STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	06/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE LANDING NURSING AND REHABILITATION CENTER	1084 US 64 EAST PLYMOUTH, NC 27962

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to allow the resident to choose to take her medication at a later time. The findings included: Resident #104 was admitted to the facility on 3/31/2015, with diagnoses to include Alzheimer's disease, congestive heart failure, and hypertension. Her admission Minimum Data Set (MDS) assessment dated 4/9/2015, revealed her cognition to be intact. She was always continent with bladder and bowel. During a medication pass observation on 6/17/2015, at 7:55 AM, Nurse #2 handed Resident #104 her medication cup with 8 pills in it. The resident poured the pills in her hand and stated she liked to take them one at a time. The resident requested to take her Lasix (a diuretic) after bingo that morning, so she would not have to go to the bathroom during bingo. The nurse told her she had already taken the Lasix pill. When the resident got to her last pill, she laid it on the bedside table and asked the nurse, "Are you sure this one isn't the Lasix?" The nurse replied that the pill was not Lasix. After going back outside the room to the medication cart, the nurse was asked what pill the last one was. The	F 242	Roanoke Landing Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Roanoke Landing Nursing and Rehabilitation Center`s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Britthaven reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Resident # 104 will continue to have choices honored and receive medication	7/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/07/2015

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F 242	Continued From page 1 nurse stated, "That was the Lasix." She stated she only had until 9:30 AM that day to give the mediation, or she would not be able to give the resident her Lasix at all that day, and bingo didn't even start until 10:00 AM. When the nurse was asked if residents ever had any choice about medication times, the nurse stated it would create a medication error if she got a time change for the Lasix on bingo days, because then the pill wouldn't be given at the same time each day. On 6/17/2015 at 9:23 AM, an interview was conducted with the Director of Nursing (DON). The DON stated in order to change a resident's medication time, the facility would just have to call the doctor and request a time change. They could do this to accommodate the resident's needs. The DON stated that resident #104 was interviewed and the facility had gotten a time change for her Lasix, to be given at 11:00 AM. On 6/18/2015 at 8:03 AM, an interview was conducted with Resident #104. The resident stated she liked to play bingo and the price is right games. She wasn't always able to make the game days though, because she had to take her Lasix and that made her go to the bathroom a lot. She liked to put it off until 11:00 AM, so she didn't have to disturb anyone during the games. On 6/18/2015 at 9:07 AM, the DON stated she expected her nurses to notify the doctor of the resident's choice for medication time, and see if he would agree to amend the medication time the resident preferred.	F 242	at time requested by resident. Lasix now to be administered at 11AM daily per resident request. Physician order obtained by licensed nurse on 06-16-15. A resident choice questionnaire was completed with 100% of all alert and oriented residents to include resident # 104 regarding preferences in care by the Social Workers. The Minimum Data Set (MDS) Nurses immediately addressed all identified areas of concerns from the resident choice questionnaire by updating the resident care plan and care guide to reflect the residents¿ preference by July 16, 2015. The Activities Director reviewed the federal resident rights with all alert and oriented residents and a copy of the federal resident¿s rights was given to the residents completed on July 7, 2015. A copy of the federal resident¿s rights was sent to the responsible party by the Administrator on July 7, 2015, for all other residents. A 100% in-service was initiated on 6/17/15 by the Social Worker with all facility staff to include Nurse # 2, all Certified Nursing Assistants (CNAs), all license nurses, dietary staff, therapy staff, housekeeping staff, maintenance staff, activities, payroll, bookkeeping, receptionist and social workers staff regarding residents rights and right to make decisions, to include making choices regarding taking medication at a later time. All newly hired staff will be in-serviced by the staff development coordinator (SDC) during orientation regarding residents rights and right to make decisions, to include making choices regarding taking medication at a	

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F 242	Continued From page 2	F 242	later time. When a resident is admitted to the facility the resident or responsible party will be informed by the Social Worker of their right to make choices regarding activities, schedules, and health care consistent with his or her interests, assessments, and plan of care; to include choosing to take medication at a later time and a choice questionnaire will also be presented to the resident and or responsible party regarding preferences in care. The MDS nurses will immediately update the resident preferences on the resident care guide and resident care plan. If during the facility stay the resident indicates a change in preferences to include taking medications at a different time the residents care plan and care guide will be updated immediately by the MDS Nurse and or the licensed nurse will contact the physician to obtain an order for changing time of administration per resident¿s request as indicated. A resident choice questionnaire will be completed with 10% of all alert and oriented residents to include resident # 104 by the MDS Nurses weekly x 8 weeks then monthly x 2 months to ensure residents preferences are being honored and for any changes in preferences to include time of medication administration utilizing a QI Residents¿ Right to Choose Tool. The MDS nurses will immediately address any identified areas of concern and update the resident care plan and resident care guide for any changes or contact the physician for order changes as needed. Resident care observations	

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F 242	Continued From page 3	F 242	will be completed with 10% of license nurses and CNAs on all shifts to include nights and weekends to observe license nurses and CNAs to ensure resident preferences are being honored to include resident # 104 utilizing a Resident Care Audit Tool 3x per week x 4 weeks, weekly x 4 weeks, then monthly x 2 months by MDS nurses, SDC, Resident Care Coordinator (RCC), and Quality Insurance (QI) Nurse. The Administrator or Director of Nursing (DON) will review and initial the resident choice questionnaires QI audit tool and the resident care audit tools weekly x 8 weeks then monthly x 2 months for completion and to ensure all concerns were addressed. The DON will compile the results of the QI Residents¿ Right to Choose Tool and the Resident Care Audit Tool and present to the Quality Improvement Committee monthly x 4 months. . Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		7/16/15

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F 278	Continued From page 4 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the MDS (Minimum Data Set) for 3 of 22 residents (#13, #49, and #78). Findings included: 1. Resident #49 had been admitted to the facility on 12/18/2014 and had been discharged on 4/17/2015. Diagnoses included Diabetes Mellitus and the resident also had a heel ulcer. The dietary care plan initiated on 12/22/2014 indicated the resident had the following problems: 1. Diabetes Mellitus: Potential for complications of hyper/hypoglycemia: Resident has history of non-compliance with diet and /or treatment regimen. Interventions included: Discuss meal times, portion sizes, dietary restrictions, snacks allowed within dietary rotation, importance and benefits of compliance with nutritional regimen	F 278	The Minimum Data Set (MDS) assessments for resident #13, #49, and #78 were reviewed and proper modifications were made to sections E, H, and M so that the coding would accurately reflect the residents¿ condition by the MDS Coordinator by 6/18/15. A 100% audit of the last completed MDS assessment for all residents to include resident # 13, #49, and #78 will be conducted by an MDS trained licensed staff nurse, MDS Consultant and Facility Nurse Consultant, to be completed by July 16, 2015, to ensure coding of the minimum data set accurately reflects the residents. For all areas of concern identified, a modification or significant correction of prior assessment	

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F 278	Continued From page 5 with resident. Obtain residents likes and dislikes; incorporate as many likes as possible that are compatible with dietary restrictions. 2. State of nourishment related to: Being on a therapeutic diet, elevated needs secondary to obesity, presence of pressure ulcer. Goal included: will adhere to prescribed therapeutic/supplemental diet thru next review. The Quality Improvement note dated 2/25/2015 indicated the staff reported the resident ordered food out at times. The resident was educated on the need for proper nutrition to aid wound healing and diabetes management. The resident voiced understanding of the teaching. No change in behavior was noted. The Dietary Supplemental Assessment dated 3/11/2015 included a comment that the resident sent outside of the facility for food at times. The Quarterly/90 day MDS assessment dated 3/14/2015 indicated the resident was cognitively intact and indicated the resident exhibited rejection of evaluation or care daily. The Quality Improvement note dated 3/25/2015 indicated the staff reported the resident ordered food from outside at times. The resident was educated on the need for proper nutrition to aid wound healing and diabetes management. The resident voiced understanding of the teaching. No change in behavior was noted. The Quarterly MDS assessment dated 4/01/2015 indicated the resident was cognitively intact and indicated the resident exhibited rejection of evaluation or care daily. The Behavior Progress Note dated 4/09/2015 indicated staff had reported resident ordered take out foods in the evenings. An interview with the MDS nurse on 6/17/2015 at 12:00 PM was conducted. The MDS nurse indicated the resident had been non-compliant	F 278	(Quarterly/Comprehensive) will be completed by the facility MDS Coordinator and facility MDS Nurse by July 16, 2015. The MDS Nurses, Social Worker, Dietary Manager and Activities Director will be re-in-serviced on proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual by MDS Consultant to be completed by July 16, 2015. The MDS Nurses were also in-serviced on the use of the Point Click Care online RAI resource manual to ensure accuracy in coding by MDS Consultant to be completed by July 16, 2015. Teleconference on MDS completion will be viewed by the Care Plan Team to include MDS Nurse Coordinator, MDS Nurse, SW, DM, and AD by 7/16/15. When coding the MDS assessment the MDS Nurse and Care Plan Team will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual and ensure that the assessment accurately reflects the resident¿s current condition. An audit of 25% of completed Minimum Data Set (MDS) assessments will be conducted weekly x 4 weeks, then bi-weekly for 4 weeks, then 10% monthly x 2 months by MDS trained licensed staff nurse, MDS Consultant or Facility Consultant using an MDS Audit Tool to ensure compliance and accuracy utilizing a MDS audit Tool. The MDS nurses will not be auditing their own assessments. All identified areas of concern will be addressed immediately by MDS trained licensed staff nurse, MDS Consultant or Facility Nurse Consultant by retraining appropriate staff making the	

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F 278	Continued From page 6 with the ordered therapeutic diet, did not follow the dietary recommendations and ordered food from outside of the facility. The nurse then stated this had been coded incorrectly. It should not have been coded as rejection of care because the resident was alert and had received education about his condition and this was a choice the resident had made. #2. Resident #13 was admitted to the facility on 10/1/2005, with diagnoses to include traumatic brain injury, stoke and hemiplegia. Resident #13's quarterly Minimum Data Set (MDS) assessment dated 2/17/2015, indicated she was cognitively intact, and occasionally incontinent, which meant 7 or fewer episodes of incontinence on the prior 7 day look back period. Resident #13's quarterly MDS assessment dated 5/11/2015, indicated she was cognitively intact, and always incontinent. On 6/17/2015 at 11:55 AM, an interview was conducted with the nursing assistant (NA #1). NA #1 stated Residents #13's toileting had gotten more incontinent during the night, but during the day she was usually dry. At 12:00 PM on 6/17/2015, the resident stated she got up during the day to use the commode, but she slept through the night and was not aware of needing to void most of the time. An interview was conducted with the floor nurse (Nurse #1), on 6/17/2015 at 12:15 PM. Nurse #1 stated resident #13 was occasionally incontinent during the day, depending on how she was feeling. She was more incontinent at night, but had been this way for quite some time and did not see a significant change in her toileting habit. On 6/17/2015 at 2:33 PM, an interview was conducted with the MDS nurse. The MDS nurse	F 278	coding error and by the MDS nurse with modification or significant correction of the MDS. The Administrator will review and initial the MDS Audit Tool weekly x 4 weeks, then bi-weekly x 4 weeks then monthly x 2 months. The results of the MDS Audit Tool will be compiled by the Administrator and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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F 278	Continued From page 7 stated he looked at the nurse's notes, the NA's documentation, and spoke to the staff to code the incontinence section of the MDS assessment. The MDS nurse stated the resident could tell you when she needed to void during the day, but did not get up at night. The MDS nurse stated the always incontinent coding was an error and it should have been coded frequently incontinent, which would include at least one continent episode. 3. Resident #78 was admitted to the facility on 8/6/14. Diagnoses included osteomyelitis of the pelvic region and dementia. Hospice care was ordered and started on 2/23/15. The significant change Minimum Data Set (MDS) dated 3/2/15 indicated Resident #78 was always incontinent of urine. Review of nurses' notes from 5/21/15 - 5/28/15 revealed mulitple entries indicating Resident #78 was incontinent. The quarterly MDS dated 5/28/15 indicated Resident #78 was always continent of urine. On 6/16/15 at 3:23 PM, an interview with a family member who visited daily revealed the resident was always incontinent. On 6/16/15 at 4:53 PM, an interview with MDS Nurse #1 revealed that Resident #78 was incorrectly coded as always continent and that she should have been coded as always incontinent.	F 278		
F 371	483.35(i) FOOD PROCURE,	F 371		7/16/15

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F 371 SS=D	Continued From page 8 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a barrier between ready to eat foods and bare hands when 2 staff members were observed to pick up bread with their bare hands while assisting 2 residents (Residents # 73 & #90) during 1 of 2 meal observations. The findings included: On 6/5/15 at 11:48 AM Nursing Assistant (NA) #2 delivered and performed set up of the lunch tray for Resident # 73. She was observed to remove the bread from a bag by grasping it with her bare hand. During an interview with NA #2 on 6/5/15 at 11:53 AM she stated she was not thinking when she handled the bread with her bare hand. She stated she knew she should not have touched the resident's food with her hands. During an interview on 6/18/15 at 9:15 AM the Dietary Manager stated ready to eat foods should not be touched with bare hands. During an interview on 6/18/15 at 9:28 AM the Director of Nursing reported staff were not to touch ready to eat foods with their bare hands. On 6/5/14 at 11:57 AM NA #3 delivered and	F 371	NA # 2 and NA # 3 were in-serviced on the need to have a barrier, such as a deli wrap, between ready to serve foods, such as bread, and bare hands when serving meals to the resident with return demonstration given by Staff Development Coordinator (SDC) completed by July 7, 2015. 100% in-service to be completed for Licensed Nurses, Certified Nursing Assistants (CNAs) and Department Managers to include NA #2 and NA #3 by the SDC and Administrator by July 16, 2015, regarding providing a barrier, such as deli wraps, between ready to eat foods, such as bread, and bare hands when serving residents meals with return demonstration given. All newly hired licensed nursing staff, CNAs and Department Managers will be in-serviced by the SDC during orientation regarding providing a barrier, such as deli wraps, between ready to eat foods, such as bread, and bare hands when serving	

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F 371	Continued From page 9 preformed set up of the tray for Resident # 90. She was observed to touch the resident ' s bread with her bare hands while removing it from the bag. During an interview on 6/5/15 at 12:05 PM NA #3 stated she did not realize she should not touch the bread with her bare hands. During an interview on 6/18/15 at 9:15 AM the Dietary Manager stated ready to eat foods should not be touched with bare hands. During an interview on 6/18/15 at 9:28 AM the Director of Nursing reported staff were not to touch ready to eat foods with their bare hands.	F 371	residents meals with return demonstration. When serving ready to eat foods, such as bread, licensed nursing staff, CNAs, and Department Managers will ensure that a barrier, such as a deli wrap, is between the ready to eat food, such as bread, and their bare hands. Meal observation audits will be conducted by SDC, Quality Improvement (QI) Nurse One, QI Nurse Two, MDS Coordinator and MDS Nurse using a Food Preparation Audit Tool for breakfast, lunch and dinner daily 5 x week x 4 weeks then weekly x 4 weeks then monthly x 2 months to ensure staff provided a barrier between ready to eat foods and bare hands. The Administrator will review the Food Preparation Audit Tool weekly x 8 weeks then monthly x 2 months and initial. The results of the Food Preparation Audit Tool will be compiled by the Administrator and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	