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 08/31/2022

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/21/22 through 8/24/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 8S9811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/21/22 through 8/24/22. Event ID# 8S9811. 2 of the 7 complaint allegations were substantiated resulting in deficiencies. The following intakes were investigated NC00188399 and NC00189964. Additional informatin was obtained on 8/30/22 and 8/31/22. Therefore, the exit date was changed to 8/31/22. The Statement of Deficiencies was amended on 9/8/22 at tag F641. Resident identifiers were updated in the practice statement. The Statement of Deficiencies was amended on 9/9/22 at tag F641. Practice statement universe was amended, an example was removed, and scope and severity was changed from an E to a D.	F 000		
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.	F 584		9/20/22

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

Electronically Signed | 09/16/2022

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 08/31/2022

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 584	Continued From page 1 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 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, resident and staff interviews and record review, the facility failed to ensure a resident room was free of urine odors	F 584	This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing	

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 08/31/2022

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 584	Continued From page 2 (Room #115) and resident rooms were clean and in good repair (Room #'s 115, 107, 113, 117, 108, 110, 114, 116 and 127). The facility also failed to clean the Packaged Terminal Air Conditioner (PTAC) and ensure the filters were in place (Room #104). This was for 10 of 16 rooms reviewed for safe and clean environment. The findings included: 1. Resident #16 was admitted on 4/13/22 into room #115. Review of her quarterly Minimum Data Set dated 7/11/22 indicated she was cognitively intact. An observation and interview was completed on 8/21/22 at 3:25 PM with Resident #16. She was in her room sitting up in her wheelchair. There was a small area of the floor visible big enough for her wheelchair with a path to her bed. There was a pungent odor noted that smelled like urine but it was unclear if the odor emanating from the resident or the room. She stated the Administrator discussed the need to routinely clean her room sometime back and she agreed to let the Housekeepers (HKs) clean her room as long as they did not to touch or move any of her personal items. An observation was completed of Resident #16's room on 8/22/22 at 3:20 PM. It was unchanged from the previous observation with the same odor noted on 8/21/22. The small area visible on the floor where her wheelchair was sitting yesterday appeared to have what looked like spills that had dried, become dark in color and sticky. The strong smell of urine was again noted. Her bed was unmade but the sheets did not appear to have spills, stains or urine stains.	F 584	compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the centers allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated. Corrective Action for the residents affected On 08/23/2022, the PTAC filters were replace by the Maintenance Director in room 104 and room 115 was deep cleaned by Housekeeping. For rooms, 107, 108, 110, 113, 114, 115, 116, 117, 127, the Maintenance Director and Housekeeping Supervisor assessed, and repairs completed 09/11/2022. Corrective action for residents potentially affected All residents have potential to be affected. On 09/12/2022, the Housekeeping Manager assessed occupied rooms for repairs needed, including cleaning of PTACs in each room and assessing for odors. A list was made of repairs needed in rooms, 102, 103, 104, 105. 106, 107, 108, 109, 110, 111, 112, 114, 115, 116, 117, 124, and 127. Repairs were made to these rooms by the Maintenance Director, Housekeeping Supervisor and Administrator in training and completed. Systemic Changes	

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 08/31/2022

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 584	Continued From page 3 An interview was conducted on 8/23/22 at 8:10 AM with the Administrator. She stated she and the Housekeeping Supervisor spoke with Resident #16 last month about the concerns related to the smell of urine in her room. The Administrator stated the HK Supervisor also tried to convince her to allow her room to be deep cleaned but Resident #16 refused. An observation was completed of Resident #16's room on 8/23/22 at 9:25 AM. It was unchanged from the previous observations. An interview was completed on 8/23/22 at 9:40 AM with HK #1. She stated she had worked at the facility for 13 years and was familiar with Resident #16. She stated Resident #16's room had a very strong smell of "old" urine. HK #1 stated Resident #16 allowed them to clean the bathroom but would not let them to clean her area of the room where the urine smell was very strong. She stated she was not aware of any occasion that Resident #16's room had been deep cleaned or thoroughly routinely cleaned. An interview was completed on 8/23/22 at 9:47 AM with the HK Supervisor. She stated sometime in July 2022, she and the Administrator met with Resident #16 about allowing her staff to deep clean or at least move some items in order to properly clean her room and surfaces but she refused stating the HK staff could clean around her personal items. The HK Supervisor stated she was aware of the strong urine smell on her side of the room but there was nothing the facility could do about it. An interview was completed on 8/23/22 at 9: 50	F 584	On 08/30/2022, the Administrator in-serviced IDT on compliance rounds to include but not limited to identifying any concerns of resident□s rooms becoming cluttered, unsafe or repairs needed. Resident□s rooms will be monitored by Interdisciplinary team (IDT) to include but not limited to social worker, Activities Director, Financial Councilor, medical records, Director of Healthcare Service, dietary, housekeeping supervisor, maintenance director, during facility compliance rounds. Concerns to be discussed in morning and or afternoon meetings and action taken to ensure residents rooms are safe, clean, comfortable and a homelike environment. The Administrator and or Administrator in Training (AIT) will monitor 3 residents□ rooms, 3 times a week for 2 weeks, then 3 residents□ rooms weekly, times 4 weeks, then 3 residents□ rooms monthly to ensure their rooms are safe/clean/comfortable and a homelike environment, utilizing the Quality Assurance monitoring tool for safe/clean/comfortable/homelike environment. Any concerns will be identified, and corrections made. Quality Assurance The results of these reviews to be submitted to the Quality Assurance Performance Improvement Committee by Administrator and or AIT and reviewed by	

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 08/31/2022

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 584	Continued From page 4 AM with HK #2. She stated Resident #16 would not allow the HK staff to properly clean her room to eliminate the urine smell but she refuses. She stated they were only allowed to clean around her personal items but the urine smell was also thought to be in her clothes and some of her personal items. HK #2 further stated Resident #16's room had not been deep cleaned since she was admitted back in April 2022. An interview was completed on 8/23/22 at 10:45 AM, Nursing Assistant (NA) #5. She stated Resident #16 was noncompliant with allowing the staff to assist her with her activities of daily living (ADLs) stated she would do it herself. NA #5 stated the urine smell on her side of the room was so bad that it was difficult to go into the room to assist her roommate with her ADLs. An interview was completed on 8/24/22 at 2:27 PM with the Administrator. She stated all resident rooms including room 115 where Resident #16 resided, were to be free of urine odors. 2a. On 8/22/22 at 2:30 PM, the following were observed on A hall: - In room 107, there were several areas of missing baseboards at the corners of the wall and between the closet, with sheetrock exposed. - In room 113, several areas of missing baseboard to the corners of the wall and to the wall between the closet, with sheetrock exposed. - In room 115, three areas of peeling wall next to bed A. - In room 117, 4 tiles had come off from the wall behind the toilet, exposing wood. The Maintenance Director was interviewed on 8/22/22 at 2:40 PM and observed the damaged wall, missing baseboards and tiles. He stated	F 584	the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. Date of Compliance: September 20, 2022	

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 08/31/2022

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 584	Continued From page 5	F 584		

administration was aware the rooms needed repair and there were plans in place for these repairs.

On 8/23/22 at 2:10 PM, the Administrator was interviewed and stated renovations had started 6 weeks ago on the D hall and had plans to repair the remaining rooms on A, B, and C halls but it was taking longer to find a less expensive vendor/contractor.

Nurse #1 was interviewed on 8/23/22 at 3:30 PM and stated the condition of the rooms on A hall were the same (damaged walls, missing/peeling baseboards, missing floor tiles) since she started working at the facility in May of 2022. She reported management was aware of this.

The Administrator provided an action plan on 8/23/22 which was reviewed. The action plan identified the missing tiles from resident rooms and resident rooms needed painting and new baseboards. The plan did not have dates as to when the repairs would start on the residents' rooms occupied on A hall.

2b. On 8/22/22 at 4:20 PM, an observation of Room 104's Packaged Terminal Air Conditioner (PTAC) unit revealed there were 2 missing filters and black scattered areas on the air vent slats.

The Housekeeping Director was interviewed on 8/23/22 at 10:06 AM, who stated housekeeping staff only cleaned the outside of the PTAC units with a rag and did not change or replace filters. She stated she was aware of room 104 having black spots on the window curtains, window moldings and PTAC vent slats earlier this month

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 08/31/2022

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 584	Continued From page 6	F 584		

(August 2022) and had cleaned the window curtains and moldings but left the PTAC vent cleaning to the maintenance department to complete.

On 8/23/22 at 11:00 AM, an observation was made of room 104 where the Housekeeping Director was seen cleaning the PTAC unit and vent slats with a rag and brush. She confirmed there had been blackened areas to the vent slats, which was removed with the brush. There was also two filters in place as well. The housekeeping director stated the filters were present when she came in to clean the PTAC unit.

The Maintenance Director was interviewed on 8/23/22 at 12:35 PM who stated he had been employed at the facility since June 2022. The Maintenance Director stated he observed the filters to the PTAC were not present during his morning rounds on 8/23/22 and replaced them. He was unable to state how long the filters had not been in place or the reason why. In addition, the Maintenance Director explained the housekeeping department was responsible for cleaning the PTAC unit to include the vent slats and he would continue the maintenance portion of the machines.

The Administrator was interviewed on 8/23/22 at 2:10 PM and explained it was the responsibility of the housekeeping department to clean the PTAC filters as well as the outer part and vent slats. Anything that required the cover coming off would be the responsibility of the Maintenance department. She was unaware the filters were missing from the PTAC in room 104 but would have expected housekeeping staff to verify 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 08/31/2022

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 584	Continued From page 7	F 584		

filters were present and clean as well as the vent slats free from any debris when the rooms were cleaned daily.
3. On 8/21/22 at 1:35 PM, the following were observed:

- In room 127, the wallpaper approximately 2 feet was observed peeling off the wall behind and adjacent to the B bed and the baseboard was peeling from the wall in the resident's room.
- Three ceiling vents on the hallway of B hall were observed to have black matter around them.

On 8/22/22 at 2:30 PM, the following were observed:

- In room 127, the wallpaper and the baseboard were of same condition, peeling off the wall.
- The 3 ceiling vents still with black matter around them.
- In room 116, the baseboards were missing from the wall near the bathroom and the closet.
- In room 108, the baseboard was off the wall in the bathroom.
- In room 110, the baseboard was missing in the room.
- In room 114, 2 floor tiles were missing and the area where the tiles were missing was black and the remainder of the floor was white tile.

On 8/22/22 at 2:40 PM, the Maintenance Director was interviewed. He observed the wallpaper and the baseboards off the wall and the missing floor tiles and stated that the administration was aware of the rooms needed repair. The Maintenance Director stated the Administrator had the plans for these repairs. He also stated that the black matter on the ceiling vents was dusts from the roof and it needed to be cleaned.

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 08/31/2022

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 584	Continued From page 8	F 584		

On 8/23/22 at 2:10 PM, the Administrator was interviewed. She stated that they had started the repair on D hall, and she already had plans to repair the rooms on A, B and C halls but it was taking a long time to find a less expensive vendor/contractor.

On 8/23/22 at 3:20 PM, the Housekeeping Supervisor was interviewed. She observed the ceiling vents and stated that the black matter was dusts from the roof. She indicated that the vents were wet from the moisture and dust collected around them. She reported that the housekeepers had not been on this hall much since there was only 1 resident. The Housekeeping Supervisor was observed to brush the ceiling and the vents, and she was able to remove the black matter.

On 8/23/22 at 3:30 PM, Nurse #1 was interviewed. She stated that the condition of the rooms on A and B halls were the same (peeling wallpaper, missing/peeling baseboards, missing floor tiles) since she started working at the facility in May of 2022. She reported the management was aware of it.

The action plan provided by the Administrator was reviewed on 8/23/22. The action plan identified the tiles missing from resident's rooms and the resident's rooms needed painting and cove base. The plan did not have dates as to when the repairs would start on the residents' occupied rooms on A and B halls. The plan indicated that the floor tiles were ordered and will be replaced by the Maintenance Director.

On 8/24/22 at 2:42 PM, the Administrator 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 08/31/2022

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 584	Continued From page 9 interviewed. She stated that she was aware that residents' rooms needed repairs and they were looking for a less expensive vendor/contractor.	F 584		
F 585 SS=B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 585		9/20/22

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 08/31/2022

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 585	Continued From page 10	F 585		

grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance,

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 08/31/2022

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 585	Continued From page 11 the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family and staff interviews, the facility failed to provide a written grievance response summary for 2 of 2 residents reviewed for grievances (Residents #22 and #4). The findings included: A review of the facility grievance policy dated 3/25/19, included, in part, "the Administrator or designee will be responsible for follow-up with the patient, authorized individual or other representative to determine the grievance has been resolved and to ensure the grievance process is understood. A copy of the completed grievance form, if requested, may be given to the complainant."	F 585	Corrective Action for the Resident Affected On 08/29/2022, Residents 22 and 4 were given a copy of their grievance resolutions by the Administrator in Training (AIT). Corrective Action for the Residents Potentially Affected\ All residents have the potential to be affected. On 09/13/2022, the Administrator reviewed grievances over the last 3 months, going back to May 2022. Of the 6 grievances reviewed, 3 grievances were copied, and hand delivered to the resident filing the grievance.	

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 08/31/2022

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 585	Continued From page 12 1. Resident #22 was admitted to the facility on 2/1/21. A quarterly Minimum Data Set (MDS) assessment dated 7/22/22 indicated she was cognitively intact. Review of the facility grievance logs from April 2022 through August 2022 indicated 4 grievance forms were initiated by Resident #22: - On 5/27/22 a grievance form was initiated regarding food. The form indicated the Dietary Manager spoke with Resident #22 on 5/30/22 and was signed by the Administrator In-Training (AIT) and Administrator on 5/31/22. There was no indication a written summary was offered, requested, or provided. - Another grievance form dated 5/27/22. The form indicated the Activities Director spoke with Resident #22 on 5/31/22 and was signed by the Administrator and AIT on 5/31/22. There was no indication a written response was offered, requested, or provided. - On 6/27/22 a grievance form was initiated regarding the hand sanitizer. The form indicated the Housekeeping Director spoke with Resident #22 on 6/28/22 and was signed by the Administrator on 6/28/22. There was no indication a written response was offered, requested, or provided. - On 8/9/22 a grievance form was initiated regarding environmental concerns. The form indicated the Housekeeping Director investigated the claims on 8/9/22, cleaned the areas, and spoke with Resident #22 regarding the resolution. The Administrator signed the grievance form on 8/10/22. There was no indication a written response was offered, requested, or provided. On 8/23/22 at 11:10 AM, an interview occurred with Resident #22, who stated she had received	F 585	Systemic Changes On 08/29/2022, the Administrator added verbiage to the grievance form, noting a copy was given to the person filing the grievance. On 08/30/2022, the Administrator in-serviced the Interdisciplinary team (IDT) to include but not limited to social worker, Activities Director, Financial Councilor, medical records, Director Healthcare service, dietary, Housekeeping supervise, maintenance director, on the grievances process and the grievance/compliant form. The in-service included the process of completion of the grievance and giving a copy of the grievance form to the person filing the grievance. On 09/10/2022, the Assistant Director of Health Care Services in-serviced all staff including but not limited to licensed nurses, nursing assistants, dietary, housekeeping, and maintenance on the grievance process and the grievance/complaint form. The in-service included the process of completion of the grievance and giving a copy of the grievance form to the person filing the grievance. Any new hires will receive training during orientation on grievance process and staff currently on FMLA will receive training upon their next scheduled shift. Quality Assurance (QA)	

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 08/31/2022

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 585	Continued From page 13 verbal resolution of her past grievance concerns but had not been offered or provided a summary in writing. The Administrator and AIT were interviewed together on 8/23/22 at 11:20 AM. The AIT stated he maintained the facility grievance log and made sure the staff responsible for investigating the concern completed the form completely. They both stated they thought a written response was only needed when requested. The Administrator added it was her expectation for the facility to adhere to the regulatory guidance regarding written grievance response summaries. 2. The facility's grievance policy dated 3/25/2019 stated the facility's Administrator or designee would be responsible for following up with the resident or resident representative to determine the grievance had been resolved and to ensure the grievance process was understood. A copy of the completed grievance may be given to the complainant. Resident #4 was admitted on 11/19/2020. Resident #4's quarterly Minimum Data Set (MDS) dated 5/10/2022 indicated the resident had moderately impaired cognition. The grievance log for July 2022 revealed a complaint by Resident #4's Responsible Party (RP) dated 7/25/2022. The grievance summary indicated the DON investigated the concerns. The grievance was signed by the DON and the Administrator and dated 7/25/2022. The grievance was not signed by the RP, nor did it indicate if the RP was satisfied with the resolution.	F 585	The Administrator, Administrator-in-training (AIT), and or the Director of Social Services will randomly select 3 completed grievances weekly times 6 weeks, then monthly utilizing the QA Monitoring Tool for grievances, to ensure that a copy has been given to the resident and or person filing the grievance. Any concerns to be addressed during the monitoring process. The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Director of Social Services for review by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: September 20, 2022	

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 08/31/2022

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 585	Continued From page 14 On 8/23/2022 at 11:47 AM an interview was conducted with the resident's RP. He stated he voiced the grievance to the DON. The RP stated there was no follow up after that discussion. He further stated the Administrator in Training (AIT) spoke to him the following day about the grievance. The AIT stated he had spoken to staff and addressed the RP's concerns. The RP stated he did not get a written notice of resolution, nor was he offered a copy of the written resolution. On 8/23/2022 at 11:20 AM an interview was conducted with the Administrator and the AIT. The AIT stated he was responsible for maintain the grievance log and assigning staff to investigate the concerns. The Administrator and the AIT stated they were not aware a written response to a grievance was required.	F 585		
F 641 SS=D	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 reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of medication (Resident #1), nutrition (Residents #18 & #1), and cognition, mood and pain (Resident #29) for 3 of 15 residents reviewed. The findings included: 1. Resident #18 was admitted on 3/22/2022 with diagnoses that included dysphagia (difficulty with swallowing).	F 641	Facility failed to accurately code the Minimum Data Set (MDS) assessment for 4 of 15 residents whose MDS assessments were reviewed. Medication (Resident #1). Resident #1 MDS ARD 8/6/2022 was modified for coding accuracy on Section N0450 A, B, C on 9/1/2022Nutrition (Resident #18 & #1). Resident #18 MDS ARD 7/20/2022 was modified for coding accuracy on section K0200 B and K0300 on 9/1/2022Resident #1 MDS 8/6/2022 was modified for	9/20/22

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 08/31/2022

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 15 The resident's medical record included a progress note by the Registered Dietician (RD) dated 7/16/2022. The progress note indicated Resident #18 had a June weight of 151.8 pounds (lbs) and a July weight of 144.2 lbs. The RD noted the resident had a significant weight loss of greater than 5% in the previous thirty days. Resident #18's quarterly Minimum Data Set (MDS) dated 7/20/2022 indicated the resident was dependent with meals and had no weight loss during the assessment period. On 8/24/2022 at 11:09 AM an interview was conducted with the Corporate MDS nurse. She stated the RD noted weight loss on 7/16/2022 therefore, the 7/20/2022 MDS should have been coded for weight loss. An interview was conducted with the Administrator and Director of Nursing on 8/24/2022 at 3:00 PM. The Administrator stated she expected MDS assessments to be coded accurately. 2. Resident # 1 was admitted to the facility on 5/7/20 with multiple diagnosis including major depressive disorder and end stage renal disease (ESRD). a. Resident #1 had a doctor's order dated 11/7/21 for Abilify (an antipsychotic drug) 15 milligrams (mgs) by mouth daily for major depressive disorder. On 2/1/22, Abilify was decreased to 12 mgs daily and on 3/7/22, Abilify was increased back to 15 mgs daily. The order indicated that a gradual dose reduction (GDR) had been attempted for the Abilify on 2/1/22.	F 641	accuracy on Section K0200 B om 9/1/2022. Cognition, Mood, and Pain (Resident # 29). Resident # 29 MDS ARD will not be modified as they cited sections are interview item sets. A new ARD has been set for 9/12/2022 and completed by Clinical Reimbursement Consultant (CRC) on 9/16/22. Any assessment noted to be inaccurate will be modified for accuracy. Review was completed by Clinical Reimbursement Consultant on 9/16/22. There were 30 MDS reviewed with 3 in nutrition, 1 in medication and 0 in cognition, mood & pain needed modification which were completed by 9/16/22. The facility has reviewed its MDS Assessment Accuracy Policy with no revisions needed. Clinical Reimbursement Consultant or designee provided education to the PRN Case Mix nurses, the Therapy Coordinator, Social Worker, Activity Director, on the MDS coding accuracy by 9/20/22. The Administrator is responsible for the Plan of Correction implementation. The Quality Assurance (QA) Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: Director of Health Services and/or designee will review the accuracy of 3 assessments per week x4 weeks and then x 5 assessments per month x3 months. Results from monitoring listed will be presented by the Administrator and/or Director of Health	

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 08/31/2022

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 16 Resident #1's quarterly Minimum Data Set (MDS) assessment dated 8/6/22 indicated that Resident #1 had received an antipsychotic drug for 7 days during the assessment period and a gradual dose reduction (GDR) had not been attempted. b. Resident #1's weights were reviewed and revealed that on 8/4/22, he weighed 415 pounds (lbs.) Resident #1's quarterly Minimum Data Set (MDS) assessment dated 8/6/22 indicated that Resident #1's weight was 404 lbs. The Corporate MDS Nurse was interviewed on 8/24/22 at 10:50 AM. She reported that the facility did not have a full time MDS Nurse. She stated that the MDS Nurses from other sister facilities were helping complete the MDS at this facility by coming onsite and at times remotely. The Corporate MDS Nurse reviewed Resident #1's doctor's orders, resident's weights and the quarterly MDS assessment dated 8/6/22. She had verified that a GDR had been attempted for the Abilify and the resident's weight was 415 lbs. during the assessment period. She stated that the MDS dated 8/6/22 was coded incorrectly under the medications (GDR) and the nutritional status (weight). The Administrator was interviewed on 8/24/22 at 2:42 PM. She stated that the facility did not have a full time MDS Nurse, and they were trying to recruit one. She indicated that the Corporate MDS Nurse had been helping them in completing their MDS in a timely manner and she expected the MDS to be coded accurately.	F 641	Services to the QA monthly x3 months or until compliance. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Date of compliance: September 20, 2022	

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 08/31/2022

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 17	F 641		

3. Resident #29 was admitted to the facility on 3/20/19.

Review of the quarterly MDS assessment dated 7/5/22 revealed that Resident #29 had adequate hearing, clear speech and usually able to make self- understood and able to understand others. Sections C (cognitive patterns), D (mood) and J (health conditions) of the assessment were blank. Section C indicated that brief interview for mental status should be conducted with the resident however, CO 200 (repetition of three words), CO 300 (temporal orientation), CO 400 (recall) and CO 500 (summary score) were blank. Section D also indicated that mood interview should be conducted with the resident however, DO 200 (symptoms presence) and DO 300 (total severity score) were blank. Section D indicated that pain assessment interview should be conducted with the resident, however JO 300 (pain presence), JO 400 (pain frequency), JO 500 (pain effect on function), and JO 600 (pain intensity) were blank.

The Corporate MDS Nurse was interviewed on 8/24/22 at 10:50 AM. She reported that the facility did not have a full time MDS Nurse. She stated that the MDS Nurses from other sister facilities were helping complete the MDS at this facility by coming onsite and at times remotely. The Corporate MDS Nurse reported that since the quarterly MDS assessment dated 7/5/22 was completed after the assessment reference (ARD) date, the interview could not be completed. She stated that the resident interview for the cognitive status, mood and pain should have been completed before or on ARD date, but it was not.

The Administrator was interviewed on 8/24/22 at 2:42 PM. She stated that the facility did not have

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 08/31/2022

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 18 a full time MDS Nurse, and they were trying to recruit one. She indicated that the Corporate MDS Nurse had been helping them in completing their MDS in a timely manner and she expected the MDS assessment completed as required.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		9/20/22

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 08/31/2022

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 656	Continued From page 19 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to comprehensively care plan a resident (Resident #17) for refusals of activities of daily living (ADLs). This was for 1 of 15 reviewed for comprehensive care planning. The findings included: Resident #17 was admitted 3/18/19. Review of Resident #17's quarterly Minimum Data Set (MDS) dated 7/5/22 indicated he was cognitively intact. Review of Resident #17's comprehensive care plan indicated it was last revised on 8/19/22. He was care planned for assistance with his ADLs on 5/24/22. Interventions included shower and nail care every Monday, Wednesday and Fridays. There was no care plan for refusals of ADL assistance. Review of Resident #17's nurses notes revealed he refused his shower on 7/22/22 and 8/6/22. On both occasions, he was given a bed bath and shaved. There was no mention of nail care An interview was completed on 8/23/22 at 10:40	F 656	Facility failed to develop a comprehensive care plan for 1 of 15 residents reviewed for comprehensive care plans. No refusal of ADL assistance care plan (Resident #17). Resident # 17 comprehensive care plan has been reviewed and revised by the Clinical Competency Coordinator completed on 9/10/2022. A refusal of ADL care assistance care plan was added to the comprehensive care plan on 9/10/2022. The facility will conduct a review of all current residents comprehensive care plans to ensure resident care needs are identified and plan of care with measurable goals and interventions are in place. Review was completed by Director of Healthcare Service (DHS) & Assistant Director of Healthcare Service (ADHS) on 9/16/22 with 12 residents noted having ADL refusals. Out of the 12 residents, there were 2 care plans corrected on 9/16 to reflect resident ADL refusals. The facility has reviewed its 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 08/31/2022

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 656	Continued From page 20 AM, with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON). Both stated Resident #17 was known to refuse his ADLs to include showers and nail care. An interview was completed on 8/23/22 at 10:45 AM, Nursing Assistant (NA) #5. She stated Resident #17 was known to refuse his showers and nail care. An interview was completed on 8/24/22 at 11:10 AM with the Corporate MDS Nurse. She stated the comprehensive care plan last revised on 8/19/22 should have included Resident #17's refusals of his ADLs. She stated the facility employed an as needed (prn) MDS Nurse and she along with MDS Nurse's from other facilities had been assisting with the completion of the care plans and it was likely an oversight. An interview was completed on 8/24/22 at 2:27 PM with the Administrator and the DON. Both stated they expected Resident #17's comprehensive care plan be complete and reflect his ADL refusals.	F 656	policy for clarity with no revisions needed. The Senior Nurse Consultant provided education to the Interdisciplinary team (IDT) to include but not limited to social worker, Activities Director, Director Healthcare service, and dietary on care plan completion per policy on 9/16/22. All new hired IDT members will receive the education on care plan during orientation. Any IDT or licensed nurse on FMLA will receive in serviced prior to return scheduled shift. The Administrator is responsible for the Plan of Correction implementation. The Quality Assurance (QA) Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: Director of Health Services and/or nurse Managers/ and or designee will review 3 residents comprehensive care plans weekly x4 weeks, and then 2 residents comprehensive care plans monthly x3 months ensuring development and completion of the comprehensive care plans. Results will be presented by the Administrator and/designee to the QA team monthly x3 months or until compliance is sustained. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Dates of compliance: September 20, 2022	
F 657 SS=D	Care Plan Timing and Revision	F 657		9/20/22

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 08/31/2022

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 657	Continued From page 21 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to review and revise the care plan in the areas of fall interventions (Resident #4), pressure ulcers (Resident #1) and urinary incontinence (Resident #17) for 3 of 15 reviewed for care plan revision. The findings included:	F 657	Corrective Action for the Resident Affected. Fall intervention (Resident#4). Resident # 4 care plan has been reviewed and revised. The fall mat has been removed as an intervention for falls to reflect the status of the resident on 9/1/2022, by 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 08/31/2022

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 657	Continued From page 22 1. Resident #4 was admitted on 11/19/2020 with diagnoses that included right sided weakness secondary to cerebral infarct (stroke). Resident #4's quarterly Minimum Data Set (MDS) dated 5/10/2022 indicated the resident had not had any falls since prior assessment. Resident #4's comprehensive care plan was last revised 8/16/2022 by the Director of Nursing (DON) and included a focus for risk of falls. Interventions included keeping the bed in low position and a fall mat next to the bed when resident was in the bed. On 8/22/2022 at 8:44 AM the resident was observed lying in bed eating breakfast. There was no fall mat next to the resident's bed. The bed was in lowest position. On 8/23/2022 at 10:02 AM the resident was observed lying in bed watching TV. Her bed was in low position but there was no fall mat next to the bed. 08/23/2022 at 11:47 AM an interview was conducted with Resident #4's Responsible Party (RP). The RP stated he visited daily and was typically in the facility for either lunch or dinner. He stated the resident had two falls from her bed, but it was a long time ago. He further stated the facility no longer placed a fall mat next to her bed. On 8/23/2022 at 11:51 AM an interview was conducted with Nurse Assistant (NA) #4 who was assigned to Resident #4. She stated the resident had not had a fall in over a year. She further stated they continue to leave the bed in low	F 657	Resource MDS Coordinator. Pressure Ulcer (Resident #1) Resident #4 care plan has been reviewed and revised. A pressure ulcer to left heel care plan has been resolved to reflect the status of the resident on 9/1/2022, by the Resource MDS Coordinator. Urinary incontinence (Resident #17)- Resident #17 Care plan has been reviewed and revised. An incontinence care plan has been resolved to reflect status of the resident on 9/1/2022, by the Resource MDS Coordinator. Corrected Action for the Residents Potentially Affected: On 9/17/22 the Director of Health Services (DHS) reviewed the care plans for 30 residents, approximately 26 were at risk for falls and their care plans were updated to address the interventions. On 9/18/22 the Assistant Director of Nursing (ADHS) reviewed 30 residents, approximately 7 care plans were revised to address the risk for pressure ulcer. On 9/12/22 the ADHS reviewed 30 residents, approximately 18 residents are incontinent and care plans were updated. Approximately 6 residents had urinary catheters, and all were appropriately care planned. System Changes:	

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 08/31/2022

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 657	Continued From page 23 position when the resident was in bed, but they no longer used a fall mat. On 8/24/2022 at 10:45 an interview was conducted with the DON who stated she was aware Resident #4 did not have a fall mat next to her bed and her care plan interventions included a fall mat. She stated the resident had not had a fall in a long time and a fall mat was no longer being utilized. The care plan should have been updated to reflect the change. 2. Resident #1 was admitted to the facility on 5/7/20 with multiple diagnoses including end stage renal disease (ESRD) and was on hemodialysis. The dietary note dated 6/30/22 indicated that Resident #1's pressure ulcer on the left heel was healed. Resident #1's skin checks and Treatment Administration Records (TARs) from June, July and August 2022 did not indicate that the resident had a pressure ulcer. Review of Resident #1's care plan initiated on 5/19/22 and was reviewed on 8/4/22 was conducted. One of the care plan problems was "resident has a pressure ulcer to left heel". The goal was "resident's ulcer will not increase in size and will not exhibit signs of infection". Resident #1 quarterly Minimum Data Set (MDS) assessment dated 8/6/22 indicated that the resident did not have a pressure ulcer. The Corporate MDS Nurse was interviewed on 8/24/22 at 10:50 AM. She reported that the facility did not have a full time MDS Nurse. She	F 657	The Senior Nurse Consultant provided education to the Interdisciplinary team (IDT) on care plan updates/revision per policy by 9/20/22. The DHS and or nurse managers will provide education to licensed nurses on care plan updates/revision policy on 9/20/22. All new hired Interdisciplinary team member and licensed nurses will receive the education on care plan policy. Any IDT or licensed nurse on FMLA will receive in serviced prior to return scheduled shift. The Administrator is responsible for the Plan of Correction implementation. The Quality Assurance (QA) Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: The DHS and or nurse manager will review 3 resident care plans weekly x4 weeks, and then 3 resident care plans monthly x3 months ensuring all care plan revisions and updates are addressed. Quality Assurance (QA): The analysis of the monitoring will be presented by the Nursing Home Administrator to the QA team monthly. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Date of compliance: September 20, 2022	

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 08/31/2022

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 657	Continued From page 24	F 657		

stated that the MDS Nurses from other sister facilities were helping the facility in developing, reviewing and revising the care plans by coming onsite and at times remotely. The Corporate MDS Nurse reviewed Resident #1's medical records and the quarterly MDS assessment dated 8/6/22. She had verified that Resident #1 did not have a pressure ulcer. She indicated that the care plan for the pressure ulcer should have been resolved when the care plan was reviewed on 8/4/22.

The Administrator was interviewed on 8/24/22 at 2:42 PM. She stated that the facility did not have a full time MDS Nurse, and they were trying to recruit one. She indicated that the Corporate MDS Nurse had been helping them in developing, reviewing and revising the care plans and she expected the care plans to be reviewed and reviewed as indicated.

3. Resident #17 was admitted 3/18/19.

Review of Resident #17's cumulative Physician orders included an order dated 6/30/22 for a indwelling urinary catheter.

Review of Resident #17's quarterly Minimum Data Set (MDS) dated 7/5/22 was coded for the presence of an indwelling urinary catheter and for urinary incontinence.

Resident #17's comprehensive care plan last revised 8/19/22 read he was care planned for urinary incontinence and for an indwelling urinary catheter.

Observations of Resident #17 on 08/21/22 at 1:44 PM, 8/22/22 at 11:00 AM and 8/23/22 at 10:35 AM revealed the presence of an indwelling

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 08/31/2022

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 657	Continued From page 25 urinary catheter. An interview was completed on 8/23/22 at 10:40 AM with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) indicated Resident #17 required the indwelling urinary catheter to aid in wound healing and has had the urinary catheter in place since March 2022. An interview was completed on 8/24/22 at 11:10 AM with the Corporate MDS Nurse. She stated the care plan last revised on 8/19/22 should have been revised to not include the care area of urinary incontinence. She stated the facility employed an as needed (prn) MDS Nurse and she along with MDS Nurse's from other facilities had been assisting with the completion and revision of care plans and it was likely an oversight. An interview was completed on 8/24/22 at 2:27 PM with the Administrator and the DON. Both stated they expected Resident #17's MDS to be care planned only for the presence of his urinary catheter.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to provide incontinence care for a resident (Resident #20) dependent on staff for assistance with his	F 677	Corrective Action for the Resident Affected On 08/23/2022, Residents #20 was given incontinence care by his assigned nursing	9/20/22

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 08/31/2022

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 677	Continued From page 26 activities of daily living (ADLS). This was for 1 of 3 residents reviewed for ADLs. The findings included: Resident #20 was admitted on 8/31/20 with a diagnosis of a Cerebral Vascular Accident. Review of his quarterly Minimum Data Set dated 7/22/22 indicated severe cognitive impairment and total assistance with toileting. He was coded for being incontinent of bladder and bowel. Resident #20 was care planned for ADL assistance on 12/4/20 and last revised on 8/4/22. He was also care planned for urinary incontinence on 9/15/20 and last revied on 8/4/22. Neither care plan included the intervention of staff assistance with his toileting, hygiene and incontinence. An observation and interview was completed on 8/23/22 10:52 AM with Nursing Assistant (NA) #4. She confirmed she was assigned Resident #20 on 8/22/22 and 8/23/22. NA #4 removed Resident #20's old brief and it was noted to be saturated all the way up the back of the brief with urine, appeared color of honey and a strong smell of urine. There was also observed stool in between his buttocks. Observation of the cloth pad positioned underneath Resident #20 was noted to be saturated in the center of the pad extending out to but not to the pad edges. The pad had a strong smell of urine. There was no observed dark circle or dark urine in his brief or the pad. NA #4 stated she last changed Resident #20 around 8:00 AM this morning. She stated she normally provided Resident #20 incontinence care when she arrived in the mornings, then before lunch and after that, whenever she got a chance. NA #4	F 677	assistant. Corrective Action for the Residents Potentially Affected All residents that are incontinent of their bladder have the potential to be affected. On 09/09/2022, the Director of Health Care Services (DHS) and the Assistant Director of Health Care Services (ADHS) reviewed resident□s charts and identified 18 residents with a diagnosis of incontinence. Of the 18 residents, it was determined that 7 residents require increase monitoring for their incontinence needs. Corrections were made in the electronic health record to increase monitoring on the activities of daily living flow sheet. Systemic Changes On 09/08/2022, the DHS and or the Assistant Director of Health Care Services initiated an in-service with the licensed nurses and nursing assistants on incontinent care needs. Any nurse or nurse assistant that did not received the in-service will not work until they have received the in-service. The in-service included how often a resident is to be monitored for incontinent care, as well as monitoring residents that require increased monitoring. This in-service will be a part of the facilities orientation process for training of new licensed and unlicensed partners. Quality Assurance (QA)	

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 08/31/2022

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 677	Continued From page 27 stated Resident #20 was a "heavy wetter" but was unable to explain why she did not increase his incontinence rounds. An interview was completed on 8/24/22 at 2:27 PM with the Director of Nursing (DON) and the Administrator. The DON stated it was her expectation that Resident #20 receive routine incontinence care and if he was known to need more frequent incontinence care, she stated it should be provided more frequently.	F 677	The DHS, ADHS and or Nurse Supervisor will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with a diagnosis of bladder incontinence are assisted with their incontinent needs every two hours or sooner by utilizing the QA monitoring tool for ADL Care. The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS and or ADHS for review by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: September 20, 2022	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		9/20/22

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 08/31/2022

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 690	Continued From page 28 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on hospital record review, facility record review, staff interviews, and interviews with the Physician and Nurse Practitioner, the facility failed to implement STAT (immediate) orders on a resident with a change in condition, delaying medical treatment four hours for 1 of 1 reviewed for urinary tract infections (Resident #31). The findings included: Resident #31 was admitted on 3/3/2021 with diagnoses that included urinary retentions with bladder neck obstruction. Resident #31's quarterly Minimum Data Set (MDS) dated 4/2/2022 indicated the resident was	F 690	Corrective Action for the Resident Affected Residents 31 was discharged to the hospital on 06/02/2022 and did not return. Nurse #3 and Nurse #4 no longer employed at the facility. Corrective Action for the Residents Potentially Affected On 09/09/2022, the Director of Health Care Services (DHS) and the Assistant Director or Health Care Services (ADHS) reviewed STAT (immediate) orders on residents for the past 30 days to ensure	

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 08/31/2022

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 690	Continued From page 29	F 690		

severely cognitively impaired, total dependent upon staff for assistance with activities of daily living and had an indwelling urinary catheter during the assessment period.
The resident's comprehensive care plan was last revised 4/26/2022 and contained a focus for an indwelling urinary catheter related to bladder outlet obstruction. Re-admitted on 4/19/2022 with diagnosis of sepsis, pyelonephritis, nephrolithiasis, and renal failure. Interventions included reporting signs of urinary tract infections.

Facility record review revealed Nurse #3 documented Resident #31 was changed from his baseline mental status at 4:00 AM on 4/3/2022. Nurse #3 made on call provider aware resident had temperature of 104.1. The provider on call gave Nurse #3 verbal order for complete blood count (CBC), comprehensive metabolic panel (CMP), urine analysis with culture and sensitivity, and Rocephin (antibiotic) 2 grams (G) to be given intramuscularly. These were STAT (to be completed immediately) orders.

At 4:19 AM on 4/3/2022 the hospital laboratory called Nurse #3 and stated they could not run the blood samples due to not having a demographic sheet or face sheet for resident #31.

At 4:20 AM Nurse #3 documented she was unable to collect a urine sample via catheter and observed blood on the tip of the urinary catheter when it was removed.

At 4:23 AM Nurse #3 documented she made the on-call provider aware she was unable to obtain a urine sample, the lab was unable to run the blood samples due to no demographic sheet, and she was unable to access the PIXUS system to obtain that there was not a change of condition, delaying medical treatment for 5 residents with Urinary Tract Infections (UTI□s).

Systemic Changes

On 09/09/2022, the DHS and or ADHS initiated an in-service to the Licensed Nurses on implementing STAT (immediate) orders on residents with a change in condition and delaying medical treatment for residents with a UTI. Any staff member that did not received the in-service will not work until they have received the in-service.

On 09/13/2022, the DHS and or ADHS initiated an in-service to the Licensed Nurses on how to print the required documents for labs and how to access the Pixus for access to emergency drugs. Any licensed nurses not available for the in-service, will be educated prior to their next scheduled shift.

The DHS, ADHS and or Nurse Manager will review STAT (immediate) orders for residents in the morning clinical meetings to ensure that orders have been followed in a timely manner and there has been no delay in treatment.

Quality Assurance

The DHS, ADHS and or administrative nurses will conduct random audits 3 times a week on STAT (immediate) orders for 6 weeks, then monthly to ensure that residents with a change in condition did

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 08/31/2022

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 690	Continued From page 30 Rocephin or intravenous fluids. Nurse #3 was advised to push oral fluids until day shift nurse arrived. At 8:16 AM Nurse #2 documented she obtained urine and submitted to lab for urine analysis and culture and sensitivity. At 9:00 AM Nurse #2 documented all STAT orders were being implemented, intravenous normal saline was administered and resident received 2G of Rocephin. A phone interview was conducted with Nurse #3 on 8/24/2022 at 4:16 PM. She stated she worked in the facility as a contract nurse in April of 2022 and she recalled Resident #31 very well. She stated she was in the facility with one other nurse, Nurse # 4 who was also a contract nurse. Nurse #3 stated she was not trained on how to print documents for lab specimens, and she did not have access to the PIXUS system. Nurse #4 also did not know how to print documents and did not have access to the PIXUS. Nurse #3 stated she called the on-call provider who also was not familiar with the facility, the resident, or the facility's electronic medical record system. Nurse #3 stated she was given verbal orders to push oral fluids until the day shift nurse arrived to complete the STAT orders. Nurse #3 stated she was concerned about the delay in treatment and had a discussion with the nursing supervisor at the time (now the DON) when she arrived the morning of 4/3/2022. She stated the nursing supervisor was not receptive to her concerns. Attempts to contact Nurse #2 were not successful.	F 690	not have a delay in medical treatment utilizing the QA Monitoring Tool for Bowel/Bladder, Incontinence, Catheter, UTI. The results of these reviews to be submitted to the QAPI Committee by the DHS and or ADHS for review by the Quality Assurance and Performance Improvement Committee members monthly. Quality monitoring schedule will be modified based on the findings of the analysis presented. Date of Compliance: September 20, 2022	

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 08/31/2022

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 690	Continued From page 31	F 690		

An interview was conducted with the Director of Nursing on 8/24/22 at 9:41 AM she stated she was not the DON in April of 2022 and she was not aware the contract staff did not have access to the PIXUS and did not know how to print documents for lab specimens.

On 8/24/2022 at 12:22 PM an interview was conducted with the medical director, he stated he was not the provider on call 4/2-4/3/2022. He stated the facility does use an offsite service for coverage sometimes. He further stated if he gave a nurse STAT order for a resident who had a change in condition and the nurse could not complete the orders for any reason, it was his expectation the resident be transferred to the hospital to prevent any further decline that could occur in a 3-4 hour delay.

On 8/24/2022 at 2:17 PM an interview was conducted with the Nurse Practitioner, she stated she did not recall getting a call from a nurse regarding Resident #31 and she did not know if she was the provider on call 4/2-4/3/2022. She stated if the nurse called her back and could not complete the STAT order, she would have ordered them to transfer the resident to the hospital.

The facility did not provide documentation regarding the on-call provider 4/2/-4/3/2022.

An interview was conducted with the Administrator and DON on 8/24/22 at 2:45 PM. The Administrator stated the facility stopped using agency 6/30/2022 because the agency staff were struggling with how things were done in the facility, specifically policy and procedures.

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 08/31/2022

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 698	Continued From page 32	F 698		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview with the Physician and staff, the facility failed to administer the medications, Renvela (used to lower the amount of phosphorus in the blood of patients receiving dialysis) and Calcium Acetate (used to treat hyperphosphatemia (too much phosphorus in the blood) in patients with ESRD who are on dialysis) as ordered for 1 of 2 sampled residents reviewed for dialysis (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/7/20 with multiple diagnoses including end stage renal disease (ESRD). The quarterly Minimum Data Set (MDS) assessment dated 8/6/22 indicated that Resident #1's cognition was intact, and he was receiving dialysis while at the facility. Resident #1's care plans initiated on 5/18/20 and was last reviewed on 8/4/22 was reviewed. The care plan problem was "resident receives dialysis three times a week on Monday, Wednesday and Friday related to ESRD". The goal was "resident will not exhibit signs or symptoms of infection or clotting at shunt site". The approaches included "resident request medications before dialysis".	F 698	Corrective Action for the Resident Affected On 09/09/2022, Resident #1 medication orders were reviewed and changed by Medical Director to reflect receiving Renvela & Calcium acetate orders to three times a day with meals on NON dialysis days and then twice a daily on dialysis days. Corrective Action for the Residents Potentially Affected On 09/09/2022, the Director of Health Care Services (DHS) reviewed all other residents, (2), receiving Dialysis services. Of the 2 other dialysis residents, 1 resident was receiving Renvela and Calcium acetate. There orders were changed by the Medical Director to receive both medications, three times a day with meals on NON dialysis days and then twice a daily on dialysis days. 1 resident was receiving Renvela, and their orders were changed by the Medical Director to receive the medication, three times a day with meals on NON dialysis	9/20/22

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 08/31/2022

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 698	Continued From page 33 Resident #1 had doctor's orders dated 10/6/21 for Renvela 800 milligrams (mgs.) 3 tablets 3 times a day (9AM, 1PM and 5PM) for ESRD and on 11/7/21 for Calcium Acetate 667 mgs - 4 capsules 3 times a day (9AM, 1PM and 5 PM) for ESRD. Resident #1 had an order dated 10/6/21 to administer his 9AM medications at 6 AM on dialysis days (Monday, Wednesday and Friday). This order was discontinued on 7/19/22. Interview with the Director of Nursing (DON) on 8/23/22 at 9:10 AM revealed that Resident #1 used to leave the facility for dialysis around 6:30 AM. A doctor's order was obtained to administer his medications at 6AM so he would not miss his 9 AM dose. On 7/19/22, the order to administer his medications at 6:00 AM was discontinued since his dialysis time was changed to 12 noon and he had to leave the facility at 11:30 AM. Review of the Medications Administration Records (MARs) revealed that Renvela and Calcium Acetate were scheduled to be administered at 9AM, 1 PM and 5 PM and they were not administered consistently as ordered. The MARs revealed that Renvela was not administered on 5/2/22 (9AM), 5/3/22 (5PM), 5/7/22(1PM), 5/11/22(1PM), 5/13/22 (1PM), 5/18/22 (1PM), 5/23/22 (9AM & 1 PM), 6/1/22 (9AM & 1PM), 6/6/22 (1PM), 6/8/22(9AM), 6/20/22 (9AM & 1PM), 6/22/22 (9AM & 1PM), 6/29/22 (1PM), 7/1/22 (1PM), 7/13/22 (1 PM), 7/15/22 (1PM), 7/18/22 (1PM), 7/22/22 (1PM), 7/25/22 (1 PM), 7/27/22 (1 PM), 7/29/22 (1PM), 8/1/22 (1PM), 8/3/22 (1PM), 8/5/22 (1 PM), 8/8/22 (1 PM) and 8/10/22 (1 PM) due to "resident unavailable".	F 698	days and then twice a daily on dialysis days. Systemic Changes In 09/09/2022, the Director of Health Care Services (DHS) and Assistant Director of Health Care Services (ADHS) initiated an in-service to licensed nurses on medication exceptions for dialysis residents to ensure they receive their medication daily as ordered. Any licensed nurse that did not received the in-service will not work until they have received the in-service. New Licensed Nurses will receive this training in the orientation process. Quality Assurance (QA) The DHS, ADHS and or administrative nurses will conduct random audits 3 times a week for dialysis resident for 6 weeks, then monthly to ensure that residents are receiving their medications as ordered. The results of these reviews to be submitted to the Quality Assurance Performance Improvement Committee by the DHS and or ADHS for review by the Interdisciplinary Team members monthly. Quality monitoring schedule modified based on findings. The Quality Assurance Performance Improvement Committee to evaluate and modify monitoring as needed. Date of Compliance: September 20, 2022	

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 08/31/2022

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 698	Continued From page 34	F 698		

The MARS revealed that Calcium Acetate was not administered on 5/2/22 (9AM), 5/3/22(5PM), 5/7/22(1PM), 5/11/22 (1PM), 5/18/22 (1PM), 5/23/22 (9AM & 1PM), 6/1/22 (9am & 1PM), 6/8/22 (9AM), 6/20/22 (9AM & 1PM), 6/22/22 (9AM & 1PM), 6/29/22 (1PM), 7/1/22 (1PM), 7/13/22 (1PM), 7/15/22(1PM), 7/18/22(1PM), 7/22/22 (1PM), 7/25/22(1PM), 7/29/22 (1PM), 8/1/22 (1PM), 8/3/22(1PM), 8/8/22(1PM) and 8/10/22 (1 PM) due to "resident unavailable".

Resident #1's laboratory results were reviewed. The results were sent to the facility from the dialysis center. His phosphorus level (normal range 3 - 5.5) were:
5/2/22 - 4.5
7/4/22 - 5.7
7/18/22 - 6
8/1/22 - 6.9 - note written on the laboratory result "too much phosphorus can cause serious bone and heart problems, itching, sores and red eyes. You can keep your phosphorus at goal by limiting the phosphorus that you eat and by taking a phosphorus binder as prescribed by your doctor." Make sure give binder before meals. In an interview with the Dialysis Nurse on 8/30/22 at 4:11 PM, she stated that the Physician or the Registered Dietician (RD) were responsible for writing notes/orders on the laboratory results, and she was not sure who reviewed the laboratory result dated 8/1/22 for Resident #1.

Nurse #1 was interviewed on 8/23/22 at 9:21 AM. She verified that she was assigned to Resident #1 on 8/5/22 and 8/10/22 on day shift. She reported that the resident had to leave the facility around 11:30 AM for dialysis and came back around 5:30 PM. The Renvela and Calcium Acetate were scheduled at 9AM, 1PM and 5 PM

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 08/31/2022

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 698	Continued From page 35	F 698		

and most of the time when he was out, these medications were not administered. The nurse reported she didn't know why the Physician, or the Nurse Practitioner (NP) was not informed but she would call the physician or the (NP) if the administration times could be changed so the resident would not miss any dose. Nurse #1 reported that there was no documentation in the medical records that the dialysis center was made aware that Resident #1 was not consistently receiving his Renvela and Calcium Acetate.

Review of Resident #1's orders revealed that the administration times for Renvela and Calcium Acetate were changed to 6AM, 12 Noon and 6 PM on 8/23/22. Nurse #1 reported on 8/23/22 at 3:05 PM that the NP had called back and ordered to change the administration times for the Renvela and Calcium Acetate to ensure Resident #1 would not miss any dose.

Resident #1 was interviewed and observed on 8/23/22 at 9:27 AM, He stated that he did not have any itching, sores or red eyes.

Nurse #5 was interviewed on 8/24/22 at 9:50 AM. She reported that she just started working at the facility a month ago and she worked on 7/1/22, 7/15/22, 7/18/22, 7/29/22 and 8/3/22 on day shift. She stated that she was assigned to Resident #1. She reviewed the July and August 2022 MARs and indicated that she did not administer the 1 PM dose of Renvela and Calcium Acetate on these dates since the resident was out of the facility on dialysis.

In an interview with the Dialysis Nurse on 8/30/22 at 4:11 PM, the Nurse stated that the dialysis

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 08/31/2022

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 698	Continued From page 36 center was not informed by the facility that Resident #1 was missing doses of his Renvela and Calcium Acetate when he was out on dialysis. She added that it was important for the dialysis staff including the RD and the physician to know to discuss options to ensure resident's medications were not missed during dialysis days. The Director of Nursing (DON) was interviewed on 8/23/22 at 9:25 AM. The DON stated that at times, she worked on the floor. She reported that she worked on the floor on 5/13/22, 5/18/22, 5/23/22, 6/1/22 and 8/1/22 on day shift. She reviewed the May, June and August 2022 MARs and stated that Renvela and Calcium Acetate were not administered on 5/13/22 (1PM), 5/18/22 (1PM), 5/23/22 (9AM & 1 PM), 6/1/22 (9am &1 PM), and 8/1/22 (1PM) since Resident #1 was out of the facility on dialysis. She reported that the night shift nurses were responsible for administering the Renvela and the Calcium Acetate but there was no documentation that they had administered them at 6AM before the resident had left for dialysis. The Physician was interviewed on 8/24/22 at 12:08 PM. The Physician stated that he expected nursing to administer the medications as ordered for dialysis residents by either giving the medications prior to dialysis or by changing the time of administration On 8/24/22 at 2:42 PM, the Administrator was interviewed. She stated that she expected nursing to administer medications as ordered for dialysis residents.	F 698		
F 732 SS=B	Posted Nurse Staffing Information	F 732		9/20/22

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 08/31/2022

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 732	Continued From page 37 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732		

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 08/31/2022

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 732	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to complete and to post the nurse staffing information daily for 3 of 30 days reviewed. Findings included: During an observation on 8/21/22 at 2:45 PM and at 5:30 PM, the nurse staffing information posted in the lobby was dated 8/18/22. On 8/21/22 at 2:47 PM, the Director of Nursing (DON) was interviewed. She stated that she was the Director of Nursing (DON) and at times worked as the Registered Nurse (RN) supervisor for the weekend. She observed the nurse staffing information dated 8/18/22 posted in the lobby and indicated that the Scheduler was responsible for completing and posting the nurse staffing information daily. On 8/22/22 at 11:25 AM, the Scheduler was interviewed. She stated that she was responsible for completing and posting the nurse staffing information Monday through Fridays and at times on the weekends. She reported that she came to work late on 8/19/22 (Thursday) and forgot to complete and to post the nurse staffing information. She added that she did not work on 8/20/22 (Saturday) and on 8/21/22 (Sunday) and so the RN supervisor was responsible for completing and posting the nurse staffing information. On 8/24/22 at 9:50 AM, Nurse #5, worked on 8/21/22, was interviewed. The nurse stated that she did not complete the nurse staffing	F 732	Corrective action for the resident affected On 08/21/2022, the facilities Medical Records Partner, completed and posted the Nurse Staffing Information. Corrective action for residents potentially affected On 9/12/22 audit completed for nursing hours completion. Nurse staffing information will be posted daily in the facility lobby. Systemic Changes On 09/09/2022, the Administrator re-educated the Director of Health Care Services (DHS) and the Assistant Director of Health Care Services (ADHS) on the regulatory requirements for posting the Nurse Staffing Information daily. The posting shall be posted in the facility lobby in a prominent location, visible to residents, partners, and visitors. On 09/09/2022, the DHS and or ADHS initiated an in-service with all licensed nurses on the requirements for posting the Nurse Staffing Information daily. The posting shall be posted in the facility lobby in a prominent location, visible to residents, partners, and visitors. Quality Assurance The DHS/ADHS and or Nursing	

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 08/31/2022

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 732	Continued From page 39 information since she was new to the facility and she didn't know who was responsible for completing and posting the nurse staffing information on the weekends. The Administrator was interviewed on 8/24/22 at 2:42 PM. She reported that the Director of Nursing (DON) was new to her position. She stated that she expected the Scheduler to complete and to post the nurse staffing information Monday through Friday and the nurse working on the floor to complete and to post the nurse staffing information on the weekends (Saturday and Sunday).	F 732	Supervisor will monitor the nurse staffing information 7 days a week for 4 weeks, then 3 times a week for 4 weeks, then monthly utilizing the QA Monitoring Tool for Nurse staffing information. Opportunities to be corrected as identified during the quality monitoring. The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS for review by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: September 20, 2022	
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	F 756		9/20/22

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 08/31/2022

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 40 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 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 interview with the Pharmacy Consultant and staff, the Pharmacy Consultant failed to identify and to report drug irregularities regarding the facility's failure to administer the medications (Renvela(used to lower the amount of phosphorus in the blood of patients receiving dialysis) and Calcium Acetate (used to treat hyperphosphatemia (too much phosphorus in the blood)) as ordered for 1 of 6 sampled residents whose drug regimens were reviewed (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/7/20 with multiple diagnoses including end stage renal	F 756	Corrective Action for the Resident Affected On 09/09/2022, Resident #1 medication orders were changed by MD to reflect receiving Renvela & Calcium acetate orders to three times a day with meals on NON dialysis days and then twice a daily on dialysis days. Corrective Action for the Residents Potentially Affected On 09/09/2022, the Director of Health Care Services (DHS) reviewed all other residents, (2), receiving Dialysis services.	

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 08/31/2022

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 41 disease (ESRD). Resident #1 had doctor's orders dated 10/6/21 for Renvela 800 milligrams (mgs.) 3 tablets 3 times a day (9AM, 1PM and 5PM) for ESRD and on 11/7/21 for Calcium Acetate 667 mgs - 4 capsules 3 times a day (9AM, 1PM and 5 PM) for ESRD. The quarterly Minimum Data Set (MDS) assessment dated 8/6/22 indicated that Resident #1's cognition was intact, and he was receiving dialysis while at the facility. Review of the Medications Administration Records (MARs) revealed that Renvela and Calcium Acetate were scheduled to be administered at 9AM, 1 PM and 5 PM. The MARs revealed that Renvela was not administered on 5/2/22 (9AM), 5/3/22 (5PM), 5/7/22(1PM), 5/11/22(1PM), 5/13/22 (1PM), 5/18/22 (1PM) and 5/23/22 (9AM & 1 PM), 6/1/22 (9AM & 1PM), 6/6/22 (1PM), 6/8/22(9AM), 6/20/22 (9AM & 1PM), 6/22/22 (9AM & 1PM), 6/29/22 (1PM), 7/1/22 (1PM), 7/13/22 (1 PM), 7/15/22 (1PM), 7/18/22 (1PM), 7/22/22 (1PM), 7/25/22 (1 PM), 7/27/22 (1 PM), 7/29/22 (1PM), 8/1/22 (1PM), 8/3/22 (1PM), 8/5/22 (1 PM), 8/8/22 (1 PM) and 8/10/22 (1 PM) due to "resident unavailable". The MARS revealed that Calcium Acetate was not administered on 5/2/22 (9AM), 5/3/22(5PM), 5/7/22(1PM), 5/11/22 (1PM), 5/18/22 (1PM), 5/23/22 (9AM & 1PM), 6/1/22 (9am & 1PM), 6/8/22 (9AM), 6/20/22 (9AM & 1PM), 6/22/22 (9AM & 1PM), 6/29/22 (1PM), 7/1/22 (1PM), 7/13/22 (1PM), 7/15/22(1PM), 7/18/22(1PM), 7/22/22 (1PM), 7/25/22(1PM), 7/29/22 (1PM),	F 756	Of the 2 other dialysis residents, 1 resident was receiving Renvela and Calcium acetate. There orders were changed by the Medical Director to receive both medications, three times a day with meals on NON dialysis days and then twice a daily on dialysis days. 1 resident was receiving Renvela, and their orders were changed by the Medical Director to receive the medication, three times a day with meals on NON dialysis days and then twice a daily on dialysis days. Systemic Changes On 09/09/2022, the Pharmacy Consultant was in-serviced by the Pharmacy Consultant Manager on identifying and reporting drug irregularities regarding the facility□s failure to administer medications during monthly review. Quality Assurance The Administrator, Administrator-in-training and or Director of Health Care Services will meet with the pharmacy consultant and review recommendations to ensure that any irregularities regarding the facility□s failure to administer medications have been identified, monthly times 12 months. The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS and or Assistant Director Healthcare Service for review by	

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 08/31/2022

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 42 8/1/22 (1PM), 8/3/22(1PM), 8/8/22(1PM) and 8/10/22 (1 PM) due to "resident unavailable". Resident #1's monthly drug regimen reviews (DRR) revealed that the Pharmacy Consultant had conducted the reviews on 5/26/22, 6/28/22, 7/19/22 and 8/23/22. The reviews did not indicate that the Pharmacy Consultant had identified and had reported to the Physician and or the DON that Resident #1 was not receiving his Renvela and Calcium Acetate as ordered. On 8/30/22 at 3:08 PM, the Pharmacy Consultant was interviewed by telephone. She stated that she was assigned to conduct the monthly DRR at the facility. She reported that she had reviewed Resident #1's drug regimens on 5/26/22, 6/28/22 and 8/23/22. She reported that another Pharmacy Consultant reviewed Resident #1's drug regimen on 7/19/22 and that Consultant had already retired. She stated that it was her understanding that the dialysis clinic was responsible for administering the Renvela and the Calcium Acetate to residents on dialysis. She also stated that she had not seen the laboratory results that were sent to the facility from the dialysis clinic. She reported that she did not know that the laboratory results from the dialysis center were scanned under the dialysis tab on the electronic records and not under the laboratory tab. On 8/31/22 at 10:20 AM, the Director of Nursing (DON) was interviewed. The DON stated that she started as DON in July 2022, and she had not received any report from the Pharmacy Consultant regarding Resident #1's missed doses of Renvela and Calcium Acetate. She also reported that she had not seen the laboratory results sent from the dialysis center.	F 756	the Interdisciplinary Team members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: September 20, 2022	

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 08/31/2022

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 43 On 8/31/22 at 11:35 AM, the Administrator was interviewed. She stated that she expected the Pharmacy Consultant to identify and to report drug irregularities to the DON and or the Physician.	F 756		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to provide a mechanical soft diet according to physician orders for 1 of 3 residents during dining observation (Resident #28). The findings included: Resident #28 was admitted to the facility on 11/14/18 with diagnoses that included Parkinson's disease, dysphagia, and type 2 diabetes. Resident #28's active physician orders included an order dated 12/3/20 for a consistent carbohydrate/liberal diabetic, mechanical soft diet. Review of a quarterly Minimum Data Set (MDS) assessment dated 6/20/22, indicated Resident #28 had moderately impaired cognition and received a mechanically altered diet.	F 805	Corrective Action for the Resident Affected On 09/08/2022, the Director of Health Services and Speech Therapist reviewed the diet order for resident #28, to determine if the mechanical soft diet was still appropriate for the resident. No adverse effects were noted. Corrective Action for the Residents Potentially Affected A review of all mechanical soft diet orders and Speech Therapy recommendations was completed on 09/08/2022 by the Assistant Director of Health Care Services (ADHS) and the Dietary Manager to determine if they are still appropriate. Of the 30 residents reviewed, 7 residents have mechanical soft diet orders, and 1 resident has a mechanical soft diet	9/20/22

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 08/31/2022

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 805	Continued From page 44 During a dining observation on 8/23/22 at 8:30 AM, Resident #28 was observed in her room, sitting up in bed with her breakfast tray in front of her. There were 2 pieces of whole bacon on her plate. Resident stated she couldn't eat the bacon like it was served. Review of Resident #28's meal ticket revealed she was on a mechanical soft diet. Review of the meal tray revealed she received cheese grits, scrambled eggs and 2 pieces of regular texture bacon. Resident #28 had consumed her grits and eggs and stated she was full. Nurse Aide (NA) #1 was interviewed on 8/23/22 at 8:50 AM and confirmed she had served Resident #28's breakfast meal. She explained she set up her meal tray but didn't notice she had been served regular textured bacon instead of mechanical soft as ordered. NA #1 stated she should have reviewed the meal ticket at the time the breakfast meal was set up to ensure it was the correct ordered consistency. On 8/23/22 at 9:00 AM, an interview was conducted with the Dietary Manager (DM) and cook. The DM reviewed Resident #28's meal ticket and stated a mechanical soft diet would have ground meat. The cook explained the meal tickets were on the trays and as they passed by, she plated the food with what was listed on the ticket. The cook and DM indicated this was an oversight that Resident #28 received the wrong diet and should have received ground up bacon or sausage.	F 805	preference. Systemic Changes The Registered Dietitian reviewed the mechanical soft diet and the menu spreadsheets with the Dietary Manager on 9/8/22 to ensure that the mechanical soft diet is adhered to with the appropriate foods per the menus. The Assistant Director of Health Services and Dietary Manager initiated an in-service on 09/08/2022 to licensed and non-licensed nursing staff and dietary staff of ensuring that the appropriated foods are provided on a mechanical soft diet and that if it is not correct on the tray, licensed and non-licensed nursing staff will obtain the correct food from kitchen. Any Staff member that was not available for the in-service will receive the information prior to beginning their next shift. This in-service will be part of the orientation process for new hires. Quality Assurance (QA) The Dietary Manager will complete quality monitoring on 3 residents on a mechanical soft diet, 2 times weekly to include breakfast, lunch and or dinner meals 6 weeks, then monthly times 3 months to validate residents are receiving the mechanical soft diet as ordered. Opportunities will be corrected by the Dietary Manager as identified during the quality monitoring.	

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 08/31/2022

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 805	Continued From page 45	F 805	The Dietary Manager will report on the results of the quality monitoring during the monthly Quality Assurance and Performance Improvement Committee meeting. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance. The Dietary Manager and Administrator are responsible for implementing and maintaining the acceptable plan of correction. Date of Compliance: September 20, 2022	
F 826 SS=E	Rehab Services Physician Order/Qualified Pers CFR(s): 483.65(b) §483.65(b) Qualifications Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure Physical Therapy (PT) services were provided by qualified personnel. This was for 4 (Resident #16, Resident #17, Resident #9 and Resident #22) of 6 residents reviewed for specialized rehabilitation services. The finding included: 1. Resident #16 was admitted on 4/13/22 with Diabetes and a left below the knee (BKA) amputation.	F 826	Corrective action for the resident affected On 09/12/2022, the Therapy Outcome Coordinator, (TOC) reviewed resident #16, #17, #9 and #22, Physical Therapy notes to ensure that during the telehealth visit, the employee that assisted the resident was a helper. A helper is defined as a staff member as indicated as being someone needed to facilitate the telemedicine experience between the patient and the clinician by managing the	9/20/22

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 08/31/2022

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 826	Continued From page 46 Resident #16's quarterly Minimum Data Set dated 7/11/22 indicated she was cognitively intact and coded for PT services. A review of Resident #16's PT daily notes included the following: -PT Daily Treatment Note dated 4/14/22 read as follows: This evaluation was delivered via telehealth. Resident consent was obtained and documented according to the facility policy. The therapist was located in Florida and the resident was located in Rockingham, North Carolina. Additional individuals present during the session included the Certified Occupational Therapy Assistant (COTA). The note was electronically signed by the PT. - PT Daily Treatment Note dated 4/15/22 read as follows: Skilled virtual session with resident permission with the COTA as the "extender". The note was electronically signed by the PT. - PT Daily Treatment Note dated 4/18/22 read as follows: Skilled virtual session with resident permission with the COTA as the "extender". The note was electronically signed by the PT. - PT Daily Treatment Note dated 4/20/22 read as follows: Skilled virtual session with resident permission with the COTA as the "extender". The note was electronically signed by the PT. - PT Daily Treatment Note dated 4/26/22 read as follows: Skilled virtual session with resident permission to co-treat with COTA as the "extender." The note was electronically signed by the PT. - PT Daily Treatment Note dated 4/27/22 read as follows: Skilled virtual session with resident permission with COTA as the "extender." The note was electronically signed by the PT. - PT Daily Treatment Note dated 4/28/22 read as follows: Skilled virtual session with resident	F 826	technology onsite at the nursing home. This is one of the bullet points under immediate key implementations as noted on CMS□s Long term care nursing home, telehealth and telemedicine toolkit (3/27/2020). Upon audit there is no corrective billing to take place as the helper did not have any billable units delivered during each telehealth treatment identified for patient□s #16, 17, 9 and 22. In each telehealth session the helper met the requirements as defined above. Corrective action for residents potentially affected On 09/08/2022, the TOC reviewed residents with orders for Physical Therapy for the past 30 days. Of the 5 residents receiving physical therapy, the telehealth visit was assisted utilizing a helper. Systemic Changes On 09/13/2022, the TOC initiated an in-service to the Physical Therapist, Physical Therapy Assistant, and Certified Occupational Therapist on performing telehealth visits per telehealth guidelines and guidance practices. Any staff unavailable for the in-service will not be allowed to work until the training is completed. The in-service will be a part of the orientation process for all new hires. The in-service provided included: "Use telehealth as a last resort and primarily for evaluations and 10th	

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 08/31/2022

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 826	Continued From page 47 permission with COTA as the "extender." The note was electronically signed by the PT. - PT Daily Treatment Note dated 5/2/22 read as follows: Skilled virtual session with resident permission with COTA as the "extender." The note was electronically signed by the PT. - PT Daily Treatment Note dated 5/3/22 read as follows: Skilled virtual session with resident permission with COTA as the "extender." The note was electronically signed by the PT. - PT Daily Treatment Note dated 5/622 read as follows: Skilled virtual session with resident permission with COTA as the "extender." The note read that the evaluation was delivered using telehealth . Resident consent obtained and documented according to the facility policy. The PT was located in Monroe, North Carolina and the resident was located in Rockingham, North Carolina. Additional individual present with the resident included COTA. Plan of care was established. The note was electronically signed by the PT. - PT Daily Treatment Note dated 5/9/22 read as follows: Skilled virtual session with resident permission with COTA as the "extender." The note was electronically signed by the PT. - PT Daily Treatment Note dated 7/8/22 read as follows: The evaluation was delivered via telehealth after resident consent obtained and documented according to the facility policy. During the session, the PT was located in Monroe, North Carolina and the resident was located in Rockingham, North Carolina. Additional individuals present with the residents during the session was the COTA. The note was electronically signed by the PT. An interview was completed on 8/23/22 at 9:38 AM with the Rehabilitation Manager (RM). She	F 826	visit/supervisory visits and reevaluations. " If regular treatments are provided by the PT or OT via telehealth, try having the helper/staff member be of the same discipline and/or the rehab tech. "Remember: As mentioned per the practice acts, the same type of quality services should be provided. "Some additional changes and updates to our documentation: o Permission must always be obtained and documented that the patient agreed to a telehealth session in the daily note. o Document the type of device and application that you are using to perform the telehealth visit (Duo/google/IPAD). o ** When a second person is present in the room, document permission from the patient for that person to be present for the treatment session and what is their function (helper/staff member providing assistance) in your daily note. (Example: If there□s anybody else in the room, meaning the second person, the helper, or if a family member were there, say, □I□m aware that so-and-so is in the room with you, are you okay with proceeding with the session and communicating with me in this manner with that person present?. Then in our daily note document this every time and what the person/helper did for the patient	

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 08/31/2022

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 826	Continued From page 48 stated while the PT was treating Resident #16, a virtual call was connected using an IPAD in order for the PT to evaluate and treat his residents virtually with the assistance of the COTA. She stated the meaning of a "extender" was the individual who provided the actual hands-on session. She stated the COTA was out on vacation and likely not answer her phone. An interview was completed on 8/23/22 at 10:10 AM with the PT. He stated he came to the facility once each week on Tuesday and had been it for about a year. The PT stated the facility did not employ a Physical Therapy Assistant (PTA) and used the COTA as his "extender". The PT stated an "extender" served as his hands on individual while he was only available by telehealth. He stated the COTA was under his direction and supervision. A telephone interview was attempted on 8/23/22 at 1:32 PM with the COTA but her phone went directly to voicemail and a message was left. There was no return call. An interview was completed on 8/24/22 at 12:00 PM with the Medical Director (MD). He stated he was aware of the scope of practice for a COTA and a PT could not direct or supervise the COTA in the care and delivery of therapy services. An interview was completed on 8/24/22 at 2:27 PM with the Administrator. She stated she was not aware that the COTA was providing PT services under the virtual direction and supervision of the PT. 2. Resident #17 was admitted 3/18/19 with a diagnosis of Multiple Sclerosis.	F 826	(held the IPAD, repositioned them to complete the task, etc.). o We need to change our verbiage from the word extender to helper and or staff member. "If a therapy staff member is present to assist with a device or support the patient, that time should be coded on the DAL as facility administrative time, but not transferred to the facility wages. "Remember, just as if we are completing a face-to-face session, all components must be skilled in nature and our documentation reflect that in our notes. "Know the CPT codes that are approved for telehealth. It is a restricted list. (Refer to list). "When you complete a telehealth session, remember to enter modifier -95 on the input daily page with the CPT codes. Drop down box and add manually. "Any use of telehealth should always be reviewed with your Regional Director (evaluations, reevaluations, 10th supervisory visits, and treatments). Also review and share with our Administrator who was seen via telehealth so they are aware. " Other strategies to consider: o If you have staffing in the other disciplines and it is an area they can treat	

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 08/31/2022

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 826	Continued From page 49 Resident #17's quarterly Minimum Data Set dated 7/5/22 indicated had moderate cognitive impairment coded for PT services. A review of Resident #17's PT daily notes included the following: - PT Daily Treatment Note dated 2/25/22 read as follows: This evaluation was delivered via telehealth. Resident consent was obtained and documented according to the facility policy. During the session, the PT was located in Monroe, North Carolina and the resident was located in Rockingham, North Carolina. Additional individuals present with the residents during the session was the Certified Occupation Therapy Assistant (COTA). The note was electronically signed by the PT. - PT Daily Treatment Note dated 3/25/22 read as follows: Skilled virtual session with resident permission with COTA as the "extender." The note was electronically signed by the PT. - PT Daily Treatment Note dated 7/7/22 read as follows: Skilled virtual session with resident permission with COTA as the "extender." The note was electronically signed by the PT. - PT Daily Treatment Note dated 7/8/22 read as follows: Skilled virtual session with resident permission with COTA as the "extender." The note was electronically signed by the PT. - PT Daily Treatment Note dated 7/13/22 read as follows: Skilled virtual session with resident permission with COTA as the "extender." The note was electronically signed by the PT. - PT Daily Treatment Note dated 8/19/22 read as follows: This evaluation was delivered via telehealth. Resident consent was obtained and documented according to the facility policy. During the session, the PT was located in	F 826	(scope of practice) refer that patient to be seen by the discipline in the building. o Complete evaluation and when possible, go ahead and initiate a restorative program. TOC is monitoring telehealth delivery to ensue all regulations and guidelines are followed including correct billing practices Quality Assurance The TOC will monitor Physical Therapy notes provided via telehealth 2 times a week for 4 weeks, then weekly times 4 weeks, then monthly utilizing the QA Monitoring tool for Rehab services to ensure that the helper utilized during the telehealth visit will not bill for treatment delivered and monitoring telehealth delivery to ensue all regulations and guidelines are followed. Opportunities to be corrected as identified during the quality monitoring. TOC monitoring telehealth delivery to ensue all regulations and guidelines are followed including correct billing practices The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the TOC for review by the Interdisciplinary Team members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring 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 08/31/2022

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 826	Continued From page 50	F 826	Date of Compliance: September 20, 2022	

Charlotte, North Carolina and the resident was located in Rockingham, North Carolina. Additional individuals present with the residents during the session was the COTA. The note was electronically signed by the PT.

An interview was completed on 8/23/22 at 9:38 AM with the Rehabilitation Manager (RM). She stated while the PT was treating Resident #17, a virtual call was connected using an IPAD in order for the PT to evaluate and treated his residents virtually with the assistance of the COTA. She stated the meaning of a "extender" was the individual who provided the actual hands-on session. She stated the COTA was out on vacation and likely not answer her phone.

An interview was completed on 8/23/22 at 10:10 AM with the PT. He stated he came to the facility once each week on Tuesday and had been it for about a year. The PT stated the facility did not employ a Physical Therapy Assistant (PTA) and used the COTA as his "extender". The PT stated an "extender" served as his hands on individual while he was only available by telehealth. He stated the COTA was under his direction and supervision.

A telephone interview was attempted on 8/23/22 at 1:32 PM with the COTA but her phone went directly to voicemail and a message was left. There was no return call.

An interview was completed on 8/24/22 at 12:00 PM with the Medical Director (MD). He stated he was aware of the scope of practice for a PT and a COTA and that a PT could not direct or supervise the COTA in the care and delivery of therapy services.

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 08/31/2022

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 826	Continued From page 51	F 826		

An interview was completed on 8/24/22 at 2:27 PM with the Administrator. She stated she was not aware that the COTA was providing PT services under the virtual direction and supervision of the PT.

3. Resident #9 was admitted to the facility on 8/29/14 with diagnoses that included generalized osteoarthritis, muscle weakness and low back pain.

An annual Minimum Data Set (MDS) assessment, dated 6/22/22, indicated Resident #9 had moderately impaired cognition.

A review of Resident #9's Physical Therapy (PT) records from 6/5/22 through 6/30/22 revealed a PT Daily Treatment Note dated 6/30/22 that read: "Skilled virtual session with patient permission. Google Duo technology with COTA as the extended. Discharge summary done". The note was electronically signed by the PT.

An interview was completed on 8/23/22 at 9:38 AM, with the Rehabilitation Manager (RM). She stated while the PT was treating Resident #9, a virtual call was connected using an IPAD in order for the PT to evaluate and treat his residents virtually with the assistance of the COTA. She stated the COTA was out on vacation and likely not answer her phone.

An interview was completed on 8/23/22 at 10:10 AM, with the PT, who stated he was present at the facility at least once a week on Tuesdays, had been doing this for almost a year. The PT stated the facility did not employ a Physical Therapy Assistant (PTA) and used the COTA as his "extender". The PT stated an "extender" served

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 08/31/2022

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 826	Continued From page 52	F 826		

as his hands on individual while he was only available by telehealth, and that the COTA was under his direction and supervision.

A telephone interview was attempted on 8/23/22 at 1:32 PM with the COTA but her phone went directly to voicemail. A message was left but there was no return call during the course of the survey.

An interview was completed on 8/24/22 at 12:00 PM with the Medical Director (MD). He stated he was aware of the scope of practice for a COTA and a PT could not direct or supervise the COTA in the care and delivery of therapy services.

An interview was completed on 8/24/22 at 2:27 PM with the Administrator. She stated she was not aware that the COTA was providing PT services under the virtual direction and supervision of the PT.

4. Resident #22 was admitted to the facility on 2/1/21 with diagnoses that included incomplete paraplegia status, lack of coordination and muscle weakness.

A quarterly Minimum Data Set (MDS) assessment dated 7/22/22 indicated Resident #22 was cognitively intact.

A review of Resident #22's Physical Therapy (PT) records from 8/5/22 through 8/19/22 revealed the following:
- PT Daily Treatment Note dated 8/5/22 read as follows: "This evaluation was delivered via telehealth using google duo application. Patient consent was obtained and is documented

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 08/31/2022

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 826	Continued From page 53	F 826		

according to facility policy. During this session, the therapist was located in Monroe North Carolina (NC) and the patient was located in Rockingham NC. Additional individuals present with patient during the session include the Certified Occupational Therapy Assistant (COTA). Evaluation was complete and goals were set". The note was electronically signed by the PT.
- A PT Daily Treatment Note dated 8/11/22 read, in part: "Skilled virtual session with patient permission. Google Duo application with COTA as the extender and I as the therapist". The note was electronically signed by the PT.
- A PT Daily Treatment Note dated 8/15/22 read in part: "Skilled virtual session with patient permission. Google Duo application with COTA as the extender and I as the therapist". The note was electronically signed by the PT.
- A PT Daily Treatment Note dated 8/17/22 read in part: "Skilled virtual session with patient permission. Google Duo application with COTA as the extender and I as the therapist". The note was electronically signed by the PT.
- A PT Daily Treatment Note dated 8/19/22 read in part: "Skilled virtual session with patient permission. Google Duo application with COTA as the extender and I as the therapist". The note was electronically signed by the PT.

An interview was completed on 8/23/22 at 9:38 AM, with the Rehabilitation Manager (RM). She stated while the PT was treating Resident #22, a virtual call was connected using an IPAD in order for the PT to evaluate and treat his residents virtually with the assistance of the COTA. She stated the COTA was out on vacation and likely not answer her phone.

An interview was completed on 8/23/22 at 10:10

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 08/31/2022

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 826	Continued From page 54 AM, with the PT, who stated he was present at the facility at least once a week on Tuesdays, had been doing this for almost a year. The PT stated the facility did not employ a Physical Therapy Assistant (PTA) and used the COTA as his "extender". The PT stated an "extender" served as his hands on individual while he was only available by telehealth, and that the COTA was under his direction and supervision. A telephone interview was attempted on 8/23/22 at 1:32 PM with the COTA but her phone went directly to voicemail. A message was left but there was no return call during the course of the survey. An interview was completed on 8/24/22 at 12:00 PM with the Medical Director (MD). He stated he was aware of the scope of practice for a COTA and a PT could not direct or supervise the COTA in the care and delivery of therapy services. An interview was completed on 8/24/22 at 2:27 PM with the Administrator. She stated she was not aware that the COTA was providing PT services under the virtual direction and supervision of the PT.	F 826		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:	F 867		9/20/22

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 08/31/2022

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 867	Continued From page 55 Based on record reviews, observations, resident, Pharmacy Consultant, family, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification and complaint survey conducted on 3/26/21. This was for 6 deficiencies that were cited in the areas of Safe/Clean/Comfortable/Homelike Environment, Grievances, Accuracy of Assessments, Activities of Daily Living (ADL) Care Provided for Dependent Residents, Drug Regimen Review/Report Irregular/Act On, and Infection Prevention and Control, previously cited on 3/26/21 and recited on the current recertification and complaint survey of 8/31/22. In addition, Infection Prevention and Control was also cited during an onsite follow-up and complaint survey on 5/19/21. The duplicate citations during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This citation is cross referenced to: 1. F584- Based on observations, resident and staff interviews and record review, the facility failed to ensure a resident room were of urine odors (Room #115) and resident rooms were clean and in good repair (Room #'s 115, 107, 113, 117, 108, 110, 114, 116 and 127). The facility also failed to clean the Packaged Terminal Air Conditioner (PTAC) and ensure the filters were in place (Room #104). This was for 10 of 16 rooms reviewed for safe and clean environment.	F 867	Corrective action for the resident affected On 09/09/2022, the Administrator had an Ad HOC Quality Assurance Performance Improvement (QAPI) meeting with the interdisciplinary team (IDT)to discuss the 6 repeat tags, F584, F585, F641, F677, F756, and F880. It was determined through the Root Cause Analysis, that the facility has gone through increased turnover in leadership and ownership in these areas. Corrective action for residents potentially affected On 09/09/2022, the Administrator reviewed surveys for the past 18 months to identify on going trends. February 2021, no survey activity. March 26, 2021, areas identified were 550D, 554D, 561E, 583D, 584B, 585A, 641E, 677D, 679E, 688D, 689K, 756E, 758E, 810D, 812E, 880D, and 883E. May 19, 2021, 880D. February18, 2022, 550D, 727D, 755D, 760D and April 18, 2022, 623D. Areas of concerns to be addressed in monthly QAPI meetings. Systemic Changes The Area Vice President of Operations for Coastal North Division and or the Senior Nurse Consultant will attend the monthly QAPI meetings to ensure that the repeat tags are monitored, monthly times 6 months, then quarterly times 3 quarters, then annually. Opportunities to be corrected as identified during the QAPI	

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 08/31/2022

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 867	Continued From page 56 During the facility's recertification survey of 3/26/21 the facility failed to ensure resident rooms were in good repair for 8 of 9 resident rooms on the A and B hall. In an interview with the Administrator on 8/24/22 at 2:45 PM, she explained that renovations had started about six months ago on a hall that no one resided on. The renovations for the rest of the building were put on hold in attempts to find vendors/contractors that were more reasonably priced. 2. F585- Based on record review and resident, family and staff interviews, the facility failed to provide a written grievance response summary for 2 of 2 residents reviewed for grievances (Residents #22 and #4). During the facility's recertification survey of 3/26/21 the facility failed to follow their grievance policy by not recording a grievance that had been verbally reported to staff for 1 of 1 resident reviewed for grievances. An interview with the Administrator on 8/24/22 at 2:45 PM revealed the facility had experienced some challenges due to staff and administrative turnover, which she thought contributed to the repeat citation. 3. F641- Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of medication (Resident #1), nutrition (Resident #18, & Resident #1), behavior (Resident #3) and cognition, mood, and pain	F 867	process. Quality Assurance The results of these reviews to be submitted in the QAPI meeting and placed in the QAPI minutes for review. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: September 20, 2022	

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 08/31/2022

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 867	Continued From page 57	F 867		

(Resident #29) for 4 of 15 residents reviewed.

During the facility's recertification survey of 3/26/21 the facility failed to accurately code the MDS assessment in the areas of medications, Preadmission Screening and Resident Review (PASRR), cognition, indwelling catheter, skin conditions, tobacco use, bowel and bladder and Activities of Daily Living (ADLs) for 12 of 27 residents reviewed.

An interview with the Administrator on 8/24/22 at 2:45 PM revealed the facility had experienced some challenges due to staff and administrative turnover, which she thought contributed to the repeat citation. The facility currently was utilizing an as needed MDS nurse as well as nurses from other facilities to assist with completing the MDS assessments.

4. F677- Based on observations, staff interviews and record review, the facility failed to provide incontinence care (Resident #20) dependent of staff for assistance with his activities of daily living (ADLS). This was for 1 of 3 residents reviewed for ADLs.

During the facility's recertification survey of 3/26/21 the facility failed to provide nail care for 2 of 5 dependent residents reviewed for ADL assistance.

An interview with the Administrator on 8/24/22 at 2:45 PM indicated the facility had experienced some challenges due to nursing staff, to include management, turnover. The corporation discontinued the use of agency staff. She added there was a new Staff Development Coordinator

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 08/31/2022

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 867	Continued From page 58	F 867		

(SDC) who would be providing education to the nursing staff.

5. F756- Based on record review and interview with the Pharmacy Consultant and staff, the Pharmacy Consultant failed to identify and to report drug irregularities regarding the facility's failure to administer the medications (Renvela(used to lower the amount of phosphorus in the blood of patients receiving dialysis) and Calcium Acetate (used to treat hyperphosphatemia (too much phosphorus in the blood)) as ordered for 1 of 6 sampled residents whose drug regimens were reviewed (Resident #1).

During the facility's recertification survey of 3/26/21, the facility failed to act upon pharmacy recommendations for 3 of 6 residents reviewed for unnecessary medications.

An interview occurred with the Director of Nursing and Administrator on 8/31/22 at 11:35 AM. The Administrator indicated the facility had experienced some challenges due to nursing staff and nursing management turnover.

6. F880- Based on record reviews, observations, and interview with staff, the facility failed to follow their Infection Control policy and the Centers for Disease Control and Prevention (CDC) guidance by not placing an unvaccinated resident who was readmitted after being out of the facility for greater than 24 hours on transmission-based precautions for 1 of 2 (Resident #11) residents reviewed for transmission-based precautions.

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 08/31/2022

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 867	Continued From page 59 During the facility's recertification and complaint survey of 3/26/21, 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. During the facility's onsite follow-up and complaint survey on 5/19/21, the facility failed to use hand hygiene after incontinence care and touched the resident's wound dressing, urinary catheter tubing and other surfaces in the resident's room with dirty, gloved hands for 1 of 2 residents observed. An interview with the Administrator on 8/24/22 at 2:45 PM indicated the facility had experienced some challenges due to nursing staff and management turnover. She added the Infection Control nurse was new to the facility and would be receiving further training regarding infection control guidelines.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		9/20/22

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 08/31/2022

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 880	Continued From page 60	F 880		

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:
(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

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 08/31/2022

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 880	Continued From page 61 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 record reviews, observations, and interview with staff, the facility failed to follow their Infection Control policy and the Centers for Disease Control and Prevention (CDC) guidance by not placing an unvaccinated resident who was readmitted after being out of the facility for greater than 24 hours on transmission-based precautions for 1 of 2 (Resident #11) residents reviewed for transmission-based precautions. The findings included: Resident #11 was admitted on 5/6/2020. The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated on 02/02/22 indicated the following regarding Managing New Admissions: In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission. The facility's policy titled COVID-19 Isolation and Cohorting Process, with effective date of	F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 08/23/2022, the resident #11 was readmitted from the hospital to his previous room with his roommate. Per facility policy titled COVID-19 Isolation and Cohorting Process with a revised dated of 08/22/2022, indicated unvaccinated or partially vaccinated residents who left the facility for greater than 24 hours would be treated as new admission and should have been quarantined for 10 days after return. Resident #11 was not up to date on his COVID vaccines and should have been placed in quarantine per policy. On 08/23/2022, upon learning resident #11 had been placed in his room with his roommate instead of quarantine, the facility immediately moved him to an isolation room. How the facility will identify other residents having the potential to be affected by 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 08/31/2022

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 880	Continued From page 62 4/10/2020 and revised date of 8/22/2022 indicated unvaccinated or partially vaccinated residents who left the facility for greater than 24 hours would be treated as new admissions or readmissions and quarantined for 10 days after return. Resident #11's medical record revealed he refused COVID-19 vaccination. The resident was discharged to the hospital on 8/19/2022. The resident was readmitted to the facility on 8/23/2022. On 8/24/2022 at 1:11 PM Resident #11 was observed in his room with his roommate. There was no signage on the door indicating the resident was quarantined. An interview was conducted with the Infection Control Preventionist (ICP) on 8/24/22 12:57 PM. She stated residents who are readmitted go back into their original room with their roommate, they do not quarantine regardless of vaccination status. When asked if that was in line with CDC guidelines, she stated she did not know CDC guidelines. On 8/24/2022 at 1:21 PM an interview was conducted with the Administrator. She stated readmissions who are not vaccinated should be quarantined for 10 days. Resident #11 should not have gone back into the room with his roommate. It was an oversight. On 8/24/2022 at 2:43 PM an interview was conducted with the Director of Nursing (DON) and the Administrator. The DON stated it was her expectation the ICP nurse have knowledge of the CDC guidelines and unvaccinated readmitted	F 880	same deficient practice: All residents have the potential to be affected by the alleged deficient practice. Prior to any new admission and or readmission, the Director of Health Care Services and or Assistant Director of Health Care Services will review the admission information to determine the vaccination status of the resident and what room they would be assigned. On 09/02/2022, the facility had a new admission. Prior to their arrival the facility reviewed their vaccination status as they had 2 primary doses of vaccines and 1 booster. The resident was admitted to an isolation room and received their 2nd booster on 09/02/2022. The facility has not had any other admissions since 09/02/2022. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Infection Preventionist Nurse was re-education by the Director of Health Care Services on 9/13/2022 ensuring that when a resident is admitted and or readmitted to the facility that their vaccination status is noted and that they are placed in an appropriate room designated according to their vaccine status. On 9/13/2022 through 9/21/2022 all staff has been re-educated on the facility policy	

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 08/31/2022

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 880	Continued From page 63 residents be quarantined for 10 days.	F 880	titled COVID-19 Isolation and Cohorting Process with a revised dated of 08/22/2022, indicating unvaccinated or partially vaccinated residents who left the facility for greater than 24 hours would be treated as new admissions or readmissions and quarantined for 10 days after return on the following days Staff that did not receive the education before midnight of 09/21/2022, will not be able to work until they do so. New hires will not be permitted to start an assignment until they have been educated on the facility policy titled COVID-19 Isolation and Cohorting Process with the revised dated of 08/22/2022. The Administrator-in-training, Director of Nursing and or Assistant Director of Nursing will complete an audit on each admission and or re-admission 3 times a week for 6 weeks, then weekly times 4 weeks, then monthly. Results of the audit will be reported to the Administrator. Any staff found not to be following infection control protocols will have progressive disciplinary action. Prior to any admissions and or readmissions to the facility, the Admissions Director will obtain the vaccination status of the resident to determine if they need an isolation room. Once this information is determined, the room assignment will be made. The licensed nurses will be notified of the admission and room number.	

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 08/31/2022

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 880	Continued From page 64	F 880	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will present the results of these audits to the Administrator at the Monthly Quality Assurance Performance Improvement (QAPI) Meeting times 6 months, for further problem resolution if needed. The Administrator is responsible for implementing the acceptable plan of correction. Date of compliance: September 20, 2022	