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 08/29/2019

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 Survey was conducted 8/26/19 to 8/29/19. The facility was found in compliance with the requirement CFR483.73, Emergency Preparedness. Event ID #7EPU11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey with complaint investigation was conducted from 8/26/19 through 8/29/19. Zero of the five complaint allegations were substantiated. See event ID 7EPU11.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		9/26/19

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

Electronically Signed | 09/23/2019

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F 584	Continued From page 1 §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 and staff interviews, the facility failed to maintain a clean and functional environment as evidenced by failure to clean dust from bed frames for 5 of 5 rooms on the A Hall (Rooms 105, 112A, 113B, 115, and 116A), maintain intact sheetrock, wall coverings, and door veneer for 8 of 11 rooms reviewed for Environment, (Rooms 105, 113, 115, 140, 141, 144, 145, and 146), maintain plumbing fixtures in 5 of 11 rooms reviewed for Environment (Rooms 105, 112, 140, 141, and 146), and maintain Packaged Terminal Air Conditioners (PTACs) in a clean and intact condition for 4 of 11 rooms reviewed for Environment (Rooms 113, 140, 144, and 145). Findings included: 1. Observations conducted during a round on 8/26/19, which started at 11:27 AM, revealed the	F 584	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. 1.Dust was cleaned from the bed frames in rooms 105, 112A, 113B, 115, and 116A by housekeeping personnel on September 23, 2019. Sheetrock paper above the toilet in the bathroom and an exposed sheetrock corner bead on the wall facing the resident room for resident room 105 will be repaired by the Maintenance Department by September 26, 2019. Room 113 will receive repair	

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F 584	Continued From page 2 following rooms had dust build up on the resident bed frames: 105, 112A, 113B, 115, and 116A. An interview was conducted with Housekeeper (HSK) #2 on 8/27/19 at 11:44 AM. The HSK stated there was not a schedule of rooms to deep clean. She said she kept a list of rooms which she had deep cleaned. She stated her routine cleaning included sweeping and mopping the floor, cleaning the over the bed tables with a disinfectant cleaner, dusting the furniture in the room (night stand, dresser, chair(s), and cleaning the bathroom. Observations conducted during a round on 8/27/19, which started at 3:58 PM, revealed the following rooms had dust build up on the resident bed frames: 105, 112A, 113B, 115, and 116A. Observations conducted during a round on 8/28/19, which started at 1:38 PM with the Housekeeping Supervisor (HSKS) and the Maintenance Director (MD), revealed the following rooms had dust build up on the resident bed frames: 105, 112A, 113B, 115, and 116A. The HSKS stated the bed frames should have been dusted as part of the routine dusting which is part of the daily cleaning routine. The HSKS stated it was her expectation for bed frames to be free of dust build up. During an interview was conducted with the administrator on 8/28/19 at 3:00 PM she stated it was her expectation for resident rooms to be clean which would include the dusting of the frames of the resident beds. 2. Observations conducted during a round on 8/26/19, which started at 11:27 AM, revealed the	F 584	from Maintenance Director to an area of sheetrock to the right of resident bed B by September 26, 2019. Veneer missing from the hinged interior side at the base bathroom door for resident room 115 will be repaired by the Maintenance Department by September 26, 2019. Sinks will be replaced in resident rooms 140, 141, &146 by the Maintenance Director by September 26, 2019. Sink in resident room 112 was securely re-mounted to the counter by the Maintenance Director by September 24, 2019. Air filter was added to the PTAC unit in resident room 113 by the Maintenance Director on September 17, 2019. Plastic outer cover of PTAC unit in resident rooms 140 & 144 was cleaned by Housekeeping personnel on September 23, 2019. Walls in resident rooms 140,141, & 146 with exposed screw heads were repaired by Maintenance Director by September 26, 2019. Wall paper will be removed/replaced in resident rooms 140 & 141 by Maintenance Department by September 26, 2019. Holes in walls and peeling base boards in the bathroom of resident rooms 144 & 145 will be repaired by Maintenance Director by September 26, 2019. Resident room 146 will have the base of the toilet cleaned and caulk added by Environmental Services personnel by September 26, 2019. Housekeepers not being trained on standardized resident room cleaning procedure and not following procedure to conduct rounds helping proactively identify maintenance related concerns followed by Supervisor oversight lead to the citation.	

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F 584	Continued From page 3 following: Room 105 had damage to the sheetrock paper above the toilet in the bathroom and an exposed sheetrock corner bead on the wall facing the resident room which surrounded the bathroom of approximately 8 inches. Room 113B had an area of where the sheetrock paper had been torn through to the right of the resident bed exposing approximately 12 inches of sheetrock. Room 115 had veneer missing from the hinged interior side at the base bathroom door of an area which was slightly larger than a softball which exposed the interior portions of the door and splintered pieces of the remaining veneer. An interview was conducted with Housekeeper (HSK) #2 on 8/27/19 at 11:44 AM. The HSK stated there was a book in which she would write communicate matters which need to be addressed by the maintenance department. Observations conducted during a round on 8/27/19, which started at 3:58 PM, revealed the following: Room 105 had damage to the sheetrock paper above the toilet in the bathroom and an exposed sheetrock corner bead on the wall facing the resident room which surrounded the bathroom of approximately 8 inches. Room 113B had an area of where the sheetrock paper had been torn through to the right of the resident bed exposing approximately 12 inches of sheetrock. Room 115 had veneer missing from the hinged interior side at the base bathroom door of an area which was slightly larger than a softball which exposed the interior portions of the door and splintered pieces of the remaining veneer. Observations conducted during a round on	F 584	2.The procedure for identification of other potential residents affected and protecting them from similar situations related to having a safe, clean, comfortable, and homelike environment are as follows: The Administrator conducted visual inspection of resident rooms on September 17, 2019. 16 resident beds were found needing dusting of the frames. Five rooms total were found with a hole needing sheetrock repair and base cove replacement. Four doors total were found with veneer missing from the door. Eight rooms were found to have a sink with rust. Two resident rooms were found with holes in the wall exposing screw heads and one room was found with exposed brackets and needing caulk replaced. One room was found missing PTAC filter. Twelve rooms were found to have bed frames in need of cleaning. Eight rooms were found to need the outside of the PTAC units cleaned. Three rooms were found needing the base of the toilet cleaned. Extra Environmental Services personnel started corrections on September 20, 2019 to help repair items in identified rooms above. 3.The facility has implemented the following measures and systemic changes to ensure this citation does not occur again: Current facility employees received education on identification, documentation, and reporting of Maintenance and Housekeeping concerns by facility Administrator on September 20, 2019. Employees received visual	

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F 584	Continued From page 4 8/28/19, which started at 1:38 PM with the Housekeeping Supervisor (HSKS) and the Maintenance Director (MD) revealed the following: Room 105 had damage to the sheetrock paper above the toilet in the bathroom and an exposed sheetrock corner bead on the wall facing the resident room which surrounded the bathroom of approximately 8 inches. Room 113B had an area of where the sheetrock paper had been torn through to the right of the resident bed exposing approximately 12 inches of sheetrock. Room 115 had veneer missing from the hinged interior side at the base bathroom door of an area which was slightly larger than a softball which exposed the interior portions of the door and splintered pieces of the remaining veneer. The MD stated he had not received a work order for observed matters requiring facility maintenance attention. He stated all the observed areas did require attention and they would be addressed. He stated it was his expectation to receive a work order from staff which would alert him to construction and building concerns requiring the attention of the maintenance department so he could properly assess and address the concerns. During an interview was conducted with the administrator on 8/28/19 at 3:00 PM she stated it was her expectation for resident rooms and facility construction to be maintained intact in order to accomplish that expectation completion of work orders or communication to the maintenance department about facility construction concerns would facilitate that process. 3. Observations conducted during a round on 8/26/19, which started at 11:27 AM, revealed the	F 584	demonstration of how to add these concerns into the facility electronic work order system. The Regional Maintenance Director provided education to the facility Maintenance Director on ¿¿¿¿¿¿September 20, 2019 regarding daily inspection and timely completion of electronic work orders. Peer to Peer education was provided to the Housekeeping Supervisor and personnel on September 24, 2019 by PruittHealth Durham Housekeeping Supervisor. This education includes cleaning techniques, cleaning schedules, documentation, and employee evaluation. Environmental Services personnel on leave of absence will receive above mentioned education upon return. Education will be added to the orientation of newly hired Environmental Services personnel. Deep Cleaning Schedule for resident rooms added to facility electronic Preventative Maintenance/Work order system by Administrator to be tracked by Housekeeping Supervisor and completed by Environmental Services Personnel. Facility Administrative (to include Human Resources, Activities Director, Social Service Director, Medical Records, and Financial Counselor, Housekeeping Supervisor, and Maintenance Director) employees conduct visual Maintenance and Housekeeping compliance rounds Monday thru Friday and input needed corrections into the facility electronic work order system. 4.To ensure solutions are sustained the facility has implemented the following	

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F 584	Continued From page 5 following: Room 105 had rust around the drain of the sink in the bathroom and the sink in the bathroom of room 112 was not properly mounted to the counter which allowed it to move freely when the water was turned on and off at the faucet. An interview was conducted with Housekeeper (HSK) #2 on 8/27/19 at 11:44 AM. The HSK stated there was a book in which she would write communicate matters which need to be addressed by the maintenance department. Observations conducted during a round on 8/27/19, which started at 3:58 PM, revealed the following: Room 105 had rust around the drain of the sink in the bathroom and the sink in the bathroom of room 112 was not properly mounted to the counter which allowed it to move freely when the water was turned on and off at the faucet. Observations conducted during a round on 8/28/19, which started at 1:38 PM with the Housekeeping Supervisor (HSKS) and the Maintenance Director (MD) revealed the following: Room 105 had rust around the drain of the sink in the bathroom and the sink in the bathroom of room 112 was not properly mounted to the counter which allowed it to move freely when the water was turned on and off at the faucet. The MD stated he had not received a work order for observed matters requiring facility maintenance attention. He stated the observed areas did require attention and they would be addressed. He stated it was his expectation to receive a work order from staff which would alert him to construction and building concerns requiring the attention of the maintenance	F 584	monitoring techniques: The facility Administrator or Administrative designee (to include Human Resources, Activities Director, Social Service Director, Medical Records, and Financial Counselor) will conduct visual Environmental rounds daily for fourteen days, then weekly for four weeks, then monthly for three months. Findings of the audits will be discussed by facility Administrator at facility Quality Assurance Performance Improvement Committee meeting monthly for three months. 5.September 26, 2019	

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F 584	Continued From page 6	F 584		

department so he could properly assess and address the concerns.

During an interview was conducted with the administrator on 8/28/19 at 3:00 PM she stated it was her expectation for resident rooms and facility construction to be maintained intact in order to accomplish that expectation completion of work orders or communication to the maintenance department about facility construction concerns would facilitate that process.

4. Observations conducted during a round on 8/26/19, which started at 11:27 AM, revealed the PTAC unit in room 113 did not have removable air filters.

An interview was conducted with Housekeeper (HSK) #2 on 8/27/19 at 11:44 AM. The HSK stated the maintenance department was responsible for cleaning and maintaining the air filters in the PTAC units in the resident rooms. She further stated she had observed the maintenance department cleaning the filters in the PTAC units last weekend.

Observations conducted during a round on 8/27/19, which started at 3:58 PM, revealed the PTAC unit in room 113 did not have removable air filters.

Observations conducted during a round on 8/28/19, which started at 1:38 PM with the Housekeeping Supervisor (HSKS) and the Maintenance Director (MD) revealed the PTAC unit in room 113 did not have removable air filters. The MD stated the PTAC unit should have had filters in it.

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F 584	Continued From page 7 During an interview was conducted with the administrator on 8/28/19 at 3:00 PM she stated it was her expectation for facility equipment, including PTAC units, to be maintained as per manufacturer's guidelines and if the units were designed to have a filter, the filter be in the unit. On 08/26/2019 at 10:27 AM an observation of room 140 revealed the plastic outer cover of the PTAC (Packaged Terminal Air Conditioner) unit located under the window splattered with dark brownish black spots. The first bed near the door way of the room was positioned against the wall and the chair rail on the side of the bed and at the head of the bed had been removed and exposed screw holes as well as some exposed screw heads. The wall paper exposed at the chair rail area did not match the wallpaper in the rest of the room. The bathroom of room 140 was observed to have no caulk around the outer rim of the sink against the counter top and the outer rim had a ring of rust around the entire sink. On 08/26/2019 at 10:43 AM the bathroom sink of room 141 was observed with no caulk around the outer rim of the sink and a visible rust colored rim was observed around the outside of the sink. The chair rail at the head of the bed nearest to the window was removed and there were exposed screw holes where the chair rail had been and the exposed wall paper did not match the wall paper in the rest of the room. On 08/26/2019 at 11: 23 AM an observation of room 145 revealed peeling baseboards on all bathroom walls with a hole about 6 inches in diameter visible behind the peeling baseboard behind the toilet on the left side that almost reached behind the toilet.	F 584		

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F 584	Continued From page 8	F 584		

The PTAC unit observed on 08/26/2019 at 2:44 PM in room 144 revealed spattered brownish black spots on the outside plastic cover of the unit. The bathroom of room 144 revealed peeling baseboard on all 4 walls of the bathroom and there was an exposed hole (that appeared about 3 - 4 inches in diameter) behind a piece of peeling baseboard on the left wall as entering the bathroom.

On 08/26/2019 at 12:36 PM an observation of the bed closest to the window in room 146 revealed a missing chair rail around the head of the bed. Exposed screw holes and old wall paper were observed where the chair rail had been removed. The bathroom of room 146 revealed no caulk at the base of the toilet and a thick coating of a dried dirt like substance around the toilet base. The sink in the bathroom was observed with a rust ring around the outer sink bowl on the counter with no visible caulk. There was also a rusted bracket wit a rusted screw visible on the left side of the sink counter The Bracket observed may have been in place to hold the sink and counter to the wall.

On 08/28/2019 at 1:32 PM environmental rounds were conducted with the Maintenance Director (md) and the housekeeping manger (hm) were conducted on the 100 hall (rooms 140,141,144,145 and 146). The md explained that the chair rails that were missing had been removed as directed about a year ago and he thought it was based on another survey entity. The md could not explain why the chair rails had not been replaced or wall paper repaired to match the wall paper in the rest of the room. The hm revealed that her housekeepers were responsible

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F 584	Continued From page 9	F 584		

to dust the rooms and PTAC covers, but not wipe them down with any cleaner and that it was maintenance responsibility to remove the PTAC covers and clean them with a cleanser. The hm wiped a finger over with PTAC cover in room 140 and the brownish black substance wiped off onto her finger. The hm asked the md if there was a moisture issue in that room from the window or in the other room where the plastic PTAC cover had the same dark brownish black substance on it. The md did not respond. The md was unable to provide a schedule for PTAC cleaning. The md observed the rust rings around the sink bowls in the bathrooms and revealed that he had not noticed the rust before and also that it did appear to him that the caulk around the sink had not been replaced and that if he knew of the concern, he would have started to repair the sinks and re-caulked the sink bowls and the counters. The md also revealed that he would re-caulk the toilet base in the bathroom of room 146. The md and hm both pushed on the toilet and it was secured to the floor. The md stated he had never seen nor had the rusty bracket and screw on the sink counter in the bathroom of room 146. He revealed that he would replace it as soon as possible to be certain the sink did not pull away from the wall it was mounted to. The md observed the peeling baseboards in the bathrooms and exposed holes behind the peeling baseboards and revealed that repairs would begin to seal the holes and repair the baseboards immediately. The md did not respond or submit a maintenance schedule for review and repairs in the facility. The hm revealed that it was expected that the house keeping staff complete a full corner to corner clean and dusting in resident care areas daily and complete deep cleaning as scheduled in all areas. The hm revealed that she

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F 584	Continued From page 10 did not have a formal tool that was used to audit facility cleaning and that she just walked through the facility and did random visual checks of care areas. The hm also was asked if she had a formal cleaning schedule for her department and she reported that if she did, she would provide it for review. No schedule was provided. On 08/29/2019 at 10:37 AM a house keeper on the 100 hall was interviewed. The house keeper revealed that her daily cleaning routine included to remove trash and replace trash cans with clean liners to rooms and bathrooms. The house keeper also revealed that she first looked through the room and took any dirty dishes to the kitchen, she cleaned the commodes, wiped dirt and dust-off soap, towel dispensers as well as night stands and table top covers. The house keeper also revealed that she completed a "big dust" in at least 4 rooms weekly if she was able to and that included moving beds and night stands. On 08/29/2019 at 10:37 AM the facility administrator was interviewed and revealed the expectation was that all areas in the facility be maintained in a clean, safe and home like manner.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	F 637		9/26/19

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PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 11 implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident and staff interviews, the facility failed to complete a significant change MDS (Minimum Data Set-a tool used for resident assessment) within 14 days after a significant change for 1 of 2 residents (Resident #67) reviewed. Findings included: Resident # 67 was admitted to the facility on 5/16/2019 with diagnoses that included post motor vehicle accident, cervical spine fracture, anxiety and depression. A review of an admission MDS dated 05/23/2019 for Resident # 67 included that Resident # 67 was cognitively impaired and required extensive assist of 2 staff for bed mobility, transfers and toileting and that Resident # 67 required 1 staff assist to eat. Resident # 67 was frequently incontinent of bladder and bowel. Resident # 67 was coded to be at risk to develop pressure ulcer and had no pressure ulcer during the MDS review period. A care plan for Resident # 67 initiated on 05/29/2019 revealed that Resident # 67 had a potential for altered skin integrity and that Resident # 67 would be free of skin breakdown through the next review. Care plan interventions included to encourage or assist Resident # 67 to reposition, provide incontinent care, report skin alterations to the charge nurse, treat as ordered	F 637	1.A significant change assessment was completed for on September 4, 2019 with an Assessment Reference Date of September 20, 2019 for Resident #67 by the facility RN Case Mix Coordinator. A change in the facility RN MDS Coordinators and need for additional training to complete resident assessments lead to the cited deficiency. 2.The procedure for identification of other potential residents affected by having a timely Comprehensive Assessment after significant change in resident condition are as follows: Current facility residents with noted changes in condition were reviewed by the Interdisciplinary Team members (Activities Director, Certified Dietary Manager, Social Service Director, and Therapy Outcomes Coordinator) on September 23, 2019. Residents with the qualifications for a significant change per the RAI manual had an assessment opened for completion by the facility RN Case Mix Coordinator starting September 24, 2019. 3.The facility has implemented the following measures and systemic changes to ensure this citation does not occur again: Facility RN Case Mix Coordinators and Interdisciplinary Team (Activities	

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 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 637	Continued From page 12 by the physician (MD) and to give vitamins and minerals as ordered. A review of a wound consult dated 06/07/2019 revealed in part that Resident # 67 developed a stage 3 pressure ulcer and a trauma wound of the left buttocks during the last week. The consult included to off load the wounds, provide a low air loss mattress, float heels and provide a pressure reduction cushion to the wheel chair. Resident # 67's medical record revealed that she was discharged to the hospital on 06/12/2019 and readmitted to the facility on 06/14/2019. A wound consult dated 06/21/2019 included in part that Resident # 67 was readmitted to the facility with an unstaged pressure ulcer of the right buttock and the pressure ulcer of the left buttock progressed to be unstaged. The wound consult revealed that the left hip trauma wound had healed. On 07/27/2019 a physician (MD) order revealed that Resident # 67 was to start Levaquin (an antibiotic) 750 milligrams (mgs) orally (po) every 2:00 PM for 10 days for wound infection. A quarterly MDS dated 08/20/2019 was marked as "in progress" in the medical record of Resident # 67. On 08/28/2019 at 5:10 PM an interview was conducted with the wound nurse. The wound nurse revealed that she did not complete any part of the MDS and that she provided the MDS nurses with a weekly skin report every Monday. On 08/29/2019 at 8:53 PM an interview was conducted with MDS nurse #1 and MDS nurse	F 637	Director, Certified Dietary Manager, Social Service Director, and Therapy Outcomes Coordinator) received training regarding completing a Comprehensive Assessment after significant change from courses taken starting September 23, 2019. Facility RN Case Mix Coordinator received Peer to Peer training from PruittHealth RN Case Mix Coordinators regarding qualifications for and completion of Significant Change assessments by September 26, 2019. 4.To ensure solutions are sustained the facility has implemented the following monitoring techniques: Regional Case Mix Coordinators will review transmitted assessments weekly for four weeks, then monthly for three months to ensure a significant change assessment was completed if needed per the RAI manual. Findings of the audits will be discussed by facility RN Case Mix Coordinators at facility Quality Assurance Performance Improvement Committee meeting monthly for three months. 5.September 26, 2019	

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 08/29/2019

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

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F 637	Continued From page 13 #2. MDS nurse # 2 revealed that she had completed the MDS dated 05/23/2019 and that based on the weekly wound report from the wound nurse and a review completed of the medical record of Resident # 67 there was no documentation of a pressure ulcer or a trauma wound. MDS nurse # 2 revealed that a significant change MDS had not been completed for Resident # 67 to include a facility acquired stage 3 pressure ulcer or trauma wound and that when Resident # 67 was readmitted to the facility a significant change MDS should have been initiated to include that the stage 3 facility acquired pressure ulcer had progressed to an unstaged pressure ulcer, the trauma wound was healed and that Resident # 67 also had been readmitted with an unstaged pressure ulcer from the hospital and was started on antibiotics for a wound infection. MDS nurse # 1 revealed that it had been an oversite on the part of the MDS nurses and that Resident # 67 had required a significant change MDS. The facility administrator was interviewed on 08/29/2019 at 1:29 PM. The administrator revealed that all MDSs should be coded accurately and capture a change in condition as per the RAI (Resident Assessment Manual).	F 637		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews observations and staff and resident interviews, the facility failed to	F 641	1. Facility RN MDS Coordinator completed corrections to sections for	9/26/19

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 08/29/2019

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 14 accurately code Minimum Data Sets (MDSs) for 6 of 8 residents reviewed for MDS accuracy (Residents #34, #32, #49, # 95 and # 82.) Resident # 34 and Resident # 49 were inaccurately coded in the areas of cognition, moods and behaviors. Resident # 32 was inaccurately coded in the MDS area of prognosis for a life expectancy of less than 6 months. Resident # 82 was inaccurately coded for activities and Resident # 95 was inaccurately coded in the section for discharge location on the MDS. Findings included: 1.Resident #34 was admitted to the facility on 09/28/2019 with diagnoses that included Alzheimer's disease, dementia, anemia and malnutrition. A review of a quarterly MDS dated 06/21/2019 revealed that Resident # 34 was coded to be rarely understood and was able to rarely understand. Resident # 34 was coded with short- and long-term memory deficits and had severely impaired ability to make daily care decisions. Resident #34 was also coded to exhibit signs and symptoms of delirium that included inattention, disorganized thinking and an altered level of consciousness that fluctuated during the review period. Resident #34 was coded to have had 2 to 6 days of feeling or appearing down, depressed or hopeless and of being short tempered or easily annoyed during the review period. Resident #34 also experienced 7 to eleven days of trouble falling asleep, staying asleep or slept to much. Resident #34 was coded that during the review period she experienced hallucinations, delusions and exhibited verbal behaviors and other	F 641	cognition, mood, and behavior for Residents #34 and #49 on September 23, 2019. Resident #32 was removed hospice services on September 4, 2019 after Interdisciplinary Team evaluation showing resident did not have life expectancy less than six months. Facility RN MDS Coordinator completed corrections to Customary and Routine Activities section for Resident #82 on September 23, 2019. Resident #95 discharge assessment was corrected on September 23, 2019 by the facility RN MDS Coordinator with regard to discharge location. A change in the facility Social Service and RN MDS Coordinators as well as need for additional training during transition to new electronic Minimum Data Set system lead to the cited deficiency. 2. The procedure for identification of other potential residents affected by inaccurate and incomplete coding on resident assessments are as follows: Admission, Quarterly, and Discharge assessments completed in the last 30 days were reviewed by the facility RN MDS Coordinator for accurate coding starting September 23, 2017. Assessments with inaccurate or incomplete coding were corrected and resubmitted by the facility RN Case Mix Coordinator starting September 24, 2019. 3. The facility has implemented the following measures and systemic changes to ensure this citation does not occur again: Facility Interdisciplinary Team members (Activities Director, Certified	

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 08/29/2019

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 behaviors to others for one to three days of the review period. An observation of Resident #34 conducted on 08/26/2019 at 2:10 PM revealed Resident #34 seated in her wheel chair at the end of the hall at the windows of the door with her head down. Resident #34 opened her eyes but did not make any verbal response to surveyor. Resident # 34 was not observed to exhibit any moods or behaviors. A review of the medical record of Resident #34 during the review period of the quarterly MDS dated 06/21/2019 revealed no documentation to support the MDS coding for signs or symptoms of delirium, altered moods or behaviors that had been coded for Resident #34. An interview conducted with nurse assistant (NA) # 1 on 08/27/2019 at 2:18 PM revealed that Resident #34 sometimes answered simple yes or no questions and that she did have rambled speech at times. NA #1 revealed that Resident #34 had never exhibited and altered moods or behaviors and that NA #1 had never been witness to Resident #34 hallucinating or with delusions. On 08/27/2019 at 2:43 PM with NA # 2 revealed that Resident #34 spoke infrequently and did make sense sometimes, but NA #2 had never witnessed Resident #34 with any altered mood, behaviors, hallucinations or delusions. On 08/28/2019 at 3:08 PM an interview was conducted with Nurse # 1. Nurse #1 revealed that she had taken care of Resident #34 for at least 4 years and she had never observed Resident # 34 with the altered moods or behaviors that were	F 641	Dietary Manager, Social Service Director, and Therapy Outcomes Coordinator) and RN MDS Coordinators received training regarding accurate completion of resident assessments after significant change from starting September 23, 2019. Facility RN Case Mix Coordinators received Peer to Peer training from PruittHealth RN Case Mix Coordinators regarding accurate completion of the cognition, mood, behavior, life expectancy, activities, and discharge location sections of the resident assessments by September 26, 2019. 4. To ensure solutions are sustained the facility has implemented the following monitoring techniques: Facility RN Case Mix Coordinators will review transmitted assessments weekly for four weeks, then monthly for three months to ensure a significant change assessment was completed if needed per the RAI manual. Findings of the audits will be discussed by facility RN Case Mix Coordinators at facility Quality Assurance Performance Improvement Committee meeting monthly for three months. 5. September 26, 2019	

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 08/29/2019

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

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F 641	Continued From page 16	F 641		

coded for Resident # 34 on the MDS dated 06/21/2019. Nurse # 1 also revealed that Resident #34 had not had any hallucinations or delusions that she witnessed or had been reported to her.

MDS Nurse # 1 and MDS Nurse # 2 were interviewed on 08/29/2019 at 8:53 AM. MDS Nurse # 1 reviewed the quarterly MDS for Resident #34 dated 06/21/2019 and revealed that the social worker had completed the MDS sections for cognition, moods and behaviors and that the social worker was no longer employed at the facility. MDS Nurse # 2 also reviewed the same MDS and revealed that Resident #34 had been miscoded by the social worker and that upon medical record review on 08/28/2019 neither MDS Nurse was able to locate any supportive documentation that supported the social worker coding in the areas of cognition, behaviors or moods. MDS Nurse #2 revealed that the social worker at the time had been educated on multiple occasions about miscoding MDSs and the need for supportive documentation. MDS Nurse # 1 revealed the quarterly MDS dated 06/21/2019 for Resident #34 had been miscoded and that the MDS Nurses did not check for documentation to support MDS coding by other disciplines prior to signing and transmitting the MDS and the MDS Nurse signature was needed to signify MDS completion. MDS Nurse # 1 also revealed that she was not aware that Resident # 34 had exhibited any of the coded answers for cognition, moods or behaviors for Resident #34. MDS Nurse #1 and MDS Nurse #2 verified that MDS coding required supportive documentation during the MDS review period.

In interview with the Director of Nurses (DON)

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 08/29/2019

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		

conducted on 08/29/2019 at 9:36 AM revealed that the MDS dated 06/21/2019 for Resident # 34 had been miscoded by the social worker at the time and that Resident # 34 had never exhibited any of the altered mood or behaviors, hallucinations or delusions.

The facility administrator was interviewed on 08/29/2019 at 1:29 PM. The administrator revealed that every section of every MDS be coded accurately and that supportive documentation be included in the medical record during the review period as directed by the Resident Assessment Manual (MDS).

2. Resident #82 was admitted to the facility on 7/31/2019 with diagnoses to include respiratory failure, seizure disorder and dementia with behavioral disturbances. The admission Minimum Data Set (MDS) assessment dated 8/7/2019 assessed Resident #82 to be severely cognitively impaired. The section Preferences for Customary Routine and Activities was blank.

The Activities Director (AD) was interviewed on 8/29/2019 at 11:30 AM and she reported Section F, Preference for Customary Routine and Activities was her responsibility to complete. The AD reported she had completed the assessment on paper and keyed the responses into the computer documentation system. The AD reported she must have made a keying error when she entered Resident #82 ' s assessment into the system.

MDS Nurse #2 was interviewed on 8/29/2019 at 12:02 PM and she reported Section F was the activities director ' s responsibility to complete.

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 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 18	F 641		

MDS Nurse #2 reported she reviewed MDS assessments for completeness by reviewing the Care Area Assessment (CAA) and Resident #82 had a CAA completed for activities. MDS Nurse #2 Went on to explain she had not reviewed each section of the MDS for completeness.

MDS Nurse #1 was interviewed on 8/29/2019 at 12:49 PM and she reported the Activities Director should have entered the information for Section F into the electronic documentation system and the MDS nurses should be looking at each section of the MDS assessment to ensure each section was completed.

The Administrator was interviewed on 8/29/2019 at 2:39 PM and she reported her expectation was the MDS was coded correctly and all staff who complete the MDS should understand how to enter data into the system. The Administrator went on to explain the staff would be trained again on documentation and data entry for the MDS assessment.

3. Resident #49 was admitted to the facility on 10/5/2018 and readmitted 6/20/2019 with diagnoses to include cellulitis, weakness and chronic pain.

The most recent quarterly Minimum Data Set (MDS) assessment dated 6/28/2019 was reviewed and Section C, cognition, Section D mood and Section E behavior were not completed.

An interview was conducted with MDS Nurse #2 on 8/29/2019 at 12:02 PM and she reported that sections C, D and E were the responsibility of the Social Worker. The MDS went on to explain 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 08/29/2019

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 19	F 641		

Social Worker was no longer employed by the facility and when the Social Worker completed the quarterly MDS for Resident #49, she had placed dashes in the sections she was responsible to complete, and the dashes indicated that the sections were finished. MDS Nurse #1 reported she had not viewed each of the sections of the quarterly MDS for Resident #49 when she signed it as completed.

MDS Nurse #1 was interviewed on 8/29/2019 at 12:49 PM and she reported the former Social Worker had not completed her sections of the MDS assessment for Resident #49 and had documented dashes to make it appear the sections had been completed.

The Administrator was interviewed on 8/29/2019 at 2:39 PM and she reported her expectation was the MDS was coded correctly and all staff who complete the MDS should understand how to enter data into the system. The Administrator went on to explain the staff would be trained again on documentation and data entry for the MDS assessment.

4. Resident #32 was originally admitted to the facility on 6/6/19 and most recently readmitted on 7/19/19. The resident's diagnoses included: Paraplegia, multiple pressure ulcers, generalized weakness, and depression.

A review of Resident #32's Minimum Data Set (MDS) revealed the most recent completed assessment was a comprehensive admission assessment with an Assessment Reference Date (ARD) of 6/13/19. The MDS assessment indicated Resident #107 had no cognitive impairment. The resident was coded for Hospice services. Further review of the MDS revealed 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 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 20	F 641		

resident was not coded as having had a prognosis, condition, or chronic disease that may result in a life expectancy of less than 6 months.

Review of Resident #32's Medical Record (MR) revealed a Notification of Admission to Hospice sheet from the Hospice provider dated 6/13/19. The communication sheet was a correspondence from the Hospice provider to the facility providing information Resident #32 was admitted to their Hospice services effective 3/20/18.

Further review of Resident #32's MR revealed a Communication Log from the Hospice provider dated 6/13/19 and timed 12:50 PM completed by the Hospice Registered Nurse (RN). Under Care Provided the following was documented: Hospice Admission visit, diagnosis-Severe Protein Calorie Malnutrition. Admission forms were signed, and an assessment was performed, the patient refused a wound/skin assessment. The RN documented there was collaboration with the facility staff and the chart was updated.

During an interview conducted with the Admissions Coordinator on 8/29/19 at 12:30 PM she stated Resident #32 was admitted to hospice services as of 6/13/19.

An interview was conducted with MDS Nurse #3 on 8/29/19 at 12:46 PM. The MDS Nurse stated Resident #32 was admitted to hospice services on 6/13/19, the same date as the admission MDS assessment. The MDS Nurse stated there was no documentation to support a diagnosis of life expectancy of less than 6 months to live for the resident and that was why she had not coded the resident as having had a life expectancy of less than 6 months to live. The MDS Nurse reviewed

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 08/29/2019

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 21	F 641		

the resident's medical record and stated the resident's admission diagnosis to hospice was severe calorie malnutrition, dated 6/13/19.

An interview was conducted with the Administrator on 8/29/19 at 3:00 PM. The Administrator stated it was her expectation for MDS assessments to have been coded accurately. She further stated an additional MDS nurse had been added to the team of MDS nurses. In addition, she stated she felt with the additional nurse added to the MDS team and having new MDS nurses on the MDS team, were important steps toward achieving her expectation.
5. A closed record review revealed Resident #95 was admitted on 5/26/19 from an acute hospital setting after having surgery for left hip fracture. Resident was admitted for rehab services with the goal of returning to the community.

The resident's discharge plan of care indicated the resident was discharged to home on 6/15/19.

The facility's Emergency transfer/Discharge log for the month of June indicated resident was discharged home on 6/15/2019 with reason for discharge documented as "met rehab goals."

Nursing notes dated 6/15/19 (no time of day documented) indicated, "Resident discharged home from facility with husband."

Resident #95's discharge minimum data set (MDS) dated 6/15/2019 documented Section A, A0310F, as Discharge assessment-return not anticipated. A2100, discharge status, indicated acute hospital. Section A was completed by the facility MDS coordinator on 6/18/19.

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 08/29/2019

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 22 The MDS coordinator was not available for interview. The facility's social service director was not available for interview and was no longer employed by the facility. On 8/29/19 at 3:20pm, an interview with the facility administrator was conducted. She acknowledged the discharge MDS, dated 6/15/19, was coded incorrectly and should have been coded to reflect the resident had been discharged to the community and not to an acute hospital setting.	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	F 656		9/26/19

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 08/29/2019

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 23 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. (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 record review, hospice representative interview, and staff interviews, the facility failed to collaborate with hospice to develop and implement an interdisciplinary care plan for one of one resident reviewed for hospice (Resident #32). Resident #32 was originally admitted to the facility on 6/6/19 and most recently readmitted on 7/19/19. The resident's diagnoses included: Paraplegia, multiple pressure ulcers, generalized weakness, and depression. A review of Resident #32's Minimum Data Set (MDS) revealed the most recent completed assessment was a comprehensive admission assessment with an Assessment Reference Date (ARD) of 6/13/19. The MDS assessment indicated Resident #107 had no cognitive impairment. The resident was coded for Hospice services.	F 656	1. Resident #32 discharged from Hospice services per their choice September 4, 2019. Facility does not have another resident on Hospice services. A change in the facility RN MDS Coordinators and need for additional training regarding collaboration with hospice agency in development of Hospice resident assessments lead to the cited deficiency. 2. The procedure for identification of other potential residents affected by comprehensive care plan development was as follows: Facility RN Case Mix Coordinators and Interdisciplinary Team (Activities Director, Certified Dietary Manager, Social Service Director, and Therapy Outcomes Coordinator) reviewed the last 30 days of resident assessments	

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 08/29/2019

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F 656	Continued From page 24 Review of Resident #32's Medical Record (MR) revealed a Notification of Admission to Hospice sheet from the Hospice provider dated 6/13/19. The communication sheet was a correspondence from the Hospice provider to the facility providing information Resident #32 was admitted to their Hospice services effective 3/20/18. Further review of Resident #32's MR revealed a Communication Log from the Hospice provider dated 6/13/19 and timed 12:50 PM completed by the Hospice Registered Nurse (RN). Under Care Provided the following was documented: Hospice Admission visit, diagnosis-Severe Protein Calorie Malnutrition. Admission forms were signed, and an assessment was performed, the patient refused a wound/skin assessment. The RN documented there was collaboration with the facility staff and the chart was updated. During an interview conducted with the Admissions Coordinator on 8/29/19 at 12:30 PM she stated Resident #32 was admitted to hospice services as of 6/13/19. A review completed of Resident #32's care plan which had signatures including the facility Activities Director, Facility Dietary Manager, Facility Director of Nursing (DON), and facility Social Worker all dated 6/26/19. The review revealed a hospice care plan with a problem onset date of 6/18/19. There was no documentation of involvement or collaboration with the contracted Hospice Services in the reviewed care plan. The review revealed no signatures identified as hospice agency staff or providing evidence the care plan had been reviewed by hospice agency staff.	F 656	for identified hospice residents. No other residents outside of Resident #32 were identified. 3. The facility has implemented the following measures and systemic changes to ensure this citation does not occur again: Facility Interdisciplinary Team members (Activities Director, Certified Dietary Manager, Social Service Director, and Therapy Outcomes Coordinator) and RN MDS Coordinators received training regarding collaborating with agencies or other appropriate entities in the development and implementation of the resident care plan starting September 23, 2019. Facility RN Case Mix Coordinators received Peer to Peer training from PruittHealth RN Case Mix Coordinators regarding involving Hospice in care plan development, implementation, and meetings by September 26, 2019. 4. To ensure solutions are sustained the facility has implemented the following monitoring techniques: Facility Administrator will review resident assessments for collaboration of participating agencies weekly for four weeks, then monthly for three months. Findings of the audits will be discussed by facility RN Case Mix Coordinators at facility Quality Assurance Performance Improvement Committee meeting monthly for three months. 5. September 26, 2019	

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	345378	A. BUILDING _____ B. WING _____	C 08/29/2019

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F 656	Continued From page 25	F 656		

A review of the Medical Record (MR) for Resident #32 was completed on 8/29/19 at approximately 11:25 AM. The review revealed no evidence of a contracted hospice agency care plan in the MR.

During an interview conducted with Nursing Assistant (NA) #4 on 8/28/19 at 11:04 AM she stated she had observed Hospice agency staff in twice a week and provided assistance to Resident #32 including giving him baths.

An interview was conducted with the Admissions Coordinator on 8/29/19 at 12:30 PM. She stated she was currently doing care plan invitations but had not been doing the care plan invitations during the month of June when Resident #32 had his care plan developed and he had a care plan meeting. She stated the resident was not admitted as a hospice resident but was picked up by the Hospice agency on 6/13/19.

An interview was conducted with MDS Nurse #3 on 8/29/19 at 12:46 PM. The MDS Nurse stated Resident #32 was admitted to hospice services on 6/13/19, the same date as the admission MDS assessment. The MDS Nurse stated if a resident was on hospice then the Hospice agency was invited to the care plan meeting. The MDS Nurse stated the facility Social Worker (SW) was in charge of sending invitations to the Hospice agency for Care Plan meetings. The MDS Nurse reviewed the Medical Record and was unable to discover the Hospice agency Care Plan.

A phone interview was conducted on 8/29/19 at 12:51 PM with the Hospice agency SW. The SW stated she had not been invited to the facility care plan meeting regarding Resident #32 and she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 08/29/2019

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PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 656	Continued From page 26 would have attended had she been invited. She stated she had not been contacted by a facility staff member to collaborate about and coordinate care plan information between the Hospice agency and the facility. She further stated the Hospice agency did have its own Care Plan regarding Resident #32 and a copy of their care plan should have been in the resident's medical record. An interview was conducted with the Administrator on 8/29/19 at 3:00 PM. The Administrator stated it was her expectation for the facility staff and the Hospice agency staff to collaborate and coordinate a Care Plan for a resident who was on hospice. She further stated she felt with an additional nurse added to the MDS team, having new MDS nurses, and having a new Social Worker, those interventions would help to facilitate communication between the facility and the Hospice agency.	F 656		
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 observations, record review, staff and resident interviews, the facility failed to provide personal hygiene, toileting and dressing assistance (Resident #13) and nail care (Resident #26) for 2 of 2 residents who were dependent upon staff for activities of daily living (Residents #13 and #26).	F 677	1. Resident #26 had their nails clipped and cleaned by facility Certified Nursing Assistant on August 30, 2019. Resident #13 was transported by facility to missed appointment on September 16, 2019. Physician seen by Resident #13 on September 16. 2019 did not schedule any follow up appointments. Not following a	9/26/19

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F 677	Continued From page 27 Findings included: 1. Resident #26 was admitted to the facility 7/7/2016 with diagnoses to include hemiplegia after stroke, abnormality of gait and hypertension. The most recent annual Minimum Data Set (MDS) assessment dated 6/5/2019 assessed Resident #26 to be cognitively intact without behaviors or rejection of care. Resident #26 was assessed to require extensive one-person assistance with hygiene and total assistance one-person assistance with bathing. The physician orders for Resident #26 were reviewed and an order dated 7/7/2016 instructed to "Nail care, check PRN (as needed). The medication administration record (MAR) was reviewed and the order to check "nail care PRN" was noted on the MAR, but no documentation had been completed for the order. Resident #26 was observed on 8/26/2019 at 4:52 PM. The fingernails on both hands were long and extended past the tip of his fingers by more than ¼ inch. A dark material was noted under some of his nails on the right hand. An observation of Resident #26 was conducted on 8/27/2019 at 12:31 PM. The fingernails on both hands were long and extended past the tip of his fingers by more than ¼ inch. A dark material was noted under the nails on the right hand. Resident #26 was observed on 8/29/2019 at 2:23 PM and the fingernails on both hands remained long and extended past the tip of his fingers by more than ¼ inch. The nails on the right hand	F 677	consistent tracking system for nail care and resident appointments lead to this citation. 2. The procedure for identification of other potential affected ADL dependent residents was as follows: On September 19, 2019 facility Administrator conducted visual nail care rounds on current facility residents. Ten residents were found to need of nail care. Certified Nursing Assistants completed nail care for these residents by September 24, 2019. On September 23, 2019 the Director of Health Services and Assistant Director of Health Services reviewed appointments for the past thirty days for missed appointments. No other residents were found to have missed scheduled appointments. 3. The facility has implemented the following measures and systemic changes to ensure this citation does not occur again: Facility employees were trained by the Director of Health Services on September 20, 2019 regarding clipping and cleaning resident nails during their assigned shower days. This task was added to the facility electronic ADL documentation system for Certified Nursing Assistants to mark when completed on assigned days. Facility employees were trained on September 20, 2019 by the Director of Health Services to check the resident calendar for resident appointments at the start of the shift to ensure residents are ready for their appointments prior to the	

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F 677	Continued From page 28	F 677		

were noted to have a dark material under the nails.

An interview was conducted with Resident #26 on 8/28/2019 at 2:23 PM and he reported he was unable to clip his nails because he did not have the use of his left hand. He reported he did not like having long nails and he needed staff to clip them for him.

An interview was conducted with Nurse #2 on 8/28/2019 at 10:33 AM and she reported Resident #26 did not refuse to have his nails cut.

Nursing assistant (NA) #4 was interviewed on 8/28/2019 at 1:41 PM and she reported Resident #26 did not refuse care.

Nurse #2 was interviewed again on 8/28/2019 at 3:41 PM. She reported she checked all resident nails on a daily basis but felt she may have forgotten to check Resident #26 ' s nails on this date. Nurse #2 was not certain why Resident #26 ' s nails were long and had a dark material under the nails of his right hand.

The Assistant Director of Nursing (ADON) was interviewed on 8/28/2019 at 4:05 PM and she reported she was not aware Resident #26 ' s nails were long and had dark material under the nails. NA #5 was interviewed on 8/28/2019 at 4:18 PM and she reported Resident #26 did not refuse care and she clipped and cleaned resident nails with their shower.

An interview was conducted with NA #6 on 8/29/2019 at 10:23 AM and she reported she had provided a shower to Resident #26 on 8/26/2019, but she had forgotten to clip or clean his nails on

appointment time. Facility Transportation Aides leave written note at nursing station for Licensed Nurses and Certified Nursing Assistants at least twenty-four hours prior to resident appointment. Certified and Licensed Nursing personnel on leave of absence will receive above mentioned education upon return. Education will be added to the orientation of newly hired Licensed and Certified Nursing personnel.

4. To ensure solutions are sustained the facility has implemented the following monitoring techniques: The facility Administrator or Administrative designee (to include Activities Director, Certified Dietary Manager, Social Service Director, Housekeeping Supervisor, and Maintenance Director) will conduct visual ADL nail care rounds daily for fourteen days, then weekly for four weeks, then monthly for three months. The Director of Health Services or Administrative Nursing designee (Assistant Director of Health Services, RN Clinical Competency Coordinator, and facility Treatment Nurses) will review facility transportation log, resident calendar, and resident nursing notes to ensure residents are taken to appointments as scheduled. This review will happen daily for fourteen days, then weekly for four weeks, then monthly for three months. Findings of these audits will be discussed by facility Administrator at facility Quality Assurance Performance Improvement Committee meeting monthly for three months.

5. September 26, 2019

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 08/29/2019

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F 677	Continued From page 29	F 677		

that date.

The Director of Nurses (DON) was interviewed on 8/29/2019 at 2:25 PM and she reported a tool would be developed to track nail care with showers and she expected the residents to receive nail clipping and cleaning with their bath or shower.

The Administrator was interviewed on 8/29/2019 at 2:39 PM and she reported it was her expectation that resident nails were kept clean and clipped and the staff would implement a monitoring system to make certain the nails of residents were clipped and clean.

2.

Resident #13 was admitted to facility on 01/30/2014 with diagnosis of muscle spasms, and type 2 diabetes mellitus with diabetic neuropathy.

Most recent quarterly minimum data set (MDS) dated 5/30/19 indicated Resident #13 was cognitively intact (BIMS) of 15, no documented behaviors, and required extensive physical assistance for all ADLs including ; personal hygiene dressing and transfers. Resident #13 was documented as requiring extensive physical assistance for toileting and total dependent in bathing. Resident requires supervision and set up for eating.

Most recent comprehensive care plan for Resident #13, dated 6/11/19, indicates requires extensive assistance with activities of daily living (ADLs) due to impaired mobility. Goal included resident having needs met daily by assisting resident daily with ADLs. Interventions included two person physical assist with transfers, assisting with oral care, and keeping eye glasses

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	345378	A. BUILDING _____ B. WING _____	C 08/29/2019

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F 677	Continued From page 30	F 677		

clean and within reach.

A review of Resident #13's medical record revealed a discharge note dated 7/29/19 which indicated he would need to follow up with hematology-oncology in 4 weeks. Discharge note read, " Next steps: Schedule an appointment as soon as possible for a visit in 4 weeks with Hematology-Oncology for symptomatic anemia; reconsider Aranesp therapy."

On 08/26/19 at 10:26 am, Resident #13 was observed in his room, on his personal cell phone trying to reschedule an appointment. At that time, an interview was conducted with the resident. He reported missing his appointment with hematology-oncology on 8/26/19 because he was not ready when the transport van left that morning. Resident further stated the staff should have gotten him out of bed, dressed, and given him breakfast, so he could be transported on the transport van to his scheduled appointment. However, that morning, no one got him up and ready, so he missed his scheduled appointment to evaluate his symptomatic anemia.

In an interview with transportation aide on 08/29/19 at 9:57am she indicated she was aware Resident #13 had an appointment with hematology-oncology on Monday August 26th in Pinehurst. However, the resident was still in his bed asleep at the time they were loading the van for his appointment. She further stated the nurses and nurse aides were notified of resident's appointments (dates and times) by transportation staff daily. The transportation aide explained the transportation staff notified the nursing staff of resident's appointment by posting the appointment notification at the nurse's station.

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	345378	A. BUILDING _____ B. WING _____	C 08/29/2019

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F 677	Continued From page 31	F 677		

She stated Resident #13's August 26th appointment notice was posted by the weekend transportation staff and was viewable to the nursing staff, but the resident was not prepared to go at the designated time.

On 08/29/19 at 1:14 pm an interview with Nurse #3, who worked on the resident's hall on Sunday 8/25/19, during the third shift, she indicated she was not aware the resident had an appointment on Monday morning 8/26/19 because she did not see the notification sheet hanging at the nurse's station. She further stated she found the notification on the nurse's station desk area late in the morning, but it was too late to get the patient up and ready for his appointment. She confirmed transportation provided the notification. She was not sure how it got in the wrong place.

A second interview was conducted with Resident #13 on 08/29/19 at 12:28pm. Resident #13 stated he was told by the night shift nurse on 8/26/19 someone would be in around 7:00 am to get him ready for his appointment, but no one came in to get him ready.

On 08/29/19 at 11:05 am, an interview with Nurse #2, who worked on Resident's #13's hall Monday morning (8/26/19) from 7am-7pm, was conducted. Nurse # 2 stated she recalled seeing the resident's appointment date and time posted at the nurse's station. She further stated the third shift nurse and nurse aide (NA) should have gotten the resident up, dressed, and given him breakfast so he would've been ready to go to appointment by 8am. The resident was not ready when she reported to her assignment on Monday morning at 7:00am and there was not enough time for her to get the resident up, dressed, and

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	345378	A. BUILDING _____ B. WING _____	C 08/29/2019

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F 677	Continued From page 32 to the van on time. An interview with the facility administrator was conducted on 8/29/19 at 3:30pm in which she acknowledged staff failed to get Resident #13 ready for transportation to take him to his medical appointment.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to apply a splint to 1 of 2 residents reviewed for range of motion (Resident #26). Findings included: Resident #26 was admitted to the facility 7/7/2016 with diagnoses to include hemiplegia (paralysis on one side of the body) after stroke, abnormality of gait and hypertension. A physician ' s order dated 4/26/2018 directed for Resident #26 to wear a right upper extremity splint 4-6 hours per day and to perform skin checks before and after application of the splint to check for skin irritation.	F 684	1. Resident #26 had physician order for splint reviewed by Therapy Outcomes Coordinator and Assistant Director of Health Services. Restorative Certified Nursing Assistants reapplied right upper extremity splint per physician order on September 20, 2019. Transition from a paper documentation system to an electronic documentation system as well as changes in Restorative Nursing Program lead to this citation. 2. The procedure for identification of potential for other residents to have Quality of Care related to splint application are as follows: The Assistant Director of Health Services and the Therapy	9/26/19

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 684	Continued From page 33 The most recent annual Minimum Data Set (MDS) assessment dated 6/5/2019 assessed Resident #26 to be cognitively intact without behaviors or rejection of care. The MDS noted Resident #26 had functional limitation of the range of motion in one side of his upper and lower body. The care plans for Resident #26 were reviewed and a care plan dated 6/14/2019 was in place for the provision of activities of daily living due to right-sided hemiplegia. An intervention was in place to apply the right upper extremity splint 4-6 hours per day and monitor Resident #26 ' s skin before and after splint application. The treatment administration record (TAR) for March through August 2019 were reviewed and an order to apply the right upper extremity splint 4-6 hours per day and check skin before and after application was noted to be on the TARs. No documentation was on the TARs indicating the splint had been applied as ordered. Resident #26 was observed on 8/26/2019 at 4:53 PM and the right upper extremity splint was not applied to him. An observation on 8/27/2019 at 12:31 PM revealed Resident #26 did not have the right upper extremity splint in place. Resident #26 was observed on 8/28/2019 at 2:23 PM and the right arm splint was in place. Nurse #2 was interviewed on 8/28/2019 at 10:33 AM and she reported Resident #26 would wear the right upper extremity splint if he felt like it.	F 684	Outcomes Coordinator reviewed current residents for physician orders related splints on September 20, 2019. The facility has eleven residents with orders for splint application. Starting September 23, 2019 residents with current physician orders for splints were evaluated by Therapy Outcomes Coordinator for appropriate fitting and application. 3. The facility has implemented the following measures and systemic changes to ensure this citation does not occur again: Facility employees were educated on September 20, 2019 about the importance of splint application and the employees that will apply the splints. Therapy Outcomes Coordinator will review current resident with splints orders starting September 23, 2019 for appropriateness and fit. Certified and Licensed Nursing personnel on leave of absence will receive above mentioned education upon return. Education will be added to the orientation of newly hired Licensed and Certified Nursing personnel. Administrative team members (Activities Director, Certified Dietary Manager, Social Service Director, and Therapy Outcomes Coordinator) will conduct visual splint compliance rounds for current residents with physician orders for splints with reports of compliance given during morning and afternoon meetings. 4. To ensure solutions are sustained the facility has implemented the following monitoring techniques: The Director of Health Services or Administrative Nurse	

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 08/29/2019

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F 684	Continued From page 34 Resident #26 was interviewed on 8/28/2019 at 2:23 PM and he reported he would ask one of the nursing assistants (NA) to apply the splint for him. NA #4 was interviewed on 8/28/2019 at 1:41 PM and she reported she was not certain if a NA or a nurse was supposed to apply the splint to Resident #26. NA #4 went on to explain if the task was assigned to the NA, it would show in the kiosk as a task that needed completed, but it was not listed as a task for Resident #26. Nurse #2 was interviewed on 8/28/2019 at 3:41 PM and she reported she had not observed the order for the splint on the medication administration record and she had not applied the splint. Nurse #3 was interviewed on 8/29/2019 at 11:00 AM and he reported Resident #26 would sometimes refuse to apply the splint to his right arm. Nurse #3 went on to explain that he thought because the order was on the TAR, it was the treatment ' s nurse ' s responsibility to apply and remove the splint. Certified occupational therapist assistant #1 was interviewed on 8/29/2019 at 1:43 PM and she reported it was her understanding nursing staff were to apply the right upper extremity splint to Resident #26. Physical therapist #1 was interviewed on 8/29/2019 at 1:49 PM and she reported she applied Resident #26 ' s splint on 8/28/2019, but the splint should be applied by nursing staff. The Director of Nursing was interviewed on 8/29/2019 at 2:25 PM and she reported the task	F 684	designee (Assistant Director of Health Services, RN Clinical Competency Coordinators, or RN Treatment Nurse) will conduct visual audits of splint application compared with current physician orders daily for fourteen days, then weekly for four weeks, then monthly for three months to ensure splint application compliance. Findings of the audits will be discussed by facility Director of Health Services at facility Quality Assurance Performance Improvement Committee meeting monthly for three months. 5. September 26, 2019	

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 08/29/2019

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PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

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F 684	Continued From page 35 for the splint application had been a nursing assistant ' s task, but when the electronic documentation system was changed, the task was not transferred. The Administrator was interviewed on 8/29/2019 at 2:39 PM and she reported she understood that the old electronic documentation system and the new system should have merged. The Administrator reported she expected the tasks for residents to be correct and applied as the physician ordered.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		9/26/19

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 842	Continued From page 36	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 37 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review resident and staff interviews, the facility failed to maintain medical records that were complete for 2 of 25 residents who had their medical records reviewed (Residents #16 and 26). Findings included: 1. Resident #16 was admitted to the facility on 4/13/2016 with diagnoses to include hypertension, diabetes and depression. The most recent quarterly Minimum Data Set (MDS) assessment dated 6/3/2019 assessed Resident #16 to be moderately cognitively impaired and required extensive one-person assistance with personal hygiene and total one-person assistance with bathing. A physician order dated 2/13/2019 ordered antifungal powder to be applied three times per day under Resident #16' s neck. The resident's medical record had no nursing note narratives documented after 4/2/19. Further review of the medical record revealed no skin assessments were completed after 5/19/19. A care plan dated 5/31/2019 identified Resident #16 had a risk of skin breakdown and interventions included observation of her skin. Resident #16 was observed on 8/26/2016 at 9:48 AM in bed and an area of redness was noted on her neck, under her chin. Resident #16 reported	F 842	1. Resident #16 had a head to toe skin audits completed with documentation on the facility electronic medical records system on September 1, 2019 by facility Licensed Nurse. Resident #26 had physician order for splint reviewed by Therapy Outcomes Coordinator and Assistant Director of Health Services on September 20, 2019. Restorative Certified Nursing Assistants reapplied right upper extremity splint per physician order on September 23, 2019 with documentation added to the facility electronic medical records system. Changes in Licensed and Certified Nursing personnel lead to this citation. 2. The procedure for identification of potential other residents affected by Resident Records related to documentation of skin monitoring and splint application are as follows: Current facility residents were reviewed on September 19, 2019 by the facility Administrator for completion of weekly skin audits and documentation of splint application. Eleven residents were found needing skin audits completed. Weekly skin audits were added to the electronic system starting September 20, 2019 by the Director of Health Services for completion by the Licensed Nurse assigned to the resident. September 20, 2019 the Assistant Director of Health Services review the documentation of	

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	345378	A. BUILDING _____ B. WING _____	C 08/29/2019

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F 842	Continued From page 38	F 842		

at this time she had a skin irritation that required medication and the nursing staff applied the medication three times per day.

Nurse #2 was interviewed on 8/28/2019 at 10:33 AM and she reported Resident #16 had a fungal infection under her neck that was recurrent and required topical medications to be applied. Nurse #2 reported the skin infection would heal but would break down because Resident #16 had difficulty holding her head up. Nurse #2 explained that a weekly skin assessment was completed for all residents and she was not aware Resident #2 did not have nursing notes since 4/2/2019 or a weekly head to toe assessment since 5/19/2019. Nurse #2 concluded by reporting the facility nurses charted on residents "by exception", or when things that were unusual occurred with the resident.

Nurse #3 was interviewed on 8/29/2019 at 11:00 AM and he reported weekly head to toe skin assessments were completed on every resident. Nurse #3 reported he was not aware Resident #16 did not have nursing notes in her chart since 4/2/2019 and no head to toe skin assessment since 5/19/2019. Nurse #3 went on to explain the facility nurses charted "by exception" and he was not certain why Resident #16 did not have documentation in her chart.

The Director of Nursing (DON) was interviewed on 8/29/2019 at 12:32 PM and she reported she was not aware nursing notes for Resident #16 were not in the chart since 4/2/2019 or no weekly head to toe skin assessments were in the chart since 5/19/2019. The DON reported the weekly head to toe skin were assigned to nurses to complete. The DON concluded by reporting it

current residents with orders for splint application. Eleven residents were found lacking documentation. Certified Restorative Aides will complete documentation of splint application in the electronic medical record starting September 26, 2019.

3. The facility has implemented the following measures and systemic changes to ensure this citation does not occur again: Facility Licensed and Certified Nursing personnel were educated starting September 20, 2019 by Director of Health Services regarding documentation of skin audits in the facility electronic medical record system. Starting September 20, 2019 the Director of Health Services in-serviced facility Licensed and Certified Nursing personnel Restorative Certified Nursing Assistants will document application of resident splint in the resident electronic medical record. Certified and Licensed Nursing personnel on leave of absence will receive above mentioned education upon return. Education will be added to the orientation of newly hired Licensed and Certified Nursing personnel.

4. To ensure solutions are sustained the facility has implemented the following monitoring techniques: The Director of Health Services or Administrative Nurse designee (Assistant Director of Health Services, RN Clinical Competency Coordinators, or RN Treatment Nurse) will conduct visual audits of skin audit as well as splint application documentation in the

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F 842	Continued From page 39 was her expectation the weekly head to toe skin assessments were completed weekly and the nurses were documenting any changes in the resident's condition in the nursing notes. The Administrator was interviewed on 8/29/2019 at 2:39 PM and she reported she expected all resident documentation to be completed to capture resident conditions and concerns in the medical record. The Administrator reported she felt the missing documentation for Resident #16 was related to staff training. 2. Resident #26 was admitted to the facility 7/7/2016 with diagnoses to include hemiplegia (paralysis on one side of the body) after stroke, abnormality of gait and hypertension. A physician's order dated 4/26/2018 directed for Resident #26 to wear a right upper extremity splint 4-6 hours per day and to perform skin checks before and after application of the splint to check for skin irritation. The most recent annual Minimum Data Set (MDS) assessment dated 6/5/2019 assessed Resident #26 to be cognitively intact without behaviors or rejection of care. The MDS noted Resident #26 had functional limitation of the range of motion in one side of his upper and lower body. A care plan was in place dated 6/14/2019 that addressed Resident #26's impaired mobility related to hemiplegia of the right side and interventions included to apply a right upper extremity splint 4-6 hours per day and to monitor the skin integrity before and after application.	F 842	electronic medical records system daily for fourteen days, then weekly for four weeks, then monthly for three months to ensure splint application compliance. Findings of the audits will be discussed by facility Director of Health Services at facility Quality Assurance Performance Improvement Committee meeting monthly for three months. 5. September 26, 2019	

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F 842	Continued From page 40	F 842		

The treatment administration records (TAR) for March 2019 through August 2019 were reviewed and an order to apply the right upper extremity splint 4-6 hours per day and check skin before and after application was noted to be on the TARs. No documentation was on the TARs regarding the application of the splint.

Resident #26 was interviewed on 8/28/2019 at 2:23 PM and he reported he would ask one of the nursing assistants (NA) to apply the splint for him. Resident #26 was noted to be wearing his splint and he reported the physical therapist applied the splint for him on this date.

Nursing Assistant (NA) #4 was interviewed on 8/28/2019 at 1:41 PM and she reported she did not know if the NA or the nurses were to apply the splint to Resident #26, but she had not applied it for him on 08/28/19.

Nurse #2 was interviewed on 8/28/2019 at 3:41 PM and she reported she had not observed the order for the splint on the TAR and she had not applied the splint to the resident's arm on 8/28/19.

Nurse #3 was interviewed on 8/29/2019 at 11:00 AM and he reported Resident #26 would sometimes refuse to apply the splint to his right arm and was aware of the order for the splint being on the resident's TAR.

The Director of Nursing (DON) was interviewed on 8/29/2019 at 12:32 PM and she reported she was not aware nursing staff were not documenting the application of the splint for Resident #26. The DON reported it was her expectation that the splint was applied as the physician ordered and the nurses 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 08/29/2019

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F 842	Continued From page 41 the application in the TAR. Physical Therapist #1 was interviewed on 8/29/2019 at 1:43 PM and she reported she had applied the splint to Resident #26 on 8/28/2019 by his request. The Administrator was interviewed on 8/29/2019 at 2:39 PM and she reported she expected all resident documentation to be completed to capture resident conditions and concerns in the medical record. The Administrator reported she felt the missing documentation for Resident #26 was related to staff training.	F 842		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 865	1. Facility RN MDS Coordinator	9/26/19

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 08/29/2019

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F 865	Continued From page 42 facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 6/21/18 recertification survey. This was for one deficiency in the area of: Accuracy of Assessments, which was originally cited in June 2018. The deficiency was recited again on the current recertification with an exit date of 6/29/19. The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program The findings included: This tag is cross referenced to: F641-Based on record reviews, observations, and staff and resident interviews, the facility failed to accurately code Minimum Data Sets (MDSs) for 6 of 8 residents reviewed for MDS accuracy (Residents #34, #32, #49, #95 and #82). Resident #34 and Resident #49 were inaccurately coded in the areas of cognition, moods, and behaviors. Resident #32 was inaccurately coded in the MDS area of prognosis for a life expectancy of less than 6 months. Resident #82 was inaccurately coded for activities. Resident #95 was inaccurately coded in the section for discharge location on the MDS. During the recertification survey of 6/21/18 the facility was cited for failure to complete the Minimum Data Set (MDS) assessment accurately in the area of life expectancy for 1 of 1 resident reviewed for hospice. An interview was conducted with the	F 865	completed corrections to sections for cognition, mood, and behavior for Residents #34 and #49 on September 23, 2019. Resident #32 was removed hospice services on September 4, 2019 after Interdisciplinary Team evaluation showing resident did not have life expectancy less than six months. Facility RN MDS Coordinator completed corrections to Customary and Routine Activities section for Resident #82 on September 23, 2019. Resident #95 discharge assessment was corrected on September 23, 2019 by the facility RN MDS Coordinator with regard to discharge location. A change in the facility Social Service and RN MDS Coordinators as well as need for additional training during transition to new electronic Minimum Data Set system lead to the cited deficiency. 2. The procedure for identification of other potential residents affected by inaccurate and incomplete coding on resident assessments are as follows: Admission, Quarterly, and Discharge assessments completed in the last 30 days were reviewed by the facility RN MDS Coordinator for accurate coding starting September 23, 2017. Assessments with inaccurate or incomplete coding were corrected and resubmitted by the facility RN Case Mix Coordinator starting September 24, 2019. 3. The facility has implemented the following measures and systemic changes to ensure this citation does not occur again: Facility Interdisciplinary Team	

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 865	Continued From page 43 Administrator on 8/29/19 at 3:11 PM. The Administrator stated at the time of the recertification last year there was one full-time MDS Nurse and one part-time MDS Nurse. She stated there was a period of time where they had experienced an absence in the MDS Nurse role, and they were utilizing interim MDS Nurses to complete MDS assessments. She further stated just recently the MDS office had been expanded and there were new MDS Nurses including two full-time MDS Nurses and one part-time MDS Nurse. She stated she felt through the expansion of the MDS office by hiring an additional MDS Nurse, hiring new MDS nurses, and also through education regarding MDS coding and accuracy the problem of MDS coding errors would be resolved.	F 865	members (Activities Director, Certified Dietary Manager, Social Service Director, and Therapy Outcomes Coordinator) and RN MDS Coordinators received training regarding accurate completion of resident assessments after significant change from starting September 23, 2019. Facility RN Case Mix Coordinators received Peer to Peer training from PruittHealth RN Case Mix Coordinators regarding accurate completion of the cognition, mood, behavior, life expectancy, activities, and discharge location sections of the resident assessments by September 26, 2019. 4. To ensure solutions are sustained the facility has implemented the following monitoring techniques: Facility RN Case Mix Coordinators will review transmitted assessments weekly for four weeks, then monthly for three months to ensure a significant change assessment was completed if needed per the RAI manual. Findings of the audits will be reported to Regional Case Mix Coordinators by facility RN Case Mix Coordinators and discussed at facility Quality Assurance Performance Improvement Committee meeting monthly. Quality Assurance Performance Improvement meetings will be attended by Regional Team monthly for six months to ensure compliance. 5. September 26, 2019	