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	345266	A. BUILDING ______ B. WING ______	C 03/07/2019

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

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F 000	INITIAL COMMENTS A Complaint survey was conducted from 03/5/2019 through 03/7/2019. Past non-compliance was identified at CFR483. at tag F-689 at scope and severity-G.	F 000	Past noncompliance: no plan of correction required.	
F 569 SS=B	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on staff interviews and Resident Trust Accounts reviewed, the facility failed to forward the balance of expired resident's trust accounts within 30 days for two of three resident trust accounts reviewed. (Resident #7 and Resident #8).	F 569	As of 3/15/2019 all funds were dispersed by the facility business office manager to the estates of Resident # 7 and Resident #8. 100% audit of all expired residents in the past 90 days were reviewed on 3/15/2019	3/22/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/22/2019

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

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F 569	Continued From page 1 The findings included: 1. Resident # 7 expired on 9/25/18 and the balance of his resident trust account, $303.00 was forwarded to the Clerk of Court on 11/5/18. During an interview on 3/7/19 at 8:55 AM, the facility Business Office Manager revealed the reason she was not able to forward the checks within thirty days was because she had several audits and there was a lot of work that needed to be done. She stated she was trying to close out expired resident's accounts within thirty days. During an interview on 3/7/19 at 9:17 AM, the Administrator stated her expectation was that the balance of expired resident funds be forwarded to the Clerk of Court within thirty days. 2. Resident #8 expired on 1/3/19 and the balance of her resident trust account, $2,473.04 was forwarded to the Clerk of Court on 3/6/19. During an interview on 3/7/19 at 8:55 AM, the facility Business Office Manager revealed the reason she was not able to forward the checks within thirty days was because she had several audits and there was a lot of work that needed to be done. She stated she was trying to close to close out expired resident's accounts within thirty days. During an interview on 3/7/19 at 9:17 AM, the Administrator stated her expectation was that the balance of expired resident funds be forwarded to the Clerk of Court within thirty days.	F 569	by the administrator to ensure funds were dispersed as required to the clerk of court (estate). No areas of concern identified. On 3/15/2019 an in-service was completed with the business office manager and payroll manager by the administrator in regards to policies and procedures for resident funds to include the conveyance of such funds per company policy and state regulations. This training included the requirement to disperse resident funds to the estate of the resident who has expired within 30 days of discharge. All resident discharged will be audited weekly by the payroll manger to ensure conveyance of funds occur within 30 days of discharge utilizing resident fund discharge audit tool weekly x 4 weeks, then monthly x 2 monthly. Any identified areas of concerns will be corrected by the business office manager during the audit. The administrator will review and initial the resident fund discharge audit tool to ensure completion and that all areas of concerns are addressed. The administrator will forward the results of the resident fund discharge audit tool to the executive QA committee monthly x 3 months. The executive QA committee will meet monthly x 3 months and review the resident fund discharge audit tool to determine trends and or issues that may need further intervention.	
F 570	Surety Bond-Security of Personal Funds	F 570		3/22/19

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F 570 SS=C	Continued From page 2 CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on review of the Resident Trust Fund Accounts, the Surety Bond and staff interviews, the facility failed to provide a surety bond which covered the total balance in the resident trust funds accounts for five of 12 months reviewed. The findings included: Review of the facility Surety Bond, read in part, "Residents individually or in aggregate care of Roanoke Landing Nursing and Rehabilitation -5/15/18-5/15/19 for $43,000.00" Balance of total Resident Trust fund accounts for 7/31/18: - $53,761.25 Balance of total Resident Trust Fund accounts for 8/31/18 - $104,058.88 Balance of total Resident Trust Fund Accounts for 11/30/18 $47,194.22 Balance of total Resident Trust Fund accounts for 12/31/18: - $55,581.92 Balance of total Resident Trust Fund Accounts for 2/1/19: - $56,347.37 During an interview on 3/7/19 at 5:44 PM, the Administrator stated her expectation was to make	F 570	As of 3/22/2019 Surety Bond covered the total balance in resident trust accounts currently. Current Surety Bond is in the amount of 100,000 with an effective date of 3/7/2019. 100 % Audit of current Resident Account Balances was completed on 3/21/2019 by Payroll Manager and indicated a balance of 71,451.06, surety bond of 100,000 met requirement of surety bond covering total balance in resident trust. On 3/21/2019 an in-service was completed with the Business Office manager and Payroll manager by the administrator in regards to policies and procedures for resident surety bond for liability insurance company policy and state regulations related to requirements for surety bond. This training included the requirement for surety bond to cover total balance in resident trust after patient monthly liability transfers. 100 % review of the Resident trust funds will be audited by the Payroll Manager monthly X 3 utilizing the Resident Trust Account Balance audit tool to ensure Resident trust account balances do not exceed the amount of the Surety bond. Any identified areas of concerns will be reported to Administrator by the Payroll	

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F 570	Continued From page 3 sure the surety bond had enough money to cover resident funds accounts.	F 570	office manager during the audit. The Administrator will review and initial the Resident Trust Account Balance audit tool to ensure completion and that all areas of concerns are addressed. The Administrator will forward the results of the Resident Trust Account Balance audit tool to the Executive QA committee monthly x 3 months. The Executive QA committee will meet monthly x 3 months and review the resident trust account balance audit tool to determine trends and or issues that may need further intervention.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff, resident and physician interview, the facility failed to transfer Resident #1 from the bedside commode to the wheelchair with a mechanical lift and lock the brakes before placing Resident #1 into her wheelchair. Resident #1 fell during the transfer and sustained a fracture of the distal femur. This problem affected one of one sample residents reviewed for supervision to prevent accidents. The findings included:	F 689	Past noncompliance: no plan of correction required.	3/22/19

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F 689	Continued From page 4 Resident #1 was originally admitted to the facility on 9/30/13, with diagnoses including: Spinal stenosis, cervical region, abnormal posture, Obstructive hydrocephalus and Age related osteoporosis without current pathological fracture. According to the most recent Minimum Data Set dated 12/18/18, Resident #1's cognition was intact. She required extensive assistance with bed mobility, and total dependence with dressing, eating, personal hygiene and bathing. Review of Resident #1's Care Plan dated 12/18/18 revealed she required a mechanical lift during transfers with one person assist Review of a Fall Incident Report dated 2/14/19, read in part, "Nurse called to room by Nursing Assistant on the hall at 9:30 PM to assess resident complaining of right lower extremity and buttock pain. The resident stated the Nursing Assistant today was transferring me from the chair to the bed this morning and the chair was not locked so I fell on the floor. She said she did not use the lift and she did it herself. I landed on my right hip and butt. She then just picked me up off the floor and put me in the chair and went out the door. Upon assessment resident with 2+ pitting edema observed in the right lower extremity with palpable pedal pulse as well as redness on buttock region, however, no bruising or skin tears observed with limited range of motion. Resident complained of strong pain 8/10. Vital signs all within normal limits. Responsible Person called at 9:55 PM. DON and Administrator called at 10:10 PM with emergency medical technicians arriving at 10:25 PM and transferred to the hospital. X-ray was done of right hip and pelvis and showed no fracture."	F 689		

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F 689	Continued From page 5	F 689		

Review of Resident #1's medical record revealed the facility medical doctor saw Resident #1 on 2/18/19 and ordered further x-rays and Doppler study. Doppler was done on 2/18/19 and was negative for Deep Vein Thrombosis. MD was notified with new order to get orthopedic appointment as soon as possible.

Review of doctor's orders dated 2/18/19, read in part, "Obtain X-ray of right hip and femur and Doppler of right lower extremity."

Review of a Nursing note dated 2/19/19 revealed a radiology X-ray results showed a right acute distal femur fracture.

Review of a Nursing note written by Nurse #3 on 2/19/19 at 6:17 PM, read in part, "Resident #1 was sent for treatment at the hospital for further X-rays and assessment. Returned with right lower extremity wrapped with cast padding and immobilizer in place.
Review of a hospital note dated 2/20/19 at 3:39 PM, per RN at hospital, "Patient reported she was being placed on a bedside commode and was dropped by a NA and the NA fell on her. RN called Department of Social Services with referral to Adult Protective Services. RN at hospital also called nursing home and reported resident was dropped by the NA. 2/22/19 Ortho Evaluation. As of this date resident still wearing immobilizer on right extremity."

During an interview on 3/5/19 at 1:41 PM, Resident #1 stated she was put in a chair and dropped on the floor and the Nursing Assistant (NA#2) fell on her. She said the wheelchair was

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F 689	Continued From page 6	F 689		

not locked and she hit the floor. She said NA#2 fell on her and that did the damage. Resident #1 stated she was in a lot of pain when it happened.

During a second interview on 3/6/19 at 2:52 PM, Resident #1 stated she was in awful pain after the fall. She said she did not tell anyone she was in pain after the fall because she thought NA#2 would tell someone. She stated NA#2 dropped her and fell on her.

NA#2's written statement regarding the incident dated 2/15/19 was reviewed. NA #2's statement noted Resident #1 was transferred to the bedside commode after lunch. She stated she got the Viking lift and yellow toileting sling. NA#2 noted she and another Nursing Assistant (NA#3) put Resident #1 on the bedside commode using the lift. The normal routine was to put the call bell on the floor and the resident turned on the call bell with her foot when finished (pancake call bell). The call light came on and she went in and put the sling back under the resident and transferred her to wheelchair. The NA noted to her knowledge Resident #1 did not hit the floor.

An attempt was made on 3/5/19 at 2:52 PM to call NA#2 for an interview. Her phone had been disconnected. The facility did not have another phone number for her.

During an interview on 3/6/19 at 1:58 PM, NA #3 stated she had no idea what happened because she was not in the room and she did not assist with transferring Resident #1. She stated she did not know anything about what happened until she got home and received a phone call from the

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F 689	Continued From page 7 facility about the incident. During an interview on 3/5/19 at 2:58 PM, NA#1 revealed she worked on 2/14/19 from 3 PM to 11 PM. NA#1 stated she went in to check on Resident #1 and she was moaning. Resident #1 told NA#1 something happened to her but did not want to say anything. Resident #1 said NA#2 put her on the potty chair and when NA#2 took her off NA#2 did not lock the wheelchair and Resident #1 hit the floor hard. Resident #1 stated it was NA#2 that transferred her. NA#1 went to get Nurse #1 after Resident #1 shared what happened to her. During an interview on 3/5/19 at 3:12 PM, the Nurse #1 revealed she worked from 7 PM to 7 AM on 2/14/19. She revealed NA #1 called her to the room and that the resident was complaining of her leg hurting. Resident #1 stated NA#2 dropped her on the floor. She said the wheelchair was not locked and NA #2 did not use the lift. Nurse #1 asked Resident #1 if the NA #2 told the nurse on the hall and she said, no that NA#2 picked her up off the floor and put her in the chair and left. Nurse #1 stated Resident #1 was alert and oriented. Nurse #1 stated staff were supposed to always use the lift when transferring this resident. She stated the resident did not say anything about NA#2 falling on her. Nurse #1 stated Resident #1 was in severe pain that night. She stated she assessed Resident #1 and she had swelling in right leg with limited range of motion. Nurse #1 stated Resident #1 had pain in her right leg and buttock. She stated she called the doctor and the resident was sent to the emergency room. NA#2 came in to work the next morning and was not allowed to work.	F 689		

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F 689	Continued From page 8	F 689		

During an interview on 3/6/19 at 1:14 PM, the Administrator revealed Resident #1 revealed NA#2 picked up Resident #1 and put her in the wheelchair, the wheelchair rolled and Resident #1 fell. She stated NA#2 picked up Resident #1 and transferred her that way. She stated the NA did not report the incident. She said during an interview, NA#2 stated another NA helped her with the transfer but that was not true. She stated NA#2 made a bad decision. The Administrator stated she terminated the employee for failing to report the incident and failing to follow the care guide. The Administrator stated NA#2 never admitted she transferred the resident herself without the lift and dropped her. The Administrator stated the fall was not purposeful or intentional and she did not see it as neglect because at that time there was no injury or fractures reported. She stated when she interviewed Resident #1 she told her the wheelchair rolled and the NA dropped her on the floor. She stated she never said the NA fell on her.
During an interview on 3/6/19 at 3:08 PM the facility physician stated Resident #1 had osteoporosis and was bed bound. He stated she saw Resident #1 for follow-up on 2/15/19 (Friday) and on Monday she went to the emergency department and was diagnosed with a distal femur fracture. He stated they initiated pain control and she was not an operative candidate. The facility Physician revealed Resident #1 had a rough couple of days and stabilized after that. He stated the fracture could have happened from the fall and that he did not know anything about what happened to cause the injury.

During an interview on 3/6/19 at 3:48 PM, the

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F 689	Continued From page 9 Administrator stated they had a QA meeting and discussed Resident #1's injury and pain. Prevention of Accident On 3/7/19 at 6:00 PM, the facility provided a plan of correction for tag 689, as follows: The Process that lead to address the Corrective Actions. Resident #1 is alert and oriented and has a diagnosis of Spinal Stenosis, cervical region, abnormal posture, dysphagia, oral phase, and muscle weakness, major depressive disorder, Hypertension, Bell's palsy, obstructive hydrocephalus, age related osteoporosis, Hemiplegia, nontramatic intracerebral subarachnoid hemorrhage, spondylosis with myelopathy, cervical region and cataract. Resident #1 is care planned for one person assist with the Viking lift. On 2/14/19 at approximately 9:30 PM, 3-11 shift, the assigned hall nurse was called to Resident #1's room by the Nursing Assistant (NA#1). Resident #1 was complaining of right lower extremity and buttock pain. The hall nurse question Resident #1 about the source of pain. Resident #1 indicated that while NA#2 was transferring resident from the bedside commode to the chair earlier that day on the 7-3 shift, NA#2 transferred resident without using a lift. During the transfer, the chair was not locked and the chair rolled out from under the resident causing a fall to the floor landing on buttocks. NA#2 then picked resident up without the use of a lift and placed resident into chair. On 2/14/19 at 9:30 PM the nurse assessed Resident #1 and noted 2 + pitting edema right lower extremity with palpable pulse, redness on buttocks region, no bruising noted, limited range of motion and strong complaint of pain. On 2/14/19 at 9:30 AM, the physician was notified of complaints of pain and possible fall	F 689		

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F 689	Continued From page 10 with new order to transfer resident to the local emergency room for evaluation. The assigned hall nurse notified the Administrator and Director of Nursing of the incident. On 2/14/19 at 9:55 PM the Resident Representative was notified by the hall nurse of the possible fall, pain, and transfer to the emergency room. On 2/14/19 at 10:10 PM, emergency medical services was notified to transport to the emergency room. On 2/18/19 at 3:20 PM the physician was in to see the resident with new order to obtain x-ray of right hip and femur, and Doppler of right lower extremity related to continued complaints of pain in right lower extremity. On 2/19/19 at 6:15 PM x-ray report revealed acute distal right femur fracture. On 2/20/19 at 12:30 PM an x-ray was ordered for confirmation of fracture of right femur. Resident was transported to local radiology. On 2/20/19 at 2:53 PM x-ray report: comminuted impacted distal femoral diaphyseal fracture. Resident was transferred to the local emergency room and Resident Representative was notified. The Administrator began an investigation of Resident #1's fall on 2/15/19. NA #1 is no longer employed at the facility as of 2/15/19. The Procedure to implement a Corrective Action Plan- 100% Resident Care Audit - Transfers with return demonstration was initiated by the assigned hall nurse and Staff Facilitator on 2/20/19 with all nursing assistants to ensure staff provided transfers utilizing appropriate technique and per care guide instructions. All areas of concern were immediately addressed by Staff Facilitator and assigned hall nurse to include education of staff on transfer technique and following care guide. Audit was completed on 2/22/19. After 2/22/19 no	F 689		

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F 689	Continued From page 11 Nursing Assistants (NA) will be allowed to work until audit completed. On 2/27/19 the return demonstration was expanded to include nurses. The nurses return demonstration will be completed by 3/1/19. After 3/1/19 no Nurse will be allowed to work until audit is completed. 100% Audit of all falls x 30 days was completed by the Director of Nursing (DON) on 2/20/19 to ensure no fall resulted from improper transfer technique. There were no identified areas of concern. 100% Resident Questionnaires were completed on 2/20/19 with all alert and oriented residents in regard to concerns during transfers. There were no concerns voiced during the interviews. 100% in-service was initiated by the DON on 2/15/19 with all nurses and Nursing Assistants in regard to Safe Handling to include reading and following the resident care guide prior to transferring a resident; fall protocol to include calling a code green; immediately reporting an incident; and not moving the resident until assessed by a nurse. The In-service was completed on 2/22/19. After 2/22/19 any nurse o NA who had not received the in-service will be mailed the in-service via certified mail by Staff Facilitator with instructions to return in-service prior to returning to work. On 2/27/19 100% in-servicing was initiated with all nurses and nursing assistants on ensuring chairs and beds are locked prior to transferring a resident. The in-service will be completed by 3/1/19. After 3/1/19 any nurse or NA who have not received the in-service will be mailed the in-service via certified mail by the Staff Facilitator with instructions to return in-service prior to returning to work. The Plan for Monitoring of the Plan of Correction- The decision to monitor reading and following the	F 689		

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 ______	C 03/07/2019

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F 689	Continued From page 12 resident care guide prior to transfers was made by the Administrator on 2/22/19. 10% of nursing assistants will be audited performing resident transfers by the assigned hall nurses, Staff Facilitator, Quality Assurance (QA) Nurse with all NAs utilizing the Resident Care Transfer Audit Tool weekly x 8 weeks then monthly x 1 month to ensure staff provided are reading and following the resident care guide for transfer and locking the bed and/or wheelchair prior to the transfer. All areas of concern will be immediately addressed by the assigned hall nurses, Staff Facilitator, and Quality Assurance (QA) Nurse to include re-educating staff on transfer technique and checking care guides. The DON will review and initial the Resident Care Transfer Audit tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The Initial Quality Assurance (QA) meeting to review the plan of correction was held on 2/22/19. The Administrator will forward the results of the Resident Care Transfer Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Resident Care Transfer Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Title of person responsible for implementing the plan of correction The Administrator and DON are responsible for the implementation of corrective actions to include all 100% audits, in-service and monitoring related to the plan of correction.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 13 Date of Corrective Action Completion Final Compliance date was 3/1/19. During the investigation observations were made of three transfers, one with Resident #1 and two transfers of a resident on the sample. The residents were transferred according to care guide instructions and the wheel chair brakes were locked. Observations included two transfers of residents from bed to wheelchair in their rooms and one observation of a transfer of a resident from a bathtub to a wheelchair. The plan of correction was verified through staff interviews and in-service education provided on transfers, safe handling, incident reporting, and pain assessment. In addition audits, and in service records were reviewed. The facility's plan of correction completion date of 3/1/19 was also verified.	F 689		