activities Director will hold a resident council on April 20, 2021 informing residents of their right to go outside as long as social distance is maintained. Activity calendar was updated by the Activity Director by May 1, 2021 to include outside activities two times a week. Activity Director or her designee will keep an attendance log of outside activities to ensure residents preferring these activities are offered a opportunity to attend. Facility employees (housekeeping, dietary, nursing, therapy, and administrative) will receive education from the Activity Director by April 20, 2021 regarding residents right to participate in activities of preference as well as their ability to get fresh air outside of scheduled activities. Education included monthly activity calendars located in Resident rooms and on hallways showing outside activities for the week. 4. To ensure solutions are sustained and facility has implemented the following monitoring techniques: Administrator will audit Activity Director log book for residents participating outside activity weekly for four weeks, then monthly for 3 months to ensure that outside activities are taking place. Audit results will be reviewed in the facility QAPI committee monthly for three months to ensure compliance 5.May 5, 2021	

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F 679	Continued From page 67 Resident #46. In a telephone interview on 3/26/21 at 12:45 PM, the Facility Physician stated he was not aware that residents weren't taken outside for fresh air. The Facility Physician stated residents' psychosocial needs were very important and expected the facility to provide opportunities to improve their psychosocial well-being such as taking them outside. In an interview on 3/26/21 at 2:30 PM, the Administrator and Director of Nursing stated it was their expectation that residents who expressed a desire to go outside for fresh air be taken outside either one at a time or at a minimum socially distanced. 2) Resident #3 was admitted to the facility on 8/21/20 with diagnoses that included a left hip fracture, chronic obstructive pulmonary disease (COPD) and type 2 diabetes. The admission Minimum Data Set (MDS) assessment dated 8/28/20 indicated Resident #3 was cognitively intact. Preferences for Customary Routine and Activities (section F) indicated going outside to get fresh air when the weather was good was very important to her. A wheelchair was used for mobility. Resident #3's psychosocial well-being care plan dated 8/21/20 read she was at risk for social isolation and low activity participation related to being a new resident. The approaches included: -Check with resident regularly to assess satisfaction with activities offered.	F 679		

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F 679	Continued From page 68 - Describe activities available and assist resident to choose activities to match interests and abilities. The quarterly MDS assessment dated 12/18/20 indicated Resident #3 was cognitively intact. Resident #3 required supervision for transfers, locomotion on and off the unit. A wheelchair and walker were used for mobility. A review of Resident #3's medical record revealed she was diagnosed with COVID-19 on 12/30/20. A review of an Activity Assessment Form dated 3/14/21, completed by the Activities Director, indicated the following for Resident #3: - The type of review was a quarterly. - Time awake was morning and evening. Preferred activity setting was marked as own room. -What are any physical limitations and adaptive devices used: Receives 1:1 in room visits due to COVID-19. - Activity Participation: 1:1 visitations and small groups. - Time and response while involved with activities: pleasant when receiving 1:1 in room visits. - Level of participation and involvement while involved in activities: Resident participates in 1:1 in room visits at least 2 to 3 times a week. - Progress toward care plan goals: resident needs assistance from staff for Activities of Daily Living (ADL's), but she is able to transfer and transport herself to and from activity programs. - Any new care plan issues: none - Progress toward activity plan/goals: Resident will be encouraged to participate in at	F 679		

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F 679	Continued From page 69	F 679		

least 2 group activity programs 2 times per week. The Activity Form did not address or indicate her preferred activities.

On 3/25/21 at 11:01 AM, an interview occurred with Resident #3 who stated since her admission to the facility she had only been outside for the purpose of doctor appointments and wished she could go and sit outside. Resident #3 stated she had not received any visits from the Activity Director, nor had she received any 1:1 activities. She kept herself busy with knitting and watching her birds at the birdfeeder and enjoyed playing Mahjong board game. She stated she wished she could find someone else to play the game with. When asked if she had voiced wanting to go outside for fresh air or her activity preferences, Resident #3 replied "It wouldn't matter if I did".

An interview occurred with the Activities Director (AD) on 3/25/21 at 10:55 AM. She provided copies of the monthly activity calendars from March 2020 to March 2021, except for July 2020, August 2020, and September 2020. She stated she did not complete an activity calendar during those months due to illness and resumed the monthly calendar in October 2020. The AD further stated she was not aware Resident #3 wanted to go outside for fresh air. She reviewed the admission MDS dated 8/28/20 and verified going outside for fresh air was very important to Resident #3. The AD stated she normally completed section F on the MDS assessment but was out of the facility at the time of Resident #3's admission MDS dated 8/28/20. The AD added she had no documentation regarding in room visits or 1:1 activity with Resident #3. She explained the Activity Assessment Form was completed on admission and quarterly and she

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F 679	Continued From page 70 met with the residents to complete the form. The AD stated she just didn't do activities or assessments like she was supposed to. A telephone interview was completed with the Medical Director (MD) on 3/26/21 at 12:45 PM. He stated he was not aware residents weren't taken outside for fresh air. The MD added residents' psychosocial needs were very important and he expected the facility to provide opportunities to improve the residents' psychosocial well-being such as taking them outside. In an interview on 3/26/21 at 2:30 PM, the Administrator and Director of Nursing (DON) stated the expectation was for residents who expressed a desire to go outside for fresh air be taken outside either one at a time or at a minimum socially distanced. The Administrator stated she was unaware the admission and quarterly activity assessments were not being completed in a timely manner.	F 679		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		5/5/21

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F 688	Continued From page 71 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and Occupational Therapist interviews, the facility failed to apply splints consistently as ordered for 1 of 4 residents reviewed for range of motion (Resident #43). The findings included: Resident #43 was originally admitted to the facility on 1/21/20 with a recent readmission date of 1/27/21. His diagnoses included a cerebral infarction (a stroke) affecting the left nondominant side, and contracture of the left knee. The quarterly Minimum Data Set (MDS) assessment dated 1/31/21 indicated Resident #43 had impaired cognition and limited range of motion to one upper and lower extremity and was not on a restorative program and received 2 days of Occupational Therapy during the 7 day look back period. A review Resident #43's active care plan, revealed a problem area initiated on 2/17/21 for Nursing to apply knee extension splint to the left knee 6 hours daily (can split into 3 hour increments over first and second shift), with skin and brace hygiene/care, for contracture management. Resident #43 had a physician's order dated	F 688	1.Resident #43 has splint applied per physician□s order by nursing assistant with application documented by Charge Nurse starting April 19, 2021. 2.Therapy Outcomes Coordinator conducted audit starting April 15, 20201 of residents discharged from therapy services within past 30 days to determine if a splint therapy program was recommended. Residents needing a splint received orders from the Therapist recommending the device for placement. Charge Nurses of the residents were educated by the Therapy Outcomes Coordinator regarding splint order and documentation of splint placement 3.Therapy Outcomes Coordinator educated nursing and administrative employees (Social Worker, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Human Resources, and Financial Coordinator) regarding application and documentation of splints to residents with orders for them to be in place starting April 19, 2021. Education included nursing assistants applying and removing the splints with Charge Nurses documenting the application. Facility administrative team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 688	Continued From page 72 2/17/21 for nursing to apply knee extension splint to the left knee 6 hours daily (can split into 3-hour increments over first and second shift), with skin and brace hygiene/care, for contracture management. The February 2021 Medication Administration Record (MAR) and Treatment Administration Record (TAR) were reviewed and did not have an area for the left knee extension splint to be documented for application or removal. A review of the nursing progress notes for 2/17/21 through 3/24/21 did not reveal the knee extension splint had been placed on Resident #43 as ordered. The March 2021 MAR and TAR were reviewed and did not have an area for the left knee extension splint to be documented for application or removal. An Interdisciplinary Referral form to rehab was present in Resident #43's electronic medical record (EMR) dated 3/15/21. The form indicated it was initiated by nursing for Occupational Therapy (OT) regarding splinting. The form was completed by OT on 3/23/21 stating splinting was in place and education was provided to staff regarding splints. On 3/22/21 at 12:20 PM, an observation occurred of Resident #43. He was lying in bed with his left knee contracted to his abdomen and no splinting was present. An interview occurred with Nurse #1 on 3/22/21 at 12:45 PM, who stated Resident #43 had a left knee splint that was applied by nursing staff daily,	F 688	(Social Worker, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Human Resources, and Financial Coordinator) will conduct rounds on residents with orders for splints to ensure they are in place. 4.Administrative Nurses (Director of Health Services, Infection Preventionist, RN MDS Coordinators, RN Skin Integrity Nurse, Assistant Director of Health Services, and RN Clinical Competency Nurse) will audit residents with orders for splints to ensure placement and subsequent documentation weekly for three weeks then monthly for three months. Results will be presented by the Director of Health Services and/or the Administrator to the Quality Assurance Performance Improvement Committee meetings monthly for three months to ensure compliance. 5.May 5, 2021	

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 688	Continued From page 73	F 688		

however she had been unable to locate the splint since last week (date unknown). She further stated she had initiated a referral to OT since she could not locate the splint. Nurse #1 added there was no documentation on the MAR or TAR, staff just knew to put the splint on since it was an order.

An observation occurred of Resident #43 on 3/22/21 at 3:30 PM, lying in the bed with his left knee contracted to his abdomen and no splinting present.

On 3/24/21 at 9:22 AM, an interview was completed with Nurse #3 who explained splints were applied by the nursing staff and nurse aides, however they did not document on the MAR or TAR when the splint was applied or removed. Nurse #3 further stated she had not observed Resident #43's left knee splint for a week (date unknown).

Resident #43 was observed lying in his bed on 3/24/21 at 9:26 AM. His left leg was contracted, and a splint was not present.

An interview was completed with the Director of Nursing (DON) on 3/24/21 at 10:32 AM. She stated the facility no longer had a Restorative Nursing Program and splints were applied by the nursing staff or nurse aides. She added there would be an order present in the EMR, but the staff did not document daily that the splints were applied or removed.

On 3/24/21 at 12:05 PM, an observation occurred of Resident #43 lying in his bed without the left knee extension splint present.

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 688	Continued From page 74 An observation was made of Resident #43 on 3/24/21 at 3:30 PM, lying in the bed with a left knee extension splint in place. The Occupational Therapist #1 (OT) was interviewed on 3/24/21 at 4:00 PM. The OT indicated she had completed an assessment on Resident #43 on 3/23/21 due to nursing staff not being able to locate the left knee extension splint. She further stated when searching his room for the splint it was found in the closet. Education was provided to nursing staff again on how to apply the splint. The OT explained when a resident was discharged from therapy with a splint in place, an order was initiated which generated to the care plan and aide care profile. A phone interview was completed with Nurse #2 on 3/25/21 at 10:30 AM, who stated she was assigned to Resident #43 last week and could not recall applying or removing his left knee splint. On 3/25/21 at 11:40 AM, an interview was conducted with the DON. She stated it was her expectation for splints to be applied as ordered.	F 688		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		5/5/21

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F 689	Continued From page 75 Based on observations, record review, and resident, staff, nurse practitioner, and facility physician interview, the facility allowed a resident to smoke in his room for over a year (9/1/2019 through 3/24/2021) in a building where oxygen was used and stored or 1 of 4 sampled residents (Resident #23) which was a fire hazard. There was a high likelihood for a fire to occur while this resident smoked in his room and oxygen was in use in the facility. The facility also failed to lock the wheels on the sit to stand lift device during transfer with a mechanical lift (Resident #41), and failed to implement fall interventions (Residents #50) for 2 of 5 sampled residents reviewed for supervision to prevent falls. Immediate Jeopardy began on 9/8/2019 for Resident #23. The resident was documented by facility staff to be smoking in his room after being educated on the facility smoking policy and hazards (during oxygen use and storage and smoking in bed). Immediate jeopardy was removed on 3/25/2021 when the facility implemented a credible allegation of immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) for finding 1 to ensure monitoring of systems are put in place and to complete employee in-service and resident education. The severity for findings 2 and 3 is no actual harm with a potential for minimal harm that is not immediate jeopardy. Findings included: 1. Facility smoking policy was dated 1/1/2015 and revised on 10/15/2019. The policy documented that "smoking was not allowed on the healthcare center premises by visitors, partners or patients/residents. Smoking will only be allowed	F 689	1.Resident #23 is having room searched daily for smoking materials. Smoking and illegal drug paraphernalia were removed from the room Resident #23 by the Rockingham Police Department on March 24. 2021 Resident #23 was issued a discharge notice from the facility on March 24, 2021 for non-compliance with smoking policy. NA #1 was educated by facility Therapy Outcomes Coordinator on proper use of the sit to stand lift to include locking the wheels of the lift while in use (Resident #41) on April 19, 2021. Resident #50 had impact placed on floor by Charge Nurse while in bed on March 26, 2021. 2.All facility residents were potentially affected by Resident #23 smoking inside of the facility. Residents noted to be grandfathered in as smokers (11 total residents) were re-educated on 3/24/2021 by facility Activity Director, Medical Records, Financial Counselor, and Nursing Scheduler regarding facility smoking policy. Residents noted to be grandfathered in as smokers were educated by Social Services and Environmental Services Director on 3/25/2021 regarding the dangers of smoking inside of the facility. Residents noted to be grandfathered in as smokers were educated by Social Services and Environmental Services Director on 3/25/2021 regarding the dangers of using illegal drugs related to negative effects on the body and mental disturbances causing resident to be a danger to self and others.	

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F 689	Continued From page 76 in outdoor designated areas for those residents "grandfathered" in prior to January 1, 2015. The Admission Director or admitting licensed nurse will inform patient/residents and/or legal representative of the smoking policy upon admission." The policy also included the following: · At no time should any fire igniting material (matches/lighters) and smoking materials to include cigarettes, smokeless, electronic cigarettes, vaping devices, cigars, snuff or loose tobacco be in a patient/resident ' s possession. Patient/resident igniting, and smoking materials will be maintained at the nurse ' s station for the safety of smokers. Resident #23 was admitted to the facility on 10/5/18 with diagnoses of neuropathy and diabetes. The quarterly Minimum Data Set (MDS) dated 1/17/21 documented Resident #23 had an intact cognition and rejection of care behavior. He required limited assistance for activities of daily living and had no functional limitation in upper extremity range of motion. The care plan start date was 10/15/19 with problem "resident is a smoker and there has been smoke in his room." The approach was to keep smoking materials at the nurses ' station, resident was informed of smoking policy, and was issued a 30-day discharge (when non-compliant). The resident ' s care plan updated on 1/19/21 revealed "problem: resident indulges in marijuana use, despite concealing an illicit drug use. Resident is a smoker and has had smoke odor in his room. The goal was for the resident not to smoke in his room."	F 689	Residents grandfathered in as smokers had their rooms searched on March 24, 2021 by Maintenance Director, Environmental Service Director, Administrator, and Admission Director to ensure no flame igniting materials, smoking materials, or drug paraphernalia were in the rooms. No other rooms were found to have flame igniting or smoking materials. Residents documented to require a sit to stand lift for transfers have the potential to be affected. Therapy Outcomes Coordinator and RN MDS Coordinator audited residents requiring a sit to stand lift for transfers on April 19, 2021. Caregivers assigned to identified residents were educated by Therapy Outcomes Coordinator on locking the wheels of the sit to stand lift while in use starting April 20, 2021. Education included return demonstration of proper use by nursing employees. RN MDS Coordinators and Director of Health Services completed an audit on April 19, 2021 of residents care planned for impact mat at bedside to ensure the mats were beside the beds of identified residents. Identified residents were found with impact mat at bedside unless out of bed. 3.Facility RN Senior Nurse Consultant educated facility Administrator and Director of Health Services on 3/24/2021 regarding safe smoking policy with emphasis on reporting smell of smoke	

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F 689	Continued From page 77 A review of Resident #23 ' s documented nurses ' notes from 8/29/19 (last recertification survey) through 3/21/21 revealed: Nurses Note (NN) 9/8/19 Resident noted with a pack of cigarettes opened on nightstand and a glass cup with partially smoked cigarettes and ashes. NN 10/9/19 Resident noted to be sitting up in his room in a wheelchair from another hall. The two were watching television this nurse stated to resident due to such a strong fresh smell of cigarette smoke in room when this nurse opened resident's door that he needed to stop smoking in the room. Resident began raising his voice to this nurse stating "ain't nobody smoking in here you full of sh-t and you just going off of what the other nurse said get out of my room "resident has frequently smoked in the room and denies smoking." NN 10/15/19 Continues to smoke in room (the resident). Will monitor. NN 11/15/19 This nurse making rounds and noted resident to be sitting up in wheelchair in room with door wide open smoking and also a strong smell of cigarette odor traveling up and down the hallway. NN 11/19/19 Resident continues to smoke in room, Administrator aware. NN 11/24/19 Smoke was smelled coming from his room and you can smell it all the way at the	F 689	with removal of smoking and flame igniting materials. On 3/25/2021 RN Senior Nurse Consultant educated Administrator and Director of Health Services regarding illegal drug use and related paraphernalia on the premises, calling the police for removal, and the dangers involved in allowing use. Facility employees (Dietary, Environmental Services, Administration, Therapy and Nursing) were educated on 3/24/2021 by Director of Health Services, Environmental Services Director, and Certified Dietary Manager, RN Treatment Nurse, Financial Counselor about safe smoking policy with emphasis on reporting smell of smoke to facility Administrator and/or Director of Nursing with removal of smoking and flame igniting materials. On 3/25/2021 current facility employees were educated by Director of Health Services, Environmental Services Director, and Certified Dietary Manager, RN Treatment Nurse, Financial Counselor regarding illegal drug use and related paraphernalia on the premises, calling the police for removal, and the dangers involved in allowing use. Newly hired employees will be educated by Human Resources/RN Clinical Competency regarding safe smoking policy with emphasis on reporting smell of smoke with removal of smoking and flame igniting materials as well as illegal drug use and related paraphernalia on the premises, calling the police for removal, and the dangers involved in allowing use. Facility employees (Dietary, Environmental	

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F 689	Continued From page 78 nursing station. NN 12/6/19 This nurse entered facility this am and noted Daisy hall to smell of marijuana smoke. This nurse then informed by 3rd shift nurse and nursing assistant (NA) that the resident was observed in his room in bed all night smoking cigarettes and marijuana. Administrative staff made aware. NN 12/7/19 The resident has continued to smoke in his bed throughout the night on this 11pm-7am shift and resident has continued to smoke both cigarettes and marijuana with the strong odor all the way up the hall past the nurses ' station. NN 12/9/19 Smell of smoke noted to come from the resident's room. No sign of cigarettes upon inspection of room. Nursing education given on smoking policy and dangers of smoking with oxygen in next room. Resident nodded his head and continued to watch television The Administrator made aware. Will continue to monitor. NN 12/10/19 Resident awake sitting up in wheelchair in room with the strong odor of fresh cigarette smoke coming from his room out into the hall. NN 1/24/20 During rounds this nurse and other staff members observed a very strong odor of marijuana coming from the resident's room. Also, resident in room smoking regular cigarette. NN 1/30/20 (observed) The resident had one hand up in the air with a lit cigarette	F 689	Services, Administration, Therapy and Nursing) were educated on 3/25/2021 by Certified Dietary Manager, RN Treatment Nurse, Financial Counselor, and Admissions Director about the dangers of smoking inside the facility and dangers of illegal drug use. Education included noting facility has oxygen and open flame will cause severe injury to residents and employees. Education also stated illegal drug use is dangerous to residents and employees due to challenging behaviors and negative physical effects from their use. Residents found out of compliance with facility smoking policy regarding safe smoking practices and using illegal drugs will be issued a discharge notice and police will be called for removal and documentation of illegal drug use. Therapy Outcomes Coordinator conducting education with nursing employees starting April 19, 2021 regarding proper use of sit to stand lifts to include wheels being locked while in use. Education including return demonstration to prove competency and understanding of training. Newly hired employees will receive training during the week of orientation from a member of the facility Therapy team (PT, OT, PTA, or OTA) prior to being assigned a shift on the floor. Director of Health Services, RN MDS Coordinators, and Infection Preventionist educated facility Charge nurses and nursing assistants starting April 19, 2021 about ensuring impact mat was at the bedside of resident with the mat as part of care plan for injury prevention. Education	

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 689	Continued From page 79 up and room filled with smoke. The resident since then has smoked more cigarettes while awake and sitting up the rest of the time the morning. NN 2/15/20 The resident continued to smoke cigarettes in his room off and on throughout the night. Also, this nurse and NAs have smelled the strong odor of marijuana from the resident's room all up and down the hall and up past the nurses ' station resident. NN 3/27/20 On this shift the resident has smoked cigarettes in his room while in bed. The resident also noted to have the very strong odor of marijuana coming from his room all the way up and down the hall past the nurses ' station. This nurse noted four different episodes and had his door closed and the window in his room opened. NN 3/28/20 This nurse and staff noted the strong odor of marijuana coming from the resident's room again. This nurse and staff have smelled very strong odor of marijuana coming from this resident ' s room at 1:05am and 3:00am and the odor traveled all up and down halls around to the nurses ' station. NN 5/23/2020 11-7 shift: Resident for the past few nights has been having a very strong odor of smoking marijuana with the smell so strong that it travels all the way up the hall and past the nurses ' station. NN 6/27/20 Resident had a very strong odor of marijuana coming from room. This nurse entered the resident's room and observed the strong odor	F 689	included alerting Nurse Management when this was started as an intervention, documentation of the mat as an intervention, and communication of fall mat as an intervention to ensure mat is in place. 4.Facility Administrative Team (Administrator, Financial Counselor, Environmental Services Director, Human Resources, Activity Director, Medical Records Coordinator, Maintenance Director, Social Service Director, and Certified Dietary Manager) will conducted room surveillance starting 3/24/21 for residents grandfathered in as smokers to ensure smoking and flame igniting materials as well as illegal drugs and related paraphernalia on the premises to include calling the police for removal and the dangers involved in allowing use are not present. Resident room smoking searches will then be conducted by Administrative team (Administrator, Financial Counselor, Environmental Services Director, Human Resources, Activity Director, Medical Records Coordinator, Maintenance Director, Social Service Director, and Certified Dietary Manager) daily for seven days, then weekly for three weeks and monthly to ensure compliance with facility smoking policy and procedures. Residents found to be noncompliant with smoking in non-designated areas, using illegal drugs, having flame igniting materials, or illegal drug use materials will have their rooms searched by a member of the facility Administrative Team (Administrator,	

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F 689	Continued From page 80 of marijuana. NN 9/11/2020 Resident was up smoking in room all night. NN 9/21/2020 The patient was smoking in his room. NN 9/23/2020 The resident smoked in his room. 10/13/20 Smoking assessment documented the resident was a supervised smoker. Facility protocol was for all residents to wear an apron. All questions were answered "no" except the resident was unable to get out of the chair independently (which made him supervised). NN 1/27/21 This nurse entered the resident ' s room and was greeted by a very strong cigarette smell. The resident also had a self-made pipe to smoke used for smoking marijuana on his bedside table. The entire hall and nurses ' station has smelled like cigarette smoke all shift. Director of Nursing made aware. NN 3/3/21 Nursing documented the resident continues to smoke. On 3/22/2020 a review of the facility matrix revealed continuous oxygen was being administered in rooms 163 and 164 on Resident #23 ' s hall, and a total of 16 residents received oxygen facility-wide. There was bottled oxygen in storage (inside the building). On 3/22/2021 at 10:50 am a strong odor that resembled cigarette smoke was smelled on Hall C. The odor came from Resident #23 ' s room. Entry to the room for observation and interview was conducted. Resident #23 had a burned	F 689	Financial Counselor, Environmental Services Director, Human Resources, Activity Director, Medical Records Coordinator, Maintenance Director, Social Service Director, and Certified Dietary Manager) daily with Rockingham Police being called if search is refused. Search results will be discussed at facility QAPI meeting by facility Administrator and/or Director of Health Services monthly for 6 months and quarterly thereafter to ensure compliance. Facility Nursing and Therapy Teams (Director of Nursing, Assistant Director of Nursing, RN MDS Coordinator, Infection Preventionist, Clinical Competency Coordinator, Skin Integrity Nurses, Physical Therapist, Occupational Therapist, Physical Therapy assistant, and Occupational Therapy Assistant) will conducted room surveillance starting April 19, 2021 to observe proper use of sit to stand lift to include locking the wheels while the lift is being used. Three residents will be observed daily for seven days, weekly for three weeks, then monthly. Surveillance results will be discussed at facility QAPI meeting by facility Administrator and/or Director of Health Services monthly for 6 months and quarterly thereafter to maintain compliance. Facility Administrative Team and Nursing Teams (Administrator, Financial Counselor, Environmental Services Director, Human Resources, Activity Director, Medical Records Coordinator,	

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F 689	Continued From page 81 cigarette with ashes in an ash tray. The resident stated that since COVID, the facility staff refused to take him outside to smoke after repeatedly asking. The resident decided to smoke in his room. The resident provided a cigarette and means to light it which was housed in his room. The resident commented that the facility staff were aware that he smoked in his room and that he was asked not to smoke due to fire hazard. On 3/24/2021 at 8:20 am an interview was conducted with Resident #23. The resident stated that he obtained his cigarettes and lighter from the internet, which was delivered to the facility. The resident commented that he obtained his marijuana from outside the facility through his window and did not want to discuss. The resident acknowledged that he has been smoking cigarettes and marijuana in his room since he got here (was admitted). The resident agreed that the bottle with brown water on his bedside table was a "bong to smoke marijuana." The resident also commented that the "facility was aware that he smoked in his room and that he was asked not to." An observation of Resident #23 ' s self and room (private) was done on 3/24/2021 at 8:20 am. A strong odor of cigarette smoke was noted in the room. A plastic bottle with brown water, foil cup, and large straw was observed on the bedside table. The foil cup had black residue and gray ash present. A package of cigarettes was lying on the bedside table. On 3/24/2021 at 1:00 pm an observation was done of Resident #23 ' s room while present. The resident ' s self-made pipe to smoke was sitting	F 689	Maintenance Director, Social Service Director, Certified Dietary Manager, Director of Nursing, Assistant Director of Nursing, RN MDS Coordinator, Infection Preventionist, Clinical Competency Coordinator, and Skin Integrity Nurses) will conduct room surveillance of residents identified as needing an impact mat at bedside as an accident prevention intervention starting April 19, 2021 to ensure mat is beside the bed. Teams will conduct surveillance daily for seven days, weekly for three weeks, then monthly. Surveillance results will be discussed at facility QAPI meeting by facility Administrator and/or Director of Health Services monthly for 6 months and quarterly thereafter to maintain compliance. 5.May 5, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 689	Continued From page 82 on the bedside table with what appeared to be a marijuana bud in the tinfoil cup. On 3/24/2021 at 12:30 pm an interview was conducted with the Administrator. The Administrator stated that she and staff had educated Resident #23 on safe smoking (outside only), fire hazard, and illegal marijuana use since his admission. The resident continued to smoke in his room. There have been numerous attempts to retrieve smoking material from the resident ' s room, but he had hidden the material. The Administrator commented that she was unaware how the resident obtained his smoking material. The Administrator had called the police in the past (last year) and the police officer informed her that there were no criminal charges, and he could not involuntarily remove the resident. The Administrator stated October 2020 the resident had ran his wheelchair into the leg of a staff member and caused injury. The resident was provided a 30-day discharge which the resident appealed. The appeal was won and there had been no further attempts to discharge the resident. The Administrator also commented that staff were instructed to inform her of the resident ' s smoking and not to attempt to retrieve the material due to the resident ' s behaviors. When informed, the Administrator stated she would enter the resident ' s room and look for and ask for smoking material. The resident would not comply. Lastly, the Administrator stated "the police could not do anything." The Administrator acknowledged that there was continuous oxygen administration and oxygen storage on the resident ' s hall and that it was a fire hazard. The Administrator and DON were notified of the Immediate Jeopardy on 3/24/21 at 2:30 PM.	F 689		

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 689	Continued From page 83	F 689		

The following nurses interviewed had documented nurses ' notes:

An interview was conducted with Nurse #1 on 3/24/2021 at 8:10 am. Nurse #1 was very familiar with and assigned (day shift) to Resident #23. Nurse #1 was aware of the cigarette and marijuana smoke in the resident ' s room and facility hallway. Nurse #1 stated she informed the Director of Nursing and Administrator when the resident smoked and documented this in the resident ' s notes (since resident ' s admission). Nurse #1 had also observed a self-made pipe for smoking marijuana in the resident ' s room and was not aware how the resident was obtaining his smoking material. This problem had been going on for a while and was reported each time. Nurse #1 indicated that the resident can reach the window and open it when up in his wheelchair. The resident used to be able to reach the window from his bed, but his bed has since been moved and is no longer reachable. Nurse #1 was aware that there were residents who received continuous oxygen and oxygen was stored on the same hall which made smoking a fire hazard. The Administrator advised staff to inform her and take smoking material away from the resident.

On 3/25/2021 at 12:20 pm an interview by telephone was conducted with Nurse #1 who was day shift nurse regularly assigned to Resident #23. Nurse #1 stated that she had observed and smelled the resident smoke cigarettes and marijuana in the resident ' s room. Nurse #1 commented that she had not tried to take away the cigarettes or marijuana because the resident was known to be violent and she was afraid. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 689	Continued From page 84	F 689		

indicated that the resident had thrown his meal tray at staff and that the Administrator was made aware.
On 3/25/2021 at 12:30 pm an interview by telephone was conducted with Nurse #2. Nurse #2 (night shift) stated she was familiar with and assigned to Resident #23. She had smelled a strong odor of cigarette smoke on the hall that was coming from Resident #23 ' s room. She entered the resident ' s room and talked to him about smoking in the facility and the policy. The resident denied cigarettes or lighter to Nurse #2. She commented that he had taken the resident ' s cigarettes to storage for scheduled/supervised smoking outside in the past. The resident was known to have outbursts when his cigarettes had been taken away.

On 3/25/2021 at 12:40 pm an interview was conducted with Nurse #3. Nurse #3 (day shift) stated that she had smelled the smoke of cigarettes and marijuana in the hall coming from Resident #23 ' s room. When Nurse #3 tried to remove the cigarettes or marijuana, the resident "yelled at me and I was concerned for safety. The resident has had verbal behavior and aggression towards me." She also stated that the Charge Nurse on duty and the Administrator were informed and documented in the nurses ' notes (approximately 2 months ago).

On 3/25/2021 at 2:40 pm an interview was conducted with Nurse #4. Nurse #4 stated she knew and was assigned to Resident #23. The resident had in the past dismissed me from his room when asked not to smoke. Nurse #4 commented that she had observed the resident smoke cigarettes in his room and this was problematic because he would not stop at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 689	Continued From page 85	F 689		

request of staff. "I was not asked to write a statement of my observation. I did not know what to do. The concern was sent up to management and I was informed not to retrieve his smoking material." Nurse #4 stated she and the other nursing staff on Resident #23 ' s hall were concerned for fire hazard (smoking with oxygen) and were not comfortable and did not know how we would remove the residents if a fire occurred." Nurse #4 stated there were residents on the same hall who use oxygen continuously and oxygen tanks were stored. Nurse #4 commented that she informed the Director of Nursing (DON) of her concerns on several occasions (over the past several months) and that the smoking had been going on for months.

On 3/26/2021 at 12:05 pm an interview was conducted with the nurse practitioner (NP) for the facility. The NP stated that she knew Resident #23 very well. The resident smoked in his room and felt it was his right to smoke. The resident was resourceful and ordered what he wanted from the internet. The resident was large and was verbally threatening. The facility was not able to handle him and keep him and other residents safe. The resident was informed of the guidelines regarding smoking and the hazards.

On 3/26/2021 at 1:10 pm an interview was conducted with the facility physician who knew Resident #23. The resident was known to smoke and be non-compliant after multiple attempts to educate and work with him. The physician commented the Administrator tried to find other suitable places for the resident to reside, but no other facility offered a transfer. There were not enough mental health facilities for the resident to transfer and as a last resort, the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 689	Continued From page 86 placed in a skilled nursing facility. The resident did not take his medication to help with his psychiatric diagnoses that would have helped with his behavior and compliance. The resident would not allow care. The resident had a wheelchair to get around and felt it was his right to go outside to retrieve packages during COVID before they were cleaned and refused to follow COVID restrictions when there was an outbreak. The resident needed to be in a psychiatric facility that can manage the behaviors and has a higher level of supervision and training for advanced mental health behaviors. The Administrator was notified of the Immediate Jeopardy on 3/24/2021 at 2:30 pm. On 3/25/2021 at 7:15 pm the facility provided an acceptable credible allegation for Immediate Jeopardy removal that included the following: "The Removal Plan: The entity ' s removal plan must include the following: ·Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and a) Facility failed to provide a safe environment and protect residents from harm when Resident #23 smoked inside of the facility creating a fire hazard for current residents and staff inside the facility. Smoking inside of the facility could cause harm to residents on the hall should oxygen in use on the hall ignite as well as residents walking in the hallway have the potential to suffer serious bodily injury.	F 689		

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 87 This is evidenced by Care Plan dated 10/15/19 stating resident #23 was a problem smoker and smoked in his room to include illicit drug use. Resident #23 ' s medical record revealed Nursing notes dated 9/8/19, 10/9/19, 10/15/19, 11/15/19, 11/19/19, 11/24/19, 12/6/19, 12/7/19, 12/9/19, 12/10/19, 1/24/19, 1/30/19, 1/24/20, 1/30/20, 2/15/20, 3/27/10, 3/28/20, 5/23/20, 6/27/20, 9/11/20, 9/23/20, 9/21/20, 9/23/20, 10/13/20, 1/27/21, 3/3/21, and 3/22/21 documenting smoke and weed odors coming from room of resident#23 and smelling strongly the hallway. Notes also show cigarettes and ashtray type holders in room of resident#23. On 3/24/2021 State Surveyor observed Resident #23 ' s self and room at 8:20 am. A strong smell of cigarette smoke was noted in the room. A plastic bottle with brown water, foil cup, and large straw was observed on the bedside table. The foil cup had black residue and gray ash present. A package of cigarettes was lying on the bedside table. On 3/24/2021 at 8:20 am an interview was conduct with Resident #23. The resident stated that he obtained his cigarettes and lighter from the internet, which was delivered to the facility. The resident commented that he obtained his marijuana from outside the facility through his window and did not want to discuss. The resident acknowledged that he has been smoking cigarettes and marijuana in his room since he got here (was admitted). The resident agreed that the bottle with brown water on his bedside table was a bong to smoke marijuana. The resident also commented that the facility was aware that he smoked in his room. It helps him with pain and anxiety. "I have PTSD." The facility should have determined if this issue could or would affect other residents.	F 689		

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 689	Continued From page 88 ·Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. b) Resolution includes - o Rockingham Police Officer called to facility at 1:44pm to remove remaining materials from room of Resident #23. Materials included ashtray, 2 packs of cigarettes, Dr. Pepper bottle cut to be used as drug paraphernalia, glass tray (Resident #23 told Officer Harris he uses this to smoke Marijuana), lighter, and mini blow torch. Facility administrator issued discharge notice to resident on 3/24/2021 at 1:20pm with a copy faxed to Ombudsman on 3/24/2021. Resident #23 was issued an Involuntary Commitment on 3/24/2021 at 4:38pm by Richmond County Magistrate after becoming verbally aggressive with facility employees. Discharging MD order notes resident #23 needs in-patient psychiatric facility. Facility will follow state and federal guidelines related to discharge. Resident #23 will be placed on 1:1 upon return to the facility with an alarm on the window (due to him stating the illegal drugs and materials are received through the window). Resident #23 will have room searches 3 times a week. Facility will involve Rockingham police department if resident refuses room search or becomes violent with employees. o All facility resident rooms (smoking and non-smoking) were searched on 3/24/2021 at 5:00p by Activity Director, Medical Records Coordinator, Financial Counselor, Human Resources Director, Environmental Services Director, Certified Dietary Manager, Maintenance Director, Admissions Director, and Social	F 689		

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 89 Services Director for smoking and flame igniting materials related to non-smokers and smokers residing and fellowshipping together. During the room sweep 1 resident (not #23) was found with cigarettes (removed by Admission Director) but no flame igniting materials. This resident was educated by the Admissions Director regarding the facility smoking policy. o Residents noted to be grandfathered in as smokers (11 total residents) were re-educated on 3/24/2021 by facility Activity Director, Medical Records, Financial Counselor, and Nursing Scheduler regarding facility smoking policy. Residents noted to be grandfathered in as smokers were educated by Social Services and Environmental Services Director on 3/25/2021 regarding the dangers of smoking inside of the facility due to being near oxygen sources and residents walking in the hallways because this can cause severe burns and oxygen will caused an increased combustible burn event. Residents noted to be grandfathered in as smokers were educated by Social Services and Environmental Services Director on 3/25/2021 regarding the dangers of using illegal drugs related to negative effects on the body and mental disturbances causing resident to be a danger to self and others. o Smoking screens were completed on current facility residents on 3/24/2021 by facility Director of Health Services and Clinical Competency RN. o RN Senior Nurse Consultant educated facility Administrator and Director of Health Services on 3/24/2021 regarding safe smoking policy with emphasis on reporting smell of smoke with removal of smoking and flame igniting materials. On 3/25/2021 RN Senior Nurse Consultant educated Administrator and Director of Health Services regarding illegal drug use and related	F 689		

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 689	Continued From page 90 paraphernalia on the premises, calling the police for removal, and the dangers involved in allowing use. o Facility employees (Dietary, Environmental Services, Administration, Therapy and Nursing) were educated on 3/24/2021 by Director of Health Services, Environmental Services Director, and Certified Dietary Manager, RN Treatment Nurse, Financial Counselor about safe smoking policy with emphasis on reporting smell of smoke to facility Administrator and/or Director of Nursing with removal of smoking and flame igniting materials. On 3/25/2021 current facility employees were educated by Director of Health Services, Environmental Services Director, and Certified Dietary Manager, RN Treatment Nurse, Financial Counselor regarding illegal drug use and related paraphernalia on the premises, calling the police for removal, and the dangers involved in allowing use. Newly hired employees will be educated by Human Resources/RN Clinical Competency regarding safe smoking policy with emphasis on reporting smell of smoke with removal of smoking and flame igniting materials as well as illegal drug use and related paraphernalia on the premises, calling the police for removal, and the dangers involved in allowing use. Facility employees (Dietary, Environmental Services, Administration, Therapy and Nursing) were educated on 3/25/2021 by Certified Dietary Manager, RN Treatment Nurse, Financial Counselor, and Admissions Director about the dangers of smoking inside the facility and dangers of illegal drug use. Education included noting facility has oxygen and open flame will cause severe injury to residents and employees. Education also stated illegal drug use is dangerous to residents and employees due to challenging behaviors and negative physical	F 689		

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 91 effects from their use. o Care Plans have been updated on 3/24/2021 by MDS Coordinators for residents noted to be grandfathered in as smokers. o Starting 3/24/2021 facility Administrative Team (Administrator, Financial Counselor, Environmental Services Director, Human Resources, Activity Director, Medical Records Coordinator, Maintenance Director, Social Service Director, and Certified Dietary Manager) will conduct 7 days of room surveillance room for residents grandfathered in as smokers to ensure smoking and flame igniting materials as well as illegal drugs and related paraphernalia on the premises to include calling the police for removal and the dangers involved in allowing use are not present. Resident room smoking searches will then be conducted by Administrative team (Administrator, Financial Counselor, Environmental Services Director, Human Resources, Activity Director, Medical Records Coordinator, Maintenance Director, Social Service Director, and Certified Dietary Manager) weekly for 3 weeks and monthly to ensure compliance with facility smoking policy and procedures. Residents found to be noncompliant with smoking in non-designated areas, using illegal drugs, having flame igniting materials, or illegal drug use materials will have their rooms searched by a member of the facility Administrative Team (Administrator, Financial Counselor, Environmental Services Director, Human Resources, Activity Director, Medical Records Coordinator, Maintenance Director, Social Service Director, and Certified Dietary Manager) daily with Rockingham Police being called if search is refused. Facility is alleging removal of the jeopardy on	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 689	Continued From page 92 3/25/2021" Validation: Validation began on 3/26/2021 at 9:00 am. As part of validation, in-service education and sign in sheets were reviewed and 91employees (including contract) participated in mandatory education for smoking and illegal substances in the facility and policy on 3/24/2021 and 3/25/2021. NA #3 was interviewed on 3/26/21 at 9:00 AM. She was educated on 3/24/21 by the DON and 3/25/2021. NA #3 was able to report on all information noted in the IJ removal plan. An interview was conducted with the DON on 3/26/21 at 9:30 am. She was educated by the Corporate Nurse Consultant on 3/24 and 3/25 on all required information noted in the IJ removal plan. 3/26/21 at 10:15am an interview with infection control/staff development coordinator (IC/SDC) confirmed she had received education on 3/25/21 regarding no smoking in the building and no smoking materials kept in rooms. If items were present, they were to be confiscated and reported to the Administrator immediately. Smell of cigarette smoke or illicit drugs was to be reported to the Police Department. On 3/26/21 at 10:37am Resident #27, who was a supervised smoker, stated he had received education on smoking (policy and safety) yesterday (3/25/2021). Resident # 46 commented on 3/26/21 at 10:35 am that three different people (facility staff) had	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 93 come in his room to tell him about no smoking in the facility and no drugs. He stated he was not aware that a resident was smoking and using marijuana in his room. Interview with the Administrator on 3/26/21 at 11:48 am confirmed education was received from the facility consultant on 3/24 and again on 3/25 for all required information in the IJ removal plan. Immediate jeopardy was removed on 3/25/21. 2. Resident #41 was admitted to the facility on 3/20/19 with diagnosis of dementia without behavior. A review of Resident #41 ' s annual MDS dated 2/2/2021 revealed that he was moderately cognitively impaired. The resident required extensive assistance of 1 staff for all activities of daily living (including transfer). His diagnoses were debility, acute respiratory disease, and aphasia. Resident #41 ' s initial care plan dated 1/12/20 revealed the problem of falls and potential. The approach to was to implement an exercise program that targets strength, gait and balance and a cushion will be placed in wheelchair to prevent sliding out of chair (did not indicate transfer status). On 3/22/2021 at 10:35 am an observation was done of Resident #41 in his room after morning care. The resident was transferred by NA #1 from his bed to his wheelchair by using a sit to stand transfer device. The NA placed the sling across the resident ' s back and began to lift the resident. The NA failed to lock the device wheels	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 689	Continued From page 94	F 689		

before standing the resident. The device moved during the transfer. NA #1 had to reposition the resident's legs during transfer due to contraction and stiffness.

An interview was conducted with Nurse #3 on 3/25/2021 at 1:40 pm. Nurse #3 stated that Resident #41 required the assistance of the sit to stand device for transfer. Staff were required to lock the wheels of the device before attaching and lifting the resident to stand position before the transfer to prevent unwanted movement. Staff were informed of locked wheels during training upon hire.

On 3/25/2021 at 2:06 pm an interview was conducted with NA #1. NA #1 commented that she was told by staff that Resident #41 required the sit to stand device for transfer. She stated that she does not usually use the sit to stand device for resident transfer. NA #1 had training for the device in January 2021 (when she was hired) but did not remember that the device needed the wheels locked before attaching and lifting the resident. NA #1 acknowledged that she did not lock the sit to stand device when transferring Resident #41 on 3/22/21.

The Director of Nursing (DON) was interviewed on 3/25/2021 at 4:05 pm. The DON commented that staff were required to lock the sit to stand device before attaching and transferring a resident to prevent unwanted movement (potential for injury). There was training for all new employees and employees who have not had experience with the sit to stand transfer device. The DON provided a device maintenance policy for the battery and care. There was no facility policy or manufacturer ' s recommendation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 689	Continued From page 95	F 689		

for device use. The DON commented that NA #1 should have locked the wheels of the device before use (sling placement and standing the resident).

3. Resident #50 was admitted to the facility on 10/9/18 with multiple diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction affecting the non-dominant side.

Resident #50 ' s care plan included, in part, a problem area related to the risk for falls. This area was initiated on 11/13/19 and revised on 1/23/20. The interventions included, in part:
- Offer to lay down resident down after meals and appointments (initiated on 11/13/19)
- Monitor for changes in condition that may warrant increased supervision (initiated on 11/13/19)
- Hoyer lift for transfers (initiated on 11/13/19)
- Encourage resident to call for assistance (initiated on 11/13/19)
- Rear wheelchair anti-tippers (initiated on 1/23/20)

A fall report dated 5/16/20 indicated Resident #50 had an unwitnessed fall from his bed that resulted in a skin tear to his right elbow. The immediate measures taken were to assist Resident #50 up from the floor to his bed, right elbow cleaned and dressing applied, and an impact mat (a mat placed at the side of the bed to reduce the risk of injury from a fall) was placed beside his bed.

On 5/16/20 Resident #50 ' s care plan related to the risk for falls was updated with the intervention

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 96	F 689		

of an impact mat on the floor beside his bed.

A fall report dated 6/2/20 at 7:15 AM completed by Nurse #10 indicated Resident #50 was observed kneeling on the floor on the side of his bed. Resident was noted with no injuries. The immediate measures taken read, "impact mat", indicating that the care plan intervention of an impact mat (initiated on 5/16/20) was not in place at the time of this 6/2/20 fall.

A nursing note dated 6/2/20 at 4:04 PM indicated an abrasion to Resident #50 ' s right knee was identified as a result of his fall earlier this day and he complained of some pain to the touch. He was noted with scheduled pain medication administered which the resident reported was effective. Resident #50 ' s abrasion was cleaned, and a dressing was applied.

The quarterly Minimum Data Set (MDS) assessment dated 2/5/21 indicated Resident #50 had short-term and long-term memory problems and moderately impaired daily decision-making skills. He required the extensive assistance of 1 with bed mobility and was dependent on 1 for dressing, toileting, and personal hygiene. Transfers and locomotion on/off the unit had not occurred during the MDS review period. Resident #50 had functional impairment with range of motion on both sides of his upper and lower extremities. He had no falls since his previous MDS assessment (1/15/21 quarterly MDS).

Based on the schedule with assignments and nursing notes for 6/2/20 the following staff were assigned to Resident #50 ' s hall at the time of his fall: Nurse #10, Nursing Assistant (NA) #11, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 689	Continued From page 97 NA #12. A phone interview was attempted with Nurse #10 on 3/25/21 at 10:40 AM. He was unable to be reached. A phone interview was conducted with NA #11 on 3/25/21 at 11:34 AM. The fall report and nursing note dated 6/2/20 related to Resident #50 ' s fall was reviewed with NA #11. The immediate intervention of an impact mat was reviewed with NA #11. NA #11 stated that she was unable to recall anything about this fall on 6/2/20 for Resident #50. A phone interview was attempted with NA #12 on 3/25/21 at 11:36 AM. She was unable to be reached. An observation was conducted of Resident #50 in bed in his room on 3/22/21 at 10:00 AM. There was no impact mat in place. A review of the active care plan for Resident #50 was conducted on 3/24/21 and revealed the intervention of an impact mat remained in place. A review of the Nursing Assistant (NA) care guide was conducted on 3/24/21 and revealed the intervention of an impact mat was not listed for Resident #50. Observations were conducted of Resident #50 in bed in his room on 3/24/21 at 9:00 AM and at 1:30 PM. There was no impact mat in place on either observation.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 98 An interview was conducted with NA #10 on 3/24/21 at 1:31 PM. She indicated that she worked with Resident #50 regularly. She was asked if Resident #50 was supposed to have an impact mat beside his bed. NA #10 stated that she was unaware of an intervention for an impact mat for Resident #50. She reported that the NA care guide for Resident #50 had not included the intervention of an impact mat. An observation of Resident #50 was conducted with NA #10. Resident #50 was in bed in his room and NA #10 verified he had no impact mat in place. An interview was conducted with Nurse #6 on 3/24/21 at 1:40 PM. She indicated that she worked with Resident #50 regularly. She reported that Resident #50 was at risk for falls and his care plan interventions included an impact mat. An observation of Resident #50 was conducted with Nurse #6. Resident #50 was observed in his bed and Nurse #6 verified the impact mat was not in place. Nurse #6 revealed that she noticed the impact mat was not in place this morning, but she had not thought to look for the mat and to put it in place at his bed side at that time. An interview was conducted with the Director of Nursing (DON) on 3/24/21 at 2:35 PM. Resident #50 ' s care plan interventions that indicated an impact mat was to be at his bedside and the NA care guide that included no intervention of the impact mat were reviewed with the DON. She reported that it required one click of a button to put the care plan interventions on the care guide. She stated that this task could have been completed by herself, an MDS Nurse, or any floor	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 99 nurse. The DON was unable to explain why this intervention was not on the NA care guide. She stated that she expected the fall risk interventions to be implemented at all times.	F 689		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		5/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 756	Continued From page 100 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Pharmacy Consultant, Psychiatric Nurse Practitioner, and Medical Director, the facility failed to act upon pharmacy recommendations for 3 of 6 residents (Residents #40, #45, and #49) reviewed for unnecessary medications. The findings included: 1. Resident #49 was admitted to the facility on 5/7/20 and most recently readmitted on 1/25/21 with multiple diagnoses that included anxiety. The quarterly Minimum Data Set (MDS) assessment dated 10/6/20 indicated Resident #49 ' s cognition was intact. He had verbal behaviors on 1 to 3 days and received antianxiety medication on 7 of 7 days. A physician ' s order from the Medical Director dated 10/6/20 indicated Ativan (antianxiety medication) 0.5 milligrams (mg) twice daily for Resident #49. A physician ' s order from the Medical Director dated 10/20/20 indicated Ativan 1 mg PRN (as needed) every evening for behaviors for Resident #49. This order for PRN Ativan had no stop date. A monthly Drug Regimen Review (DRR) note dated 11/18/20 completed by the Pharmacy	F 756	1.Resident #49□s pharmacy recommendation from for condition and duration related to the Ativan order was followed up on by facility Medical Director on April 15, 2021 and uploaded to the system. Resident #45□s pharmacy recommendation for a Gradual Dose Reduction related to the Trazadone order was addressed by facility Medical Director on April 15, 2021. No GDR recommendations Resident #40□s pharmacy recommendation for a reduction of Xanax was addressed by facility medical director on April 19, 2021. No GDR recommendations 2.An audit of resident pharmacy recommendations since March 2021 was completed by April 15, 2021 by the Regional Senior Nurse Consultant with response uploaded to electronic medical record system. Recommendations requiring follow up were given to the Medical Director on April 19, 2021 for completion by April 23, 2021. Changes requiring physician orders were added to the residents□ medical record by facility Charge Nurses.	

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	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 756	Continued From page 101 Consultant indicated Resident #49 had no psychiatric notes in his medical record and he was prescribed Ativan 1 mg PRN. The Pharmacy Consultant wrote that a recommendation was made. A monthly DRR note completed by the Pharmacy Consultant on 12/17/20 indicated Resident #49 had no psychiatric notes in his medical record and he continued with Ativan 1 mg PRN as well as routine Ativan 0.5 mg twice daily. The Pharmacy Consultant wrote that a recommendation was made. A nursing note dated 1/19/21 at 12:52 AM indicated Resident #49 was transferred to the Emergency Room (ER) for a change in mental status. A monthly DRR note completed by the Pharmacy Consultant on 1/19/21 indicated Resident #49 was sent the Emergency Room (ER) last night for a change in mental status. He was noted with no psychiatric notes in his medical record and he continued on Ativan 1 mg PRN as well as Ativan 0.5 mg twice daily. The Pharmacy Consultant wrote that a recommendation was made. A nursing note dated 1/25/21 indicated Resident #49 was readmitted to the facility. On 1/25/21 Resident #49 ' s 10/6/20 physician ' s order for Ativan 0.5 mg twice daily was discontinued and a new order for Ativan 0.5 mg twice daily was initiated (same dosage and frequency of previous order from 10/6/20). On 1/25/21 Resident #49 ' s 10/20/20 order for Ativan 1 mg PRN every evening was discontinued	F 756	3.On April 19, 2021 Regional Senior Nurse Consultant provided education to Director of Health Services related to timely completion of Pharmacy Recommendation with subsequent documentation to include obtaining new physician orders and communication to facility Pharmacy consultant. Facility Administrator educated Medical Director on timely follow up Pharmacy recommendations to include medication used primarily for mental health and mood stability on April 19, 2021. 4.Director of Health Services and/or designee will conduct an audit of Pharmacy recommendations weekly for three weeks, then monthly for three months to ensure timely completion with documentation in the resident medical record. Results of this audit will be reported to facility Quality Assurance Performance Improvement Committee to ensure compliance with plan of action monthly for three months then quarterly thereafter. 5.May 5, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 756	Continued From page 102	F 756		

and a new order for Ativan 1 mg PRN every evening for behaviors was initiated (same dosage and frequency as previous order from 10/20/20). This order for PRN Ativan had no stop date.

The annual Minimum Date Set (MDS) assessment dated 2/4/21 indicated Resident #49 ' s cognition was intact. He had no behaviors and no rejection of care. Resident #49 received antianxiety medication daily.

A monthly DRR completed by the Pharmacy Consultant on 2/16/21 indicated Resident #49 had no psychiatric notes in his medical record and he continued with Ativan 1 mg PRN as well as routine Ativan 0.5 mg twice daily. The Pharmacy Consultant wrote that a recommendation was made.

On 3/8/21 Resident #49 ' s 1/25/21 order for Ativan 1 mg PRN every evening was discontinued by the Medical Director with the discontinue order entered by the Director of Nursing (DON).

Resident #49 ' s active physician ' s orders were reviewed on 3/25/21 and indicated the 1/25/21 order for Ativan 0.5 mg twice daily remained in place.

During a phone interview with the Psychiatric Nurse Practitioner (PNP) on 3/25/21 at 3:55 PM she revealed that last week (3/22/21), the DON sent her multiple pharmacy recommendations by email related to psychotropic medications that had not yet been completed going back to September 2020. She further revealed that several of the residents these recommendations were for were not being seen for psychiatric services. The PNP stated that she addressed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 756	Continued From page 103	F 756		

only the residents who were being followed by psychiatric services and she informed the DON that she would not complete recommendations for residents who had not consented to psychiatric services and who she was not familiar with.

On 3/26/21 at 10:49 AM the PNP provided the pharmacy recommendations she was sent by the DON last week (3/22/21). Included in these documents were the following pharmacy recommendations for Resident #49:
- A Consultant Pharmacist Communication to Physician form dated 1/19/21 indicated a pharmacy recommendation was completed by the Pharmacy Consultant and addressed to the Medical Director. This was noted to be a repeat recommendation from November 2020. Resident #49 had an order for Ativan 1 mg PRN every evening for behaviors. The Pharmacy Consultant reported that PRN Ativan was limited to 14 days except if the prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, he/she should document their rationale, including that medication is necessary to treat a diagnosed specific condition in the progress notes, and indicate the duration of the PRN order. The Pharmacy Consultant indicated that an indefinite duration was not considered to be acceptable. He requested a condition and duration be noted on the pharmacy recommendation form, for a clarification order to be written, and for the physician/practitioner to document a response to the recommendation on the bottom of the form with a corresponding signature and date. The PNP noted on the form that Resident #49 had not consented to and was not followed by psychiatric services. There was no response noted on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 104	F 756		

recommendation by any other medical provider.
- A Consultant Pharmacist Communication to Physician form dated 1/19/21 indicated a pharmacy recommendation was completed by the Pharmacy Consultant and addressed to the Medical Director. This was noted to be a repeat recommendation from November 2020. Resident #49 required an evaluation for a Gradual Dose Reduction (GDR) of Ativan 0.5 mg twice daily. The pharmacy consultant requested the physician/practitioner select one of the three options for routine Ativan: 1) GDR not possible clinically without a negative effect on the underlying psychiatric illness; 2) Previous attempts have failed and are documented in previous progress notes; 3) New order to decrease Ativan to 0.25 mg twice daily. The pharmacy consultant additionally requested the response to the recommendation be documented on the bottom of the form with a corresponding signature and date. The PNP noted on the form that Resident #49 had not consented to and was not followed by psychiatric services. There was no response noted on the form by any other medical provider.

A phone interview was conducted with the Pharmacy Consultant on 3/26/21 at 12:16 PM. He stated that he was completing his monthly DRRs remotely from April 2020 through January 2021. He indicated that he took a 3-day period to complete all the monthly DRRs and on the 3rd day he emailed all the pharmacy recommendations to the DON and Administrator. He indicated these Pharmacy Recommendations were documented on the Consultant Pharmacist Communication to Physician forms and were addressed to the resident ' s attending physician. He indicated that the protocol was for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 756	Continued From page 105 physician/practitioner to review the form, complete any information required on the form, sign the form, implement any necessary orders, and return the form to the facility to be scanned into the electronic medical record. He reported that his expectation was to have all recommendations acted upon/responded to and to be scanned into the electronic medical record by the time of his next monthly DRR. The Pharmacy Consultant stated that if the recommendation had not been acted upon/responded to by his next review he made a note on the monthly report he provided to the facility. He explained that every month when he sent in the pharmacy recommendations to the DON and Administrator he also provided a report that was generally 5-8 pages that included information on psychotropic medication use and it also listed any recommendations that were not acted upon/responded to from the previous month. He reported that during the following monthly DRR if the recommendation had still not been acted upon/responded he repeated the recommendation to the attending physician on the Consultant Pharmacist Communication to Physician form with a notation that it was a repeat recommendation. The Pharmacy Consultant revealed that the facility had an ongoing issue with responding to pharmacy recommendations related to psychotropic medications. He further revealed that this had been a significant issue since at least September 2020. He reported that he spoke with the DON about this issue and she acknowledged that she was having difficulty receiving responses to recommendations related to psychotropic medications. He indicated that as of this time (3/26/21) the problem had not been resolved.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 756	Continued From page 106 An interview was conducted with the DON on 3/26/21 at 12:40 PM. She stated that when she received the pharmacy recommendations each month, she put all recommendations addressed to the Medical Director in his facility mailbox that same day. She stated that her expectation was for the Medical Director to respond to the recommendations within 3 business days. The DON revealed that she had been having difficulty with the Medical Director responding to pharmacy recommendations. She explained that the facility protocol was for all residents on psychotropic medications to be followed by the psychiatric provider. She revealed that this was not the case for all residents as some had not consented to psychiatric services. The DON stated that if the resident was not followed by the psychiatric provider that the PNP would not complete those pharmacy recommendations as she was not familiar with the residents and the Medical Director had not wanted to complete the pharmacy recommendations either. She revealed that this was an ongoing issue that had not been resolved and it resulted in multiple pharmacy recommendations that were not acted upon/responded to every month. The DON confirmed she sent the PNP multiple pharmacy recommendations related to psychotropic medications last week that were from September 2020 through present that had not yet been acted upon/responded to. She further confirmed that these pharmacy recommendations included 2 recommendations for Resident #49 from January 2021 related to Ativan and that both of these recommendations were repeat recommendations from November 2020. She revealed that Resident #49 was not followed by psychiatric services so the PNP had not acted upon/responded to these pharmacy	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 107	F 756		

recommendations. The DON was asked how these pharmacy recommendations were missed if her expectation was that they be completed within 3 business days. She was unable to explain why these pharmacy recommendations had not been acted upon and/or responded to.

A phone interview was conducted with the Medical Director on 3/26/21 at 12:45 PM. He stated that he came to the facility 2 to 3 times per week. He indicated he checked his mailbox at the facility on each visit and if there were pharmacy recommendations there, he completed them that same day and returned them to the mailbox. He reported that he preferred for the psychiatric provider to complete recommendations related to psychotropic medications as this was their specialty. He indicated if a pharmacy recommendation related to a psychotropic medication was in his mailbox, that he wrote a note on the form referring it to the PNP. The Medical Director was asked who responded to the pharmacy recommendation if the resident was not followed by psychiatric services. He reported that the facility protocol was to have all residents on psychotropic medications followed by the psychiatric provider. He indicated that if there was a resident who was not on psychiatric services that he completed these pharmacy recommendations. The Medical Director stated that if he had not written anything on the Consultant Pharmacist Communication to Physician form that he was never given the form for review.

2) Resident #45 was admitted to the facility on 3/2/18 with diagnoses that included cerebral infarction (a stroke), major depressive disorder and insomnia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 108 The quarterly Minimum Data Set (MDS) assessment dated 2/4/21 indicated Resident #45 was able to understand others and sometimes make self-understood. There were no behaviors coded for the 7 day look back period. Resident #45 was coded as receiving 7 out of 7 days of an antianxiety and hypnotic medication. Gradual dose reduction (GDR) attempts were not coded on the MDS assessment. A review of Resident #45's active care plan, last reviewed on 2/9/21 revealed the following problem areas: - Psychotropic Drug Use. Risk for adverse reactions related to use of psychotropic medications for diagnosis of depression. Approaches included GDR as indicated, provide medication as ordered. -Other- diagnosis of insomnia. Approaches included to provide medications as ordered. A monthly Drug Regimen Review (DRR) dated 9/15/20 completed by the Pharmacy Consultant indicated Resident #45 had a psychiatric note in his medical record dated 9/10/20 and Venlafaxine was increased for depression. He was prescribed Restoril (hypnotic) 7.5 milligrams (mg) at bedtime as needed (prn), Trazodone (an antidepressant) 50 mg at bedtime and Venlafaxine (an antidepressant) 100 mg three times a day. No recommendations were noted to be made. A monthly DRR dated 10/20/20 completed by the Pharmacy Consultant indicated Resident #45 had a psychiatric note in his medical record dated 10/8/20. He was prescribed Buspirone 5 mg twice a day, Trazodone 50 mg at bedtime, Venlafaxine 100 mg three times a day and Restoril was	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 109	F 756		

discontinued. A recommendation was noted to be made.

A review of Resident #45's medical record revealed no evidence of the Pharmacy Recommendation referred to in the 10/20/20 monthly DRR.

A monthly DRR dated 11/16/20 completed by the Pharmacy Consultant indicated Resident #45 had a psychiatric note in his medical record dated 10/8/20 and was prescribed Buspirone 5 mg twice a day, Trazodone 50 mg at bedtime, Venlafaxine 100 mg three times a day and Restoril 7.5 mg at bedtime that was restarted on 10/20/20. A recommendation was noted to be made.

A review of Resident #45's medical record revealed no evidence of the Pharmacy Recommendation referred to in the 11/16/20 monthly DRR.

A monthly DRR completed by the Pharmacy Consultant on 12/15/20 indicated Resident #45 had a psychiatric note in his medical record dated 12/3/20 and he continued Trazodone 50 mg at bedtime, Venlafaxine 100 mg three times a day and Restoril 7.5 mg at bedtime. Buspirone was increased from 5 mg twice a day to 10 mg three times a day on 11/25/20. A recommendation was noted to be made.

A review of Resident #45's medical record revealed no evidence of the Pharmacy Recommendation referred to in the 12/15/20 monthly DRR.

A monthly DRR completed by the Pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 110	F 756		

Consultant on 1/19/21 indicated Resident #45 had a psychiatric note in his medical record dated 12/3/20. He continued and he continued Trazodone 50 mg at bedtime, Venlafaxine 100 mg three times a day, Restoril 7.5 mg at bedtime and Buspirone 10 mg three times a day. A recommendation was noted to be made.

A review of Resident #49's medical record revealed no evidence of the Pharmacy Recommendation referred to in the 1/19/21 monthly DRR.

During a phone interview with the Psychiatric Nurse Practitioner (PNP) on 3/25/21 at 3:55 PM, she revealed that last week (3/22/21), the Director of Nursing (DON) sent her multiple pharmacy recommendations by email related to psychotropic medications that had not yet been completed going back to September 2020. She further revealed that for several of the residents they were not being followed by psychiatric services. The PNP stated she addressed only the residents who were being followed by psychiatric services and she informed the DON that she would not complete recommendations for residents who had not consented to psychiatric services and who she was not familiar with.

On 3/26/21 at 10:49 AM, the PNP provided the pharmacy recommendations she was sent by the DON last week (3/22/21). Included in these documents were the following pharmacy recommendations for Resident #45:
- A Consultant Pharmacist Communication to Physician form dated 1/19/21 indicated a communication/recommendation was completed by the Pharmacy Consultant and addressed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 111	F 756		

the Medical Director. On 11/19/20 psychiatry wrote to increase Buspirone from twice a day to three times a day. Resident #45 was getting 5 mg twice a day and the dose was increased to 10 mg three times a day. The Pharmacy Consultant requested to clarify if the dose was 5 mg or 10 mg three times a day and if the intent was to triple the dose. The PNP noted Resident #45 had achieved psychiatric stability on the current dose of 10 mg three times a day and to continue as prescribed. The form was signed by the PNP and dated 3/8/21.

- A Consultant Pharmacist Communication to Physician form dated 1/19/21 indicated a communication/recommendation was completed by the Pharmacy Consultant and addressed to the Medical Director. This was noted to be a repeat recommendation from September 2020. Resident #45 required an evaluation for a Gradual Dose Reduction (GDR) of Trazodone 50 mg at bedtime. The pharmacy consultant requested the physician/practitioner select one of the three options for the routine Trazodone: 1) GDR not possible clinically without a negative effect on the underlying psychiatric illness; 2) Previous attempts have failed and are documented in previous progress notes; 3) New order to decrease Trazodone to 25 mg at bedtime. The pharmacy consultant additionally requested the response to the recommendation be documented on the bottom of the form with a corresponding signature and date. The PNP signed and dated the form on 3/8/21 indicating a GDR was not possible clinically without a negative effect on the underlying psychiatric illness.

- A Consultant Pharmacist Communication to the Physician form dated 3/16/21 indicated a communication/recommendation was completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 112	F 756		

by the Pharmacy Consultant and addressed to the Medical Director. This was noted to be a repeat recommendation from January 2021. On 11/19/20 psychiatry wrote to increase Buspirone from twice a day to three times a day. Resident #45 was getting 5 mg twice a day and the dose was increased to 10 mg three times a day. The Pharmacy Consultant requested to clarify if the dose was 5 mg or 10 mg three times a day and if the intent was to triple the dose. The PNP noted this was a duplicate and had already been completed and sent to DON on 3/8/21.
- A Consultant Pharmacist Communication to Physician form dated 3/16/21 indicated a communication/recommendation was completed by the Pharmacy Consultant and addressed to the Medical Director. This was noted to be a repeat recommendation from September 2020. Resident #45 required an evaluation for a Gradual Dose Reduction (GDR) of Trazodone 50 mg at bedtime. The pharmacy consultant requested the physician/practitioner select one of the three options for the routine Trazodone: 1) GDR not possible clinically without a negative effect on the underlying psychiatric illness; 2) Previous attempts have failed and are documented in previous progress notes; 3) New order to decrease Trazodone to 25 mg at bedtime. The pharmacy consultant additionally requested the response to the recommendation be documented on the bottom of the form with a corresponding signature and date. The PNP noted at the bottom of the form this was a duplicate and had already been completed and sent to the DON on 3/8/21.

A phone interview was conducted with the Pharmacy Consultant on 3/26/21 at 12:16 PM. He stated he was completing his monthly DRRs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 113	F 756		

remotely from April 2020 through January 2021. He indicated he took a 3-day period to complete all the monthly DRRs and on the 3rd day he emailed all the pharmacy recommendations to the DON and Administrator. He indicated these Pharmacy Recommendations were documented on the Consultant Pharmacist Communication to Physician forms and were addressed to the resident's attending physician. He explained the protocol was for the physician/practitioner to review the form, complete any information required on the form, sign the form, implement any necessary orders, and return the form to the facility to be scanned into the electronic medical record (EMR). He reported his expectation was to have all recommendations acted upon/responded to and scanned into the EMR by the time of his next monthly DRR. The Pharmacy Consultant stated if the recommendation had not been acted upon/responded to by his next review he made a note on the monthly report which was provided to the facility. He explained that every month when he sent in the pharmacy recommendations to the DON and Administrator, he also provided a report that was generally 5-8 pages that included information on psychotropic medication use and it also listed any recommendations that were not acted upon/responded to. He reported that during the following monthly DRRs if the recommendation had still not been acted upon/responded he repeated the recommendation to the attending physician on the Consultant Pharmacist Communication to Physician form with a notation that it was a repeat recommendation. The Pharmacy Consultant revealed that the facility had an ongoing issue with responding to pharmacy recommendations related to psychotropic medications. He further revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 114	F 756		

that this had been a significant issue since at least September 2020 and had spoken with the DON about this issue and she acknowledged that she was having difficulty receiving responses to recommendations related to psychotropic medications. He indicated that as of this time (3/26/21) the problem had not been resolved.

An interview was conducted with the DON on 3/26/21 at 12:40 PM. She stated when she received the pharmacy recommendations each month, she put all recommendations addressed to the Medical Director in his facility mailbox that same day. She stated it was her expectation for the Medical Director to respond to the recommendations within 3 business days. The DON revealed she had been having difficulty with the Medical Director responding to pharmacy recommendations. She stated that the Medical Director was resistant to responding to any recommendations related to psychotropic medications. She explained the facility protocol was for all residents on psychotropic medications to be followed by the psychiatric provider for medication management. She revealed this was not the case for all residents as some had not consented to psychiatric services. The DON stated if a resident was not followed by the psychiatric provider, the PNP would not complete those pharmacy recommendations as she was not familiar with the residents and the Medical Director had not wanted to complete the pharmacy recommendations either. She revealed this was an ongoing issue that had not been resolved and had resulted in multiple pharmacy recommendations that were not acted upon/responded to every month. The DON confirmed she sent the PNP multiple pharmacy recommendations related to psychotropic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 115	F 756		

medications last week that were from September 2020 through present that had not yet been acted upon/responded to or may have been duplicates.

A phone interview was conducted with the Medical Director on 3/26/21 at 12:45 PM. He stated he came to the facility 2 to 3 times per week, would check his mailbox at the facility on each visit and if there were pharmacy recommendations there, he completed them that same day and returned them to the mailbox. He reported he preferred for the psychiatric provider to complete recommendations related to psychotropic medications as this was their specialty. He indicated if a pharmacy recommendation related to a psychotropic medication was in his mailbox, he wrote a note on the form referring it to the PNP. The Medical Director was asked who responded to the pharmacy recommendation if the resident was not followed by psychiatric services and he responded that the facility protocol was to have all residents on psychotropic medications followed by the psychiatric provider. He indicated if there was a resident who was not on psychiatric services then he would have completed the pharmacy recommendations. The Medical Director stated if he had not written anything on the Consultant Pharmacist Communication to Physician form then he was never given the form for review.

3. Resident #40 was Admitted 3/24/20 w/subdural hemorrhage, convulsion, aphasia and dysphagia, seizures, left decompressive hemicraniectomy. She readmitted on 10/29/21 with a cranioplasty.

Resident #40 was care planned for the use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 116	F 756		

psychotropic medications on 4/24/20 with the intervention of a gradual dose reduction (GDR) by the pharmacist and the Physician.

Resident #40's annual MDS dated 1/31/21 indicated severe cognitive impairment and physical behaviors not directed toward others. She was coded as taking an antidepressant and an antianxiety medication daily.

Review of Resident #40's March 2020 Physician orders included an order for Xanax (antianxiety). The order date read 10/29/20 on her readmission to the facility.

Review of a Pharmacy Communication to the Physician dated 1/19/21 recommended a GDR of her Xanax. The recommendation was not addressed by the Physician until 3/3/21 declining a GDR of her Xanax due to underlying psychiatric illness. The pharmacist and the facility could not provide any evidence that this recommendation was re-addressed during the February 2021 pharmacy review.

In a telephone interview on 3/25/21 at 3:55 PM, the Psychiatric Nurse Practitioner (PNP) revealed that last week (3/22/21), the Director of Nursing (DON) sent her multiple pharmacy recommendations by email related to psychotropic medications that had not yet been completed going back to September 2020. She stated Resident #40 was not being seen for psychiatric services and she informed the DON that she would not complete recommendations for residents who had not consented to psychiatric services and who she was not familiar with.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 117 In a telephone interview on 3/26/21 at 12:16 PM, the Pharmacy Consultant stated that he was completing his monthly pharmacy reviews remotely from April 2020 through January 2021. He indicated that he took a 3-day period to complete all the monthly reviews and on the 3rd day he emailed all the pharmacy recommendations to the DON and Administrator. He indicated these Pharmacy Recommendations were documented on the Consultant Pharmacist Communication to Physician forms and were addressed to the resident's attending physician. He indicated that the protocol was for the physician/practitioner to review the form, complete any information required on the form, sign the form, implement any necessary orders, and return the form to the facility to be scanned into the electronic medical record. He reported that his expectation was to have all recommendations acted upon/responded to and to be scanned into the electronic medical record by the time of his next monthly pharmacy review. The Pharmacy Consultant stated that if the recommendation had not been acted upon/responded to by his next review he made a note on the monthly report he provided to the facility. He explained that every month when he sent in the pharmacy recommendations to the DON and Administrator he also provided a report that was generally 5-8 pages that included information on psychotropic medication use and it also listed any recommendations that were not acted upon/responded to from the previous month. He reported that during the following monthly pharmacy review if the recommendation had still not been acted upon/responded he repeated the recommendation to the attending physician on the Consultant Pharmacist Communication to Physician form with a notation	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 118	F 756		

that it was a repeat recommendation. The Pharmacy Consultant revealed that the facility had an ongoing issue with responding to pharmacy recommendations related to psychotropic medications. He further revealed that this had been a significant issue since at least September 2020. He reported that he spoke with the DON about this issue and she acknowledged that she was having difficulty receiving responses to recommendations related to psychotropic medications. He indicated that as of this time (3/26/21) the problem had not been resolved.

In an interview on 3/26/21 at 12:40 PM, the DON stated that when she received the pharmacy recommendations each month, she put all recommendations addressed to the Medical Director in his facility mailbox that same day. She stated that her expectation was for the Medical Director to respond to the recommendations within 3 business days. The DON revealed that she had been having difficulty with the Medical Director responding to pharmacy recommendations. She explained that the facility protocol was for all residents on psychotropic medications to be followed by the psychiatric provider. She revealed that this was not the case for all residents as some had not consented to psychiatric services. The DON stated that if the resident was not followed by the psychiatric provider that the PNP would not complete those pharmacy recommendations as she was not familiar with the residents and the Medical Director had not wanted to complete the pharmacy recommendations either. She revealed that this was an ongoing issue that had not been resolved and it resulted in multiple pharmacy recommendations that were not acted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 756	Continued From page 119 upon/responded to every month. The DON confirmed she sent the PNP multiple pharmacy recommendations related to psychotropic medications last week that were from September 2020 through present that had not yet been acted upon/responded to. The DON was asked how these pharmacy recommendations were missed if her expectation was that they be completed within 3 business days. She was unable to explain why these pharmacy recommendations had not been acted upon and/or responded to. A phone interview was conducted with the Medical Director on 3/26/21 at 12:45 PM. He stated that he came to the facility 2 to 3 times per week. He indicated he checked his mailbox at the facility on each visit and if there were pharmacy recommendations there, he completed them that same day and returned them to the mailbox. He reported that he preferred for the psychiatric provider to complete recommendations related to psychotropic medications as this was their specialty. He indicated if a pharmacy recommendation related to a psychotropic medication was in his mailbox, that he wrote a note on the form referring it to the PNP. The Medical Director was asked who responded to the pharmacy recommendation if the resident was not followed by psychiatric services. He reported that the facility protocol was to have all residents on psychotropic medications followed by the psychiatric provider. He indicated that if there was a resident who was not on psychiatric services that he completed these pharmacy recommendations.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		5/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 758	Continued From page 120 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 758	Continued From page 121 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Pharmacy Consultant, and the Medical Director, the facility failed to ensure PRN (as needed) psychotropic medications were time limited in duration for 2 of 6 residents reviewed for unnecessary medications (Residents #43 and #49). The findings included: 1) Resident #43 was originally admitted to the facility on 1/21/20 with a recent readmission date of 1/27/21. His diagnoses included cerebral infarction (stroke) affecting the left nondominant side, type 2 diabetes, and seizure disorder. Review of the medical record revealed an order dated 12/19/20 for Lorazepam (Ativan-an antianxiety medication) 0.5 milligrams (mg) three times a day as needed (PRN) for anxiety. This order for PRN Lorazepam was entered into the Electronic Medical Record (EMR) by Nurse #1 and had no stop date. A nursing note dated 1/18/21 indicated Resident #43 was transferred to the Emergency Room for seizure activity and elevated blood sugar.	F 758	1.Resident #43 received an order modification from attending physician for PRN Ativan medication adding a stop date of April 13, 2021. Resident #49 received an order modification from attending physician for PRN Ativan adding a stop date of April 3, 2021. 2.Residents receiving PRN psychotropic medications were reviewed by Director of Health Services and/or RN MDS Coordinator by April 20, 2021 to ensure 14-day use limit was adhered to. Attending physician of residents with PRN psychotropic medication without a stop date were contacted by Director of Health Services and/or RN MDS Coordinator and a stop date was implemented and added to electronic medical record. Resident□s charge nurse was notified of the change to psychotropic order by Director of Nursing. 3.On April 19, 2021 Regional Senior Nurse Consultant provided education to Director of Health Services related to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 758	Continued From page 122 A nursing note dated 1/27/21 indicated Resident #43 was readmitted to the facility. A review of the hospital After Visit Summary (AVS) dated 1/27/21 revealed Resident #43 was to stop taking Lorazepam 0.5mg. A quarterly Minimum Data Set (MDS) assessment dated 1/31/21 indicated Resident #43 was cognitively impaired. He had no behaviors and was not coded for antianxiety medication during the 7 day look back period. Review of the March 2021 Medication Administration Record revealed Resident #43 received Lorazepam 0.5 mg PRN on 3/15/21, 3/16/21, 3/18/21, 3/19/21, 3/21/21, 3/22/21 and 3/24/21. An interview occurred with the Pharmacy Consultant on 3/24/21 at 2:09 PM who reported PRN psychotropic medications were limited to a 14-day duration. He indicated there were some exceptions for psychotropic medications that were not classified as antipsychotics. He further explained all psychotropic medications other than antipsychotics, that if the prescribing practitioner believed it was appropriate for the PRN order to be extended beyond 14 days, they were required to document their rationale, including the medication was necessary to treat a diagnosed specific condition in the progress notes and to indicate the duration of the PRN order. The Pharmacy Consultant indicated an indefinite duration was not considered acceptable. On 3/25/21 at 11:40 AM, an interview occurred with the Director of Nursing (DON). She reviewed the order dated 12/19/20 for Lorazepam prn and	F 758	obtaining a stop date when a PRN psychotropic is ordered by attending physician. Director of Health Services educated licensed nurses starting April 19, 2021 related to obtaining a stop date when a PRN psychotropic is ordered by attending physician. 4.Nursing Administrative Team (Director of Health Services, Assistant Director of Health Services, RN MDS Coordinators, Skin Integrity Nurse, Infection Preventionist, and/or Clinical Competency Nurse) will conduct audits of PRN psychotropic medication to ensure stop date is in place and adhered to weekly for four weeks, then monthly for three months. Director of Nursing will report findings of audits to facility Quality Assurance and Performance Improvement committee monthly for six months to ensure compliance. 5.May 5, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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F 758	Continued From page 123	F 758		

the hospital AVS dated 1/27/21. She confirmed the order was present without a stop date and should have been discontinued on 1/27/21. The DON indicated she was aware of the regulation that required all PRN psychotropic medications to be time limited in duration and she expected this regulation to be followed.

A phone interview was conducted with the Medical Director on 3/26/21 at 12:45 PM, who stated he was aware of the regulation that required all PRN psychotropic medications to be time limited in duration. He indicated it was error if a stop date was not included in a physician's order for a PRN psychotropic medication.

An interview occurred with Nurse #1 on 3/26/21 at 1:05 PM. The physician's order dated 12/19/20 for Lorazepam 0.5mg three times a day PRN that was entered into the EMR by Nurse #1 was reviewed. Nurse #1 was asked if she was aware of the regulation that required PRN psychotropic medications to be time limited in duration. She revealed she was aware, and it was an oversight when she received the order.

2. Resident #49 was admitted to the facility on 5/7/20 and most recently readmitted on 1/25/21 with multiple diagnoses that included anxiety.

A physician' s order dated 10/20/20 indicated Ativan (antianxiety medication) 1 milligram (mg) as needed (PRN) every evening for behaviors for Resident #49. This order for PRN Ativan was entered in the Electronic Medical Record (EMR) by Nurse #8 and had no stop date.

A nursing note dated 1/19/21 at 12:52 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 124	F 758		

indicated Resident #49 was transferred to the Emergency Room (ER) for a change in mental status.

A nursing note dated 1/25/21 indicated Resident #49 was readmitted to the facility.

On 1/25/21 Resident #49 ' s 10/20/20 order for Ativan 1 mg PRN every evening was discontinued and a new order for Ativan 1 mg PRN every evening for behaviors was initiated (same dosage and frequency as previous order from 10/20/20). This order for PRN Ativan was entered into the EMR by Nurse #9 and had no stop date.

The annual Minimum Data Set (MDS) assessment dated 2/4/21 indicated Resident #49 ' s cognition was intact. He had no behaviors and received antianxiety medication on 7 of 7 days.

On 3/8/21 Resident #49 ' s 1/25/21 order for Ativan 1 mg PRN every evening was discontinued.

A phone interview was conducted with Nurse #8 on 3/26/21 at 1:15 PM. The physician ' s order dated 10/20/20 for Ativan 1 mg PRN every evening that was entered into the EMR by Nurse #8 was reviewed. Nurse #8 was asked if she was aware of the regulation that required PRN psychotropic medications to be time limited in duration. She revealed that she thought PRN psychotropic medications could have an indefinite duration if there were behaviors documented in the medical record.

A phone interview was conducted with Nurse #9 on 3/26/21 at 10:09 AM. The physician ' s order dated 1/25/21 for Ativan 1 mg PRN every evening

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 125	F 758		

that was entered into the EMR by Nurse #9 was reviewed. Nurse #9 was asked if he was aware of the regulation that required PRN psychotropic medications to be time limited in duration. He revealed that he was not aware of this regulation.

A phone interview was conducted with the Pharmacy Consultant on 3/26/21 at 12:16 PM. The Pharmacy Consultant reported that PRN psychotropic medications were limited to a 14-day duration. He indicated that there was an exception for psychotropic medications that were not classified as antipsychotics. He explained that for all psychotropic medications other than antipsychotics, that if the prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, they were required to document their rationale, including that the medication was necessary to treat a diagnosed specific condition in the progress notes, and to indicate the duration of the PRN order. The Pharmacy Consultant indicated that an indefinite duration was not considered acceptable.

A phone interview was conducted with the Medical Director on 3/26/21 at 12:45 PM. The Medical Director stated he was aware of the regulation that required all PRN psychotropic medications to be time limited in duration. He indicated that it was an error if a stop date was not included in a physician ' s order for a PRN psychotropic medication.

An interview was conducted with the Director of Nursing (DON) on 3/26/21 at 12:40 PM. She indicated that she was aware of the regulation that required all PRN psychotropic medications to be time limited in duration and that she expected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 126 this regulation to be followed. She reported that if there was no stop date on a PRN psychotropic medication order that this was an error.	F 758		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide an Adhered Cup to 1 of 1 residents reviewed for adaptive devices (Resident #27). The findings included: Resident #27 was originally admitted to the facility on 5/6/20 with a recent readmission date of 3/12/21. His diagnoses included quadriplegia, and a significant history of urinary tract infections. A physician's order dated 10/21/20 indicated for an Adhered Cup to the bed frame with an accessible straw. Replenish every shift with ice and water. A review of the quarterly Minimum Data Set (MDS) assessment dated 1/18/21 indicated Resident #27 was able to understand others and make self-understood. He required extensive to total assistance from staff for all Activities of Daily Living (ADL's) and had limited range of motion to all extremities.	F 810	1.Therapy outcomes Coordinator added Adhered cup for Resident #27 to bedside on April 19, 2021. Another Adhered cup was ordered on April 6, 2021. 2.Therapy Outcomes Coordinator and Dietary Manager conducted an audit of assistive devices for eating and drinking to verify presence and resident use by April 20, 2021. Any device found not present was ordered on the same day as the audit. Resident Care plans were updated by RN MDS Coordinator to reflect adaptive equipment used 3.Therapy Outcomes Coordinator provided education to nursing employees starting April 19, 2021 about use of adaptive equipment order by physician to aide residents in meals and hydration. Education included verification equipment was in place and assisting resident to use equipment if needed.	5/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 810	Continued From page 127 The active care plan for Resident #27 was last reviewed on 3/17/21 and included the following problem areas: - Inability to maintain self-hydration. The approach was for an Adhered Cup to the bed frame with an accessible straw. Replenish every shift with ice and water. - Alteration in ADL's related to a gunshot wound resulting in spinal cord injury with quadriplegia. Contractures present to bilateral upper and lower extremities. The approach was to provide assistive devices as needed. A review of the March 2021 Medication Administration Record (MAR) revealed an entry for an Adhered Cup to the bed frame with an accessible straw- replenish every shift with ice and water. The MAR indicated Resident #27 was out of the facility on 3/10/21 and 3/11/21. Nursing initials were present for every shift from 3/1/21 to 3/9/31 and 3/12/21 until 3/22/21. On 3/22/21 at 11:46 AM an observation was completed with Resident #27. A water pitcher with a long straw was present on the bedside table, but there was not an Adhered Cup present to Resident #27's bed. An interview occurred with Nurse Aide (NA) #9 on 3/22/21 at 12:45 PM. She confirmed an Adhered cup was not present to Resident #27's bed and stated Resident #27 would ask for water and staff would offer fluids during routine checks and after personal care had been rendered. On 3/24/21 at 9:21 AM, an observation and interview was conducted with Resident #27. A water pitcher and straw were present on his	F 810	4.Therapy Outcomes Coordinator and/or Dietary Manager will conduct an audit of resident adaptive equipment used for meals and hydration to verify equipment presence and assistance provided to resident if needed daily for seven days, weekly for three weeks, then monthly for three months. Results of the audit will be brought to facility Quality Assurance and Performance Improvement committee by the Therapy Outcomes Coordinator and/or Dietary Manager monthly for three months. 5.May 5, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 810	Continued From page 128	F 810		

bedside table and no Adhered Cup was present on the bed. Resident #27 recalled the device being present on his siderail before he was hospitalized and when he returned to the facility on 3/12/21, the device was not present on the bed he was occupying in the quarantine unit. Resident #27 further stated when the device was present on his bed, he was able to obtain water independently when he desired as he was able to reach the straw when he turned his head.

A follow-up interview occurred with NA #9 on 3/24/21 at 9:40 AM. She recalled Resident #27 having the Adhered Cup device to the left siderail of his bed before he went to the hospital, but the device had not been transferred with his other belongings to the quarantine room upon his return to the facility on 3/12/21.

An interview occurred with Nurse #1 on 3/24/21 at 12:47 PM. She stated she was unsure if the Adhered Cup was present to Resident #27's bed. The March 2021 MAR was reviewed, and she stated when she initialed the entry, she was making sure water and ice had been replenished and the Adhered Cup was offered. Nurse #1 further stated the Adhered Cup might not have been moved with his belongings upon readmission from the hospital on 3/12/21 to the quarantine unit.

An observation was made of Resident #27's bed on 3/25/21 at 10:54 AM and the Adhered Cup was not present to the bed frame.

On 3/25/21 at 10:55 AM, an interview was completed with NA #2 who stated an Adhered Cup was not present to Resident #27's bed frame but instead a water pitcher and a long straw were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 810	Continued From page 129 present on the bedside table. She added staff offered/assisted with water when completing routine checks and after personal care had been rendered. An interview occurred with the Director of Nursing on 3/25/21 at 4:35 PM. She indicated it was her expectation for adaptive devices to present as ordered and Resident #27's Adhered Cup, should have been placed on the quarantine bed upon his return to the facility on 3/12/21.	F 810		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record review, the facility failed to ensure the floor tiles in the kitchen were in good	F 812	1.On March 25, 2021 Dietary employees cleaned the filters over the kitchen exhaust hood. On March 25, 2021 Dietary	5/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 130 repair for 2 of 2 observations. The facility also failed to clean the kitchen hood filters over the stove and failed to clean the deep fryer. These practices had the potential to affect the food being served to the residents. The findings included: In an observation and tour of the kitchen on 3/22/21 at 9:40 AM, the tile floor in front of the dishwasher was broken and individual tiles were lying on the floor around the drain. The hood filters over the stove were dirty with built up grease and what appeared to be dust debris. The deep fryer was observed with dark brown almost black cooking oil, crumbs, and fried food debris in and around the deep fryer. There was noted a strong odor of fried food coming from the deep fryer. In an interview on 3/22/21 at 9:50 AM, the dietary (DM) manager stated the tiles were broken when there was a problem with the drain and a pipe had to be replaced. The Dietary Manager (DM) stated that since COVID-19, the Maintenance Director had been cleaning the stove hood filters monthly and the deep fryer was cleaned weekly by the kitchen staff. She stated both were due for a cleaning. In a second observation of the kitchen on 3/24/21 at 11:50 AM, the broken tile floor in front of the dishwasher was covered with cardboard boxes that appeared wet. The DM stated the Maintenance Director put the boxes over the broken tiles yesterday. The stove hood filters were clean and the deep fryer had been cleaned and was drained. The DM stated she was unable	F 812	Employees changed the oil and cleaned the deep fryer. Maintenance Director will have the tile floor in the dish room repaired by May 5, 2021. 2.Facility acknowledges that residents receiving meals from the kitchen have the potential to be affected by kitchen not being maintained in accordance with food service safety. On April 19, 2021 the Dietary Manager completed an audit of kitchen equipment to ensure it was clean and in good repair. Equipment found to be in need of cleaning was cleaned by Dietary employees. 3.On April 21, 2021 Dietary Manager will receive education from Regional Dietician regarding maintaining the kitchen in accordance with food service safety to include cleaning the hood exhaust and deep fryer as well as keeping the tile on the floor repaired. The Dietary Manager educated the kitchen employees on March 24, 2019 and again on April 19, 2021 regarding maintaining the kitchen in accordance with food service safety to include cleaning the hood exhaust and deep fryer as well as keeping the tile on the floor repaired. Training included placing items in need of repair in facility electronic work order system for Maintenance Director follow up. The Dietary Manager implemented cleaning schedules signed off on by dietary employees and for the exhaust hood and deep fryer weekly and monthly cleaning schedules to be signed off on by dietary employees and turned into her after	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 03/26/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 131 to recall when the deep fryer was last cleaned but it was cleaned on 3/24/21. The DM stated the Maintenance Director finished cleaning the hood filters earlier this morning. She stated kitchen staff utilized a daily cleaning form but the cleaning of the deep fryer was not listed on the form. Review of the daily cleaning forms from 3/1/21 to 3/24/21 revealed the deep fryer was handwritten in the section for the steam table on 3/3/21, 3/10/21, 3/17/21 and 3/24/21. There was only one set of initials for the entire steam table section where the deep fryer was added. The DM was unable to confirm that the deep fryer had been cleaned weekly based on the appearance of it on 3/22/21. In an interview on 3/25/21 at 11:10 AM, the Maintenance Director stated a water pipe burst in kitchen in 2019 and he obtained one estimate dated 12/31/19 then COVID-19 hit and no venders allowed in the facility. He stated as best as he could recall, he cleaned the hood filters approximately 3 months ago but stated he could not find any documentation about it. He confirmed he cleaned the hood filters on 3/24/21. In an interview on 3/26/21 at 2:30 PM, the Administrator and Director of Nursing stated it was important for the kitchen floor in be good repair and safe for the staff. They stated it was their expectation that the stove hood filters be grease and debris free, cleaned monthly and the deep fryer be cleaned and the oil changed at least weekly.	F 812	completion of cleaning task 4.The Dietary Manager will audit kitchen exhaust hood and deep fryer for cleanliness as well as kitchen floor for repair needs weekly for four weeks then monthly for three months. Results of audit will be brought to facility QAPI committee monthly for three months. 5.May 5, 2021	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/5/21

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F 880	Continued From page 132 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 133 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to use hand hygiene after incontinence care and touched other surfaces in the resident ' s room with dirty, gloved hands for 1 of 1 resident observed (Resident #41). Findings included: An observation was done of Resident #41 on 3/22/2021 at 10:10 am of incontinence care by Nursing Assistant #1 (NA). The resident had a bowel movement and was cleaned by NA #1 who	F 880	1)Nursing assistant (NA)#1 was Re-educated on hand hygiene (washing/hand sanitizer before and after providing incontinence care and removal of soiled gloves prior to touching clean surface) was completed on April 19, 2021 by the Facility Administrator. 2)An audit was conducted starting April 19, 2021 by the Administrative Team (Financial Counselor, Housekeeping	

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F 880	Continued From page 134 wore gloves and used disposable wipes. After the care was completed, NA #1 bagged the garbage with the soiled gloves from incontinence care and proceeded to place items in the resident ' s bedside table, touch the resident ' s bed and bed control, and walk to the door to exit and touch the doorknob with the same gloves. After disposing the garbage, the NA removed her gloves and used hand sanitizer. On 3/24/2021 at 10:00 am Nurse #2 participated in an interview. Nurse #2 was informed of the observation on 3/22/2021 of incontinence care with Resident #41 and NA #1. Nurse #2 stated that all staff are required to perform hand hygiene after all resident contact. Nurse #2 commented that she would remind the NA. NA #1 participated in an interview on 3/24/2021 at 11:20 am. NA #1 was informed of the incident on 3/22/21 (NA was not available before this time) of incontinence care for Resident #41 and commented that she forgot. NA #1 also commented that Nurse #2 reminded her. On 3/26/2021 at 10:30 am the Director of Nursing was informed of the infection control observation on 3/22/2021 with NA #1. The DON stated that all staff were required to follow the facility infection control policy (hand hygiene after each resident contact).	F 880	Supervisor, Medical Records Coordinator, Maintenance Director, Human Resources, Admissions Director, and Social Worker) on all hallways and shifts observing incontinence care and hand hygiene. Nursing assistants not performing hand hygiene following incontinence care properly were immediately educated on proper hand hygiene. 3)The Infection Preventionist and/or Nurse Manager will complete hand hygiene audits daily (until the quality assurance and performance improvement committee decrease to weekly) to include hand washing and hand sanitizer usage of ten employees per day " The Infection Preventionist and/or Nurse Manager will complete in-service to clinical nursing staff including licensed practical nurses, registered nurses and nursing assistants on proper hand hygiene before and after incontinence care will be completed by April 23, 2021. Any staff not receiving the in-service due to Leave of Absence and schedule time will receive the in-service before the next schedule shift. Education will be added to new hire orientation conducted by the Infection Preventionist or Nurse Manager. "The Administrator and/or Infection Preventionist has provided the videos(provided by the CDC/CMS) to all staff including but not limited to clinical nursing staff, dietary, maintenance, housekeeping, MDS, Social service, finance department, and admission on hand hygiene/ infection prevention. These videos provided by the CDC/CMS will be completed by May 5,	

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F 880	Continued From page 135	F 880	2021. Any staff not receiving the in-service due to Leave of Absence and schedule time will receive the in-service before the next schedule shift. Education will be added to new hire orientation conducted by the Clinical Competency Coordinator. 4)Administrator and the Infection Preventionist/Nurse Manager will review finding from the hand washing / hand sanitizer audits performed and bring results to the monthly Quality Assurance and Performance Improvement committee for further recommendations as needed until compliance is maintained for three consecutive months then quarterly thereafter. 5)May 5, 2021	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		5/5/21

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F 883	Continued From page 136 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883		

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F 883	Continued From page 137 Based on record reviews and staff interviews, the facility failed to assess residents for eligibility of the pneumococcal vaccine and ensure residents were offered the pneumococcal vaccine for 3 of 5 residents reviewed for immunization (Residents #34, #62 and #63). The findings included: The facility's pneumococcal vaccine policy and procedure dated 8/28/19 was reviewed. The policy stated, in part, to vaccinate all residents against pneumococcal disease unless refused or contraindicated. The facility policy further stated that at the time of admission every effort would be made to obtain documentation of the date of prior pneumococcal vaccinations and would be entered into the clinical record. 1) Resident #34 was originally admitted to the facility on 2/28/19 with a recent readmission date of 5/1/19. Her diagnoses included vascular dementia, coronary artery disease, type 2 diabetes, and chronic obstructive pulmonary disease (COPD). Review of the annual Minimum Data Set (MDS) assessment dated 1/9/21 indicated Resident #34 had severe cognitive impairment. The Pneumococcal vaccine questions were not answered if the vaccination was up to date or if the vaccine was refused the reason why. A review of Resident #34's medical record revealed there were no records in the Electronic Medical Record (EMR) system to indicate whether Resident #34's responsible party (RP) had received education regarding the benefits and the potential side effects of the	F 883	1.Records of Resident #34 received pneumococcal vaccine on March 25, 2021 and resident electronic medical records was updated to reflect this. Resident #62□s electronic medical record was updated by Infection Preventionist on March 25, 2021 showing pneumococcal vaccine was given in the facility on January 27, 2017. Resident #63□s electronic medical record was updated by Infection Preventionist on March 25, 2021 showing pneumococcal vaccine was given in the facility on December 13, 2016. 2.Residents eligible for the pneumococcal vaccine have the potential to be affected. Director of Health Services and/or RN MDS Coordinators conducted an audit on April 19, 2021 or residents assessed to be eligible for pneumococcal vaccine to ensure residents were offered and received the vaccine if they requested it. All eligible residents were offered the vaccine and received it if desired. 3.Regional Senior Nurse consultant educated Director of Health Services regarding offering eligible residents pneumococcal vaccine and documenting residents response to the offer in the medical record. Director of Health Services and RN MDS Coordinators educated Charge Nurses on offering eligible residents the pneumococcal vaccine and documenting response to the offer in the resident medical record. 4.Director of Health Services and/or RN	

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F 883	Continued From page 138 pneumococcal vaccine. In addition, there was no documentation to indicate whether Resident #34 received or refused the pneumococcal vaccines. An interview occurred with the facility Infection Control Preventionist (ICP) on 3/25/21 at 10:16 AM. She explained at the time of admission a discussion occurred with the RP/family to determine if the pneumococcal vaccine had already been received. The ICP produced a hard copy of a Pneumococcal Vaccine Consent/Refusal form for Resident #34 dated 2/28/19. The form was marked refusal and "has taken- up to date" handwritten next to the refusal area. There was no indication on the form which pneumococcal vaccine had been received or the date and was signed by the resident. The ICP further stated she failed to obtain dates of the vaccines when she spoke with Resident #34, follow up with the family/RP nor did she attempt to obtain immunization information from the previous provider. An interview was conducted with the Administrator on 3/26/21 at 2:10 PM and indicated it was her expectation that pneumococcal information be obtained on admission, pneumococcal information be placed in the EMR, immunization education be provided and immunizations be administered as stated in their policy after consent was obtained. 2) Resident #62 was originally admitted to the facility on 7/9/19 with a recent readmission date of 12/5/19. His diagnoses included vascular dementia, chronic kidney disease and anemia. Review of the quarterly Minimum Data Set (MDS) assessment dated 3/8/21 indicated Resident #62	F 883	MDS Coordinators will conduct an audit of residents eligible to receive the pneumococcal vaccine to ensure they are offered vaccine and response to offer is documented in the medical record weekly for four weeks then monthly for three months. Results of the audit will be reported in facility QAPI committee meeting monthly for three months 5.May 5, 2021	

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F 883	Continued From page 139 had cognitive impairment. The Pneumococcal Vaccine was marked as up to date. A review of Resident #62's medical record revealed there were no records in the Electronic Medical Record (EMR) system to indicate whether Resident #62's responsible party (RP) had received education regarding the benefits and the potential side effects of the pneumococcal vaccine. In addition, there was no documentation to indicate whether Resident #62 received or refused the pneumococcal vaccines. An interview occurred with the facility Infection Control Preventionist (ICP) on 3/25/21 at 10:16 AM. She explained at the time of admission a discussion occurred with the RP/family to determine if the pneumococcal vaccine had already been received. The ICP produced a hard copy of a Pneumococcal Vaccine Consent/Refusal form for Resident #62 dated 7/9/19. The form was marked refusal and "has taken- up to date" handwritten next to the refusal area. There was no indication on the form which pneumococcal vaccine had been received or the date. The ICP further stated she failed to obtain dates of the vaccines when she spoke with Resident #62 and his RP, nor did she attempt to obtain immunization information from the previous provider. An interview was conducted with the Administrator on 3/26/21 at 2:10 PM and indicated it was her expectation, pneumococcal information be obtained on admission, pneumococcal information be placed in the EMR, immunization education be provided and immunizations be administered as stated in their policy after consent was obtained.	F 883		

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F 883	Continued From page 140	F 883		

3) Resident #63 was originally admitted to the facility 3/25/19 with a recent readmission date of 2/19/21. Her diagnoses included a history of a stroke, emphysema, and anxiety.

Review of a Significant Change in Assessment MDS dated 2/25/21 indicated Resident #63 had severe cognitive impairment. The Pneumococcal Vaccine was marked as up to date.

A review of Resident #63's medical record revealed there were no records in the Electronic Medical Record (EMR) system to indicate whether Resident #63's responsible party (RP) had received education regarding the benefits and the potential side effects of the pneumococcal vaccine. In addition, there was no documentation to indicate whether Resident #63 received or refused the pneumococcal vaccines.

An interview occurred with the facility Infection Control Preventionist (ICP) on 3/25/21 at 10:16 AM. She explained at the time of admission a discussion occurred with the RP/family to determine if the pneumococcal vaccine had already been received. The ICP produced a hard copy of a Pneumococcal Vaccine Consent/Refusal form for Resident #63 dated 3/25/19. The form was marked refusal and "has taken- up to date" handwritten next to the refusal area. There was no indication on the form which pneumococcal vaccine had been received or the date. The ICP further stated she failed to obtain dates of the vaccines when she spoke with Resident #63's RP, nor did she attempt to obtain immunization information from the previous provider.

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F 883	Continued From page 141 An interview was conducted with the Administrator on 3/26/21 at 2:10 PM and indicated it was her expectation, pneumococcal information be obtained on admission, pneumococcal information be placed in the EMR, immunization education be provided and immunizations be administered as stated in their policy after consent was obtained.	F 883		