DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING ______ B. WING ______	C 10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	**305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870**

(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 on 9/23/19 through 9/26/19 the facility was found in compliance with requirement CFR482.73 Emergency Preparedness Event ID# 737O11.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint investigation survey was conducted on 9/23/19 through 9/26/19. Event ID#737O11. The survey team entered the facility on 9/23/2019 and exited on 9/26/2019. Additional information was obtained on 10/2/2019. Therefore, the exit dated was changed to 10/2/2019. 1 of 16 of the complaint allegations was substantiated for another resident.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		10/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 10/17/2019

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

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F 623	Continued From page 1 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State	F 623		

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F 623	Continued From page 2 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notice of reason	F 623	Notification was provided to the identified resident that was affected by not being	

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F 623	Continued From page 3 for discharge to hospital to resident representative for 1 of 1 resident (Resident # 75) reviewed for hospitalization. Findings included: Resident #75 was readmitted to the facility on 6/19/19 with the following diagnoses: Anemia, Diabetes Mellitus, Non-Alzheimer's Dementia. A review of the most recent MDS (Minimum Data Set) dated 8/23/19 revealed Resident #75 was cognitively impaired with short- and long-term memory issues and high visual impairment. Resident # 75 required extensive assistance from staff with ADLS. A review of physician's orders revealed an order dated 6/15/19 to send resident to hospital for increased heart rate and increased temperature. Resident #75 was readmitted to facility on 6/19/19. An interview was conducted with the Social Worker on 9/25/19 at 4:32 PM and she stated that she was responsible for making sure that the resident representative received a copy of the bed hold policy. An interview conducted with the DON on 9/25/19 at 4:40 PM, revealed discharge notification was done verbally by nursing and documented in the electronic health record (EHR). The DON further stated that she was not aware that written notification was sent to resident representative. A review of the discharge and transfer form revealed resident was discharged to hospital on 6/15/19 and Ombudsman notified on 7/1/19.	F 623	provided written notification of discharge. The identified resident numbered 75. This notification was provided to the resident and/or responsible party no later than 10/18/19. 2. All residents have to potential to be affected. An audit of the current resident population was completed and notifications were provided for those affected starting the month of October 2019 and going forward. 3. Education on the written notification of discharge policy was provided to all licensed nursing staff, Admissions and Social worker. This education will be complete by 10/18/19. This training will also be provided to all Admission staff and licensed nurses upon hire during orientation. 4. Ongoing audits by the Administrator or Director of Nursing for observation and review of proper execution of notification of discharge. These audits will be conducted twice a week for four weeks, weekly for three weeks, monthly for three months, and then random audits each month for two months. These audits will also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued	

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F 623	Continued From page 4 There was no documentation of written notification of resident representative.	F 623	compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and DNS is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 30, 2019.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for mental cognition for 4 of 27 residents (Resident #9, 17, 55, and 75) reviewed, and failed to accurately code for anticoagulants for 1 of 1 (Resident #4) reviewed and failed to code the diagnosis 1 of 3 residents (Resident #27) reviewed for indwelling catheters. The findings included: 1. Resident # 9 was admitted to the facility on 11/4/2014 with diagnoses to include congestive heart failure and hypertension.	F 641	The facility failed to accurately code the MDS reviewed for Resident #9, #17, #55 and #75 for mental condition, Resident #4 reviewed for anticoagulants and Resident #27 reviewed for indwelling catheters. MDS Coordinator modified and re-submitted MDS for Residents #4 and #27. MDS Coordinator immediately educated regarding expectations for accurately coding MDS upon identification of errors. 2.All residents have the potential to be affected by this alleged deficient practice. The MDS Coordinator/designees and	10/30/19

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F 641	Continued From page 5 Resident # 9's quarterly Minimum Data Set (MDS) assessment dated 6/26/2019 revealed a Brief Interview for Mental Status (BIMS) assessment should be conducted. The assessment was left blank and no score was documented. On 9/25/2019 at 1:38 PM, an interview was conducted with MDS nurse #1, who stated she was not employed by the facility at that time the assessment was due. The MDS nurse stated Resident #9's MDS assessment was completed by the Special Projects Consultant on 7/9/2019, and since the BIMS was not assessed within the Assessment Reference Date (ARD), the MDS had to be submitted without the BIMS section completed. On 9/25/2019 at 2:11 PM, an interview was conducted with the Social Worker (SW), who stated she was responsible to compete the BIMS section of the MDS assessments. The SW stated she was new to the facility and was not employed at the time of Resident #9's BIMS assessment was due. On 9/26/2019 at 9:08 AM, an interview was conducted with the Special Projects Consultant (SPC), who stated she had come in to help complete the MDS assessments. The SPC stated the BIMS section could be completed by a nurse or SW as close to the ARD as possible but could not go past that date. The SPC stated MDS nurse #2 gave her a calendar of what was to be completed when she came to the facility, but the ARD date had already passed and she was unable to interview the resident after the ARD date.	F 641	Regional MDS Consultant will complete a review of assessments to ensure Brief Interview for Mental Status (BIMS) has been conducted, accurate medication has been coded, and residents that have an indwelling catheter have a diagnosis coded during the 7 day look back period. Modifications will be completed as indicated by MDS Coordinator. 3.Education provided to MDS Coordinators on was provided on MDS accuracy and capturing appropriate diagnosis for MDS coding on 10/17/19. The Regional MDS Consultant or designee will complete an audit of 3 resident□s MDS Assessments weekly x 8 weeks to ensure accurate coding; then 2 resident□s MDS Assessments weekly x 4 weeks: then 1 monthly resident□s MDS Assessments x 3 months. Education will be provided as indicated. All data will be summarized and presented to the facility QAPI meeting monthly x 3 months by the MDS Coordinator. Any issues or trends identified will be addressed by the QAPI Committee as they arise and the plan will be revised to ensure continued compliance. 4.The Administrator and Director of Nursing is responsible for implementing and maintain the acceptable plan of correction. 5.The Administrator and DNS is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be	

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F 641	Continued From page 6	F 641	completed by October 30, 2019.	

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On 9/26/2019 at 1:29 PM, an interview was conducted with MDS nurse #2, who stated she started working at the facility in March but was only able to keep up with the Medicare MDS assessments, and Resident #9's assessment did not fall in that category.
On 9/26/2019 at 2:03 PM, an interview was conducted with the Administrator who stated the previous SW had left at the beginning of June 2019 and the new SW started in July, and MDS nurse #1 was new to the facility around that time as well. The Administrator stated she expected the MDS to be accurate and completed on time.

2. Resident #17 was admitted to the facility on 8/16/2018 with diagnoses to include hypertension, diabetes and history of a stroke.

Resident #17's annual MDS assessment dated 7/25/2019 revealed a Brief Interview for Mental Status (BIMS) assessment should be conducted. The assessment was left blank and no score was documented.

On 9/25/2019 at 1:38 PM, an interview was conducted with MDS nurse #1, who stated she was still learning to complete the assessments at the time Resident #17's assessment was due. The MDS nurse stated she completed the assessment on 7/31/2019 and was unsure why the BIMS section was not completed by the Social Worker, but she was unable to go back and do the interview because the Assessment Reference Date (ARD) was 7/25/2019 and had already passed.

On 9/25/2019 at 2:11 PM, an interview was

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F 641	Continued From page 7	F 641		

conducted with the Social Worker (SW), who stated she was responsible to compete the BIMS section of the MDS assessments. The SW stated she was new to the facility and was still learning how to complete the BIMS sections when Resident #17's BIMS assessment was due.

On 9/26/2019 at 1:29 PM, an interview was conducted with MDS nurse #2, who stated she started working at the facility in March but was only able to keep up with the Medicare MDS assessments, and Resident #17's assessment did not fall in that category.

On 9/26/2019 at 2:03 PM, an interview was conducted with the Administrator who stated the previous SW had left at the beginning of June 2019 and the new SW started in July, and MDS nurse #1 was new to the facility around that time as well. The Administrator stated she expected the MDS to be accurate and completed on time.

3. Resident # 55 was admitted to the facility on 7/3/2019 with diagnoses to included cancer, hypertension and dementia.

Resident # 55's admission Minimum Data Set (MDS) assessment dated 7/10/2019 revealed a Brief Interview for Mental Status (BIMS) assessment should be conducted. The assessment was left blank and no score was documented.

On 9/25/2019 at 1:38 PM, an interview was conducted with MDS nurse #1, who stated she was new to the facility in July 2019. The MDS nurse stated Resident #55's MDS assessment was completed by the Special Projects

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F 641	Continued From page 8 Consultant on 7/23/2019, and since the BIMS was not assessed within the Assessment Reference Date (ARD) of 7/10/2019, the MDS had to be submitted without the BIMS section completed. On 9/25/2019 at 2:11 PM, an interview was conducted with the Social Worker (SW), who stated she was responsible to compete the BIMS section of the MDS assessments. The SW stated she was new to the facility and was still learning how to complete the BIMS sections when Resident #55's BIMS assessment was due. On 9/26/2019 at 9:08 AM, an interview was conducted with the Special Projects Consultant (SPC), who stated she had come in to help complete the MDS assessments. The SPC stated the BIMS section could be completed by a nurse or SW as close to the ARD as possible but could not go past that date. The SPC stated MDS nurse #2 gave her a calendar of what was to be completed when she came to the facility, but the ARD had already passed and she was unable to interview the resident after the ARD date. On 9/26/2019 at 1:29 PM, an interview was conducted with MDS nurse #2, who stated she started working at the facility in March but was only able to keep up with the Medicare MDS assessments, and Resident 55's assessment did not fall in that category. On 9/26/2019 at 2:03 PM, an interview was conducted with the Administrator who stated the previous SW had left at the beginning of June 2019 and the new SW started in July, and the MDS nurse was new to the facility around that	F 641		

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F 641	Continued From page 9	F 641		

time as well. The Administrator stated she expected the MDS to be accurate and completed on time.

4. Resident #75 was admitted to the facility on 7/3/2016 with diagnoses to include anemia, diabetes and dementia.

Resident #75's quarterly MDS assessment dated 7/11/2019 revealed a Brief Interview for Mental Status (BIMS) assessment should be conducted. The assessment was left blank and no score was documented.

On 9/25/2019 at 1:38 PM, an interview was conducted with MDS nurse #1, who stated she was new to the facility in July 2019. The MDS nurse stated Resident #75's MDS assessment was completed by one of the Special Projects Consultant on 8/8/2019, and since the BIMS was not assessed within the Assessment Reference Date (ARD) of 7/11/2019, the MDS had to be submitted without the BIMS section completed.

On 9/25/2019 at 2:11 PM, an interview was conducted with the Social Worker (SW), who stated she was responsible to compete the BIMS section of the MDS assessments. The SW stated she was new to the facility and was still learning how to complete the BIMS sections when Resident #75's BIMS assessment was due.

On 9/26/2019 at 1:29 PM, an interview was conducted with MDS nurse #2, who stated she started working at the facility in March but was only able to keep up with the Medicare MDS assessments, and Resident #75's assessment

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did not fall in that category.

On 9/26/2019 at 2:03 PM, an interview was conducted with the Administrator who stated the previous SW had left at the beginning of June 2019 and the new SW started in July, and the MDS nurse was new to the facility around that time as well. The Administrator stated she expected the MDS to be accurate and completed on time.

5. Resident #4 was admitted to the facility on 2/4/2010 with diagnoses to include diabetes, hypertension and dementia.

Resident # 4's Minimum Data Set (MDS) assessment dated 6/19/2019 revealed her cognition was intact and she was on an anticoagulant for 7 days during the look back period.

Resident # 4's Physician orders for June 2019 did not reveal anticoagulants were ordered.

Resident #4's Medication Administration Record (MAR) for June 2019 did not reveal anticoagulants were dispensed.

On 9/25/2019 at 1:25 PM, an interview was conducted with MDS nurse #2 who stated after reviewing the Physician orders and MAR, the anticoagulants was an error and she would correct the MDS.

On 9/26/2019 at 2:03 PM, an interview was conducted with the Administrator who stated she expected the MDS to be completed accurately.

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F 641	Continued From page 11 6. Resident #27 was admitted to the facility on 7/25/2019 with diagnoses to include pneumonia, and congestive heart failure. Resident #27's Physician orders dated 7/25/2019 included orders to change urinary catheter as needed, and catheter care to be conducted every shift. No diagnosis for the catheter was included on the Physician orders. Resident #27's admission MDS assessment dated 8/1/2019 revealed her cognition was intact, she required total assistance from staff for activities of daily living and she had an indwelling urinary catheter. No diagnosis for the catheter was included on the MDS. On 9/25/2019 at 1:38 PM, an interview was conducted with MDS nurse #1 who stated there was not a diagnosis attached to the catheter order and so there was no diagnosis included in the MDS assessment. The MDS nurse stated the nursing staff would be responsible to obtain the diagnosis. On 9/26/2019 at 2:03 PM, an interview was conducted with the Administrator who stated the new MDS nurse was new to the facility about the time of this MDS assessment when the diagnosis was missed, and she expected the MDS to be completed accurately.	F 641		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		10/30/19

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F 657	Continued From page 12 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to invite a resident to Care Plan meeting for 1 of 2 residents reviewed for invitation to care plan meeting. (Resident #23) The findings included: Resident #23 was originally admitted to the facility on 1/14/16 with diagnoses including Muscle Weakness (generalized), Hypertension, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus without complications and End Stage Renal Disease. According to Resident #23 ' s	F 657	1.The invitation for a care plan meeting was provided immediately and care plan meeting held for Resident #23 by 10/18/19. 2.All residents have the potential to be affected by the deficient practice. Care plan meetings have been scheduled for all the residents that are due in the month of October and invitations have been mailed. 3.Education to the Social Services Director and MDS nurses provided by	

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F 657	Continued From page 13 Annual Minimum Data Set dated 7/27/19, Resident #23 had disorganized thinking and altered mental status. Resident #23 ' s Care Plan was last revised on 9/23/19. The facility could not find evidence that Resident #23 or her family member was invited to attend her care plan meeting. During an interview with Resident #23 and her family member on 9/23/19 at 4:38 PM, Resident #23 revealed she could not recall if she was invited to or attended her care plan meeting because she was in and out of the hospital. During an interview on 9/26/19 at 9:42 AM, the facility Social Worker stated Resident #23 was not invited to attend her care plan meeting. The Social Worker did not know the date of Resident #23 ' s last care plan meeting. During an interview on 9/26/19 at 10:00 AM, the Director of Nursing (DON) revealed, going forward, they will make sure that all invitations to care plan meetings were done. During an interview on 9/26/19 at 2:00 PM the Director of Nursing revealed her expectation was that all residents were invited by letter to attend their care plan meeting. During an interview on 9/26/19 at 2:39 PM, the Administrator said her expectation was, going forward care plan letters would be sent out inviting residents and families to care plan meetings.	F 657	MDS nurse consultant. This education was complete by 10/18/19. This training will also be provided to the MDS coordinators upon hire during orientation and at least annually. 4. Ongoing audits by the Administrator for review and validation of care plan invitations through daily PPS meetings as well as random audits. These audits will be conducted 5 days per week for two weeks, then weekly for two weeks, then monthly for three months. These audits will include any affected residents that are admitted and current resident population. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Social Services Director. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5.The Administrator and DNS is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 30, 2019.	
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)	F 661		10/30/19

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F 661	Continued From page 14 §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a recapitulation of stay discharge summary for 1 of 1 resident reviewed for discharge. (Resident #100). The findings included: Resident #100 was originally admitted to the	F 661	1.Recapitulation of stay discharge summary completed for Resident #100. This recapitulation was completed no later than 10/18/19. 2.All residents have the potential to be affected. An audit of the current resident population was completed and	

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F 661	Continued From page 15 facility on 7/1/19. The resident was discharged home on 7/19/19. During an interview on 9/26/19 at 12:20 PM, the Director of Nursing (DON) revealed a recapitulation of stay discharge summary was not done for Resident #100. During an interview on 9/26/19 at 1:33 PM the facility Social Worker, who was responsible for the recapitulation of stay discharge summary revealed she did not complete the recapitulation of stay discharge summary. During an interview on 9/26/19 at 2:00 PM, the DON revealed her expectation was that the recapitulation of stay discharge summary would be done from that day forward upon the resident's discharge from the facility. During an interview on 9/26/19 at 2:00 PM, the Administrator said going forward when a person was discharged from the facility a recapitulation of stay would be completed.	F 661	recapitulation of stay discharge was completed for those residents discharged in the month of October 2019 and going forward. 3.Education on the recapitulation of stay discharge summary policy was provided to the Social Services Director. This education will be complete by 10/18/19. This training will also be provided to the Social Services Directors upon hire during orientation. 4.Ongoing audits by the Administrator or Director of Nursing for observation and review of proper execution of recapitulation of stay discharge summary. These audits will be conducted twice a week for four weeks, weekly for three weeks, monthly for three months, and then random audits each month for two months. These audits will also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

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F 661	Continued From page 16	F 661	5.The Administrator and DNS is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 30, 2019.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review observation and staff interviews the facility failed to provide nail care for 1 of 3 resident (Resident #88) reviewed for activities of daily living. Findings included: Resident #88 was admitted to the facility on 1/31/19 with diagnoses that included hypertension, End Stage Renal Disease, Hypertensive heart disease with heart failure. A review of the most recent MDS dated 8/30/19 revealed the resident was cognitively intact. Resident #88 was totally dependent on staff for dressing, toileting, personal hygiene, bathing and transfer. A review of Resident #88's care plan revealed he was at risk for selfcare deficit with interventions that included assistance with ADL care, assist with fingernails as required.	F 677	1.Nail care was provided for Resident #88. 2.To ensure no other residents were affected, an audit of the current resident population was conducted to validate nail care was provided. Nail care will be provided to newly admitted residents upon admission if deemed necessary. 3.Education on nail care was provided to the licensed nurses and the certified nursing assistants. This education will be complete by 10/18/19. This training will also be provided to all licensed nurses and certified nursing assistants upon hire during orientation. 4.Ongoing audits by the Unit Managers for observation and validate nail care has been provided. These audits will be conducted twice a week for four weeks, weekly for three weeks, monthly for three	10/30/19

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F 677 Continued From page 17

During an observation on 9/23/19 at 10:35 am, Resident # 88 was in his room lying in bed. Resident # 88 stated that he was waiting to go to dialysis and that staff assisted him with ADLS. The resident was observed with long nails and brown matter beneath nails on both hands.

During an observation on 9/24/19 at 8:43 am, Resident was observed to have long fingernails with brown matter beneath nails.

During an interview on 9/25/19 at 9:55 AM NA#1 stated that staff are to look at nails daily. She stated that if the resident is a diabetic or has vascular issues then the NA reports to the nurse that the resident nails need to be trimmed.

During an interview on 9/25/19 at 10:35 AM NA#4 reported that nails are to be looked at daily during personal care.

An observation on 9/25/19 at 2:11 PM revealed Resident #88 had long nails with brown matter beneath them.

During an interview on 9/25/19 at 2:13 PM Resident #88 stated that it was hard to get someone to cut his fingernails. Resident #88 stated his nails had to be cut by family members because the staff would say they were going to cut them and never returned. Resident #88 stated he had a large pair of nail clippers and had cut his nails himself.

During an interview on 9/25/19 @2:22 PM NA#2 stated Resident#88 required extensive assistance to total care with ADLS. NA#1 stated Resident#88 was able to bath independently with setup help. She stated staff are to look at resident nails daily.

F 677

months, and then random audits each month for two months. These audits will include 10 residents per audit. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.

5.The Administrator and DNS is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 30, 2019.

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F 677	Continued From page 18 NA#2 further stated she attempted to do as much as she could during her shift. She stated if she did not have time to complete nail care she would pass it on to the next shift. During an interview on 9/25/19 @ 2:30 PM NA# 3 stated staff are to look at resident nails daily and provide nail care. NA#3 stated that all resident care was documented in the Kiosk by staff each shift. An interview was conducted with Nurse #2 on 9/26/19 at 11:02 AM. Nurse#2 stated that Resident #88 was alert and with it. He further stated Resident #88 was totally dependent on staff for all care and there was no way he could cut his own nails due to left hand weakness. An observation conducted with Director of Nursing (DON) on 9/26/2019 at 11:23 AM revealed that Resident #88 had long fingernails with brown matter beneath to his right hand. The DON stated she would get that taken care of immediately.	F 677		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		10/30/19

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F 690	Continued From page 19 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to ensure a resident had a diagnosis or clinical condition for the use of an indwelling urinary catheter for 1 of 3 residents (Resident #27) reviewed for catheters. The findings included: Resident #27 was admitted to the facility on 7/25/2019 with diagnoses to include bacteremia, urinary tract infection (UTI), pneumonia, and chronic obstructive pulmonary disease.	F 690	1.The affected resident, #27 foley catheter has been removed and resident will be seen by the urologist on 10/25/19. 2.In house review of all residents with a catheter that have the potential to be affected by the deficient practice was completed by 10/18/19. It was found that no other residents were affected. Newly admitted residents with indwelling catheters will be reviewed to ensure each resident has a diagnosis/clinical condition for the use of an indwelling catheter and/or have the indwelling catheter	

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F 690 Continued From page 20

Resident # 27's Hospital discharge summary of 7/25/2019 revealed the resident completed a 15-day course of intravenous antibiotics for pneumonia and urinary tract infection. An additional note read, "Family asking that (catheter) be continued, for patient comfort and because handling increases patient skin tears and bruising." No diagnosis was included on the summary for the use of the catheter.

Facility Physician orders dated 7/25/2019, for Resident #27, included to change the catheter as needed for leakage, blockage or dislodgment, and catheter care every shift. There was no diagnosis or reason attached to the Physicians order for the use of the catheter.

A Physician progress note dated 7/27/2019 did not address the resident's indwelling catheter.

Resident #27's admission Minimum Data Set (MDS) assessment dated 8/1/2019 revealed her cognition to be intact. She required extensive to total assistance from staff for activities of daily living, and she had an indwelling catheter. There were no diagnoses in the assessment to support the use of an indwelling catheter. The Care Area Assessment (CAA) included a family interview that requested the catheter for comfort. No diagnosis was attached to the CAA for a clinical reason for use of the catheter.

A Physician progress note dated 9/12/2019 did not address the resident's indwelling catheter.

Resident # 27's care plan, dated 8/1/2019, included a problem of an indwelling catheter, with a goal of no UTI's or urethral trauma. Interventions for the indwelling catheter included

F 690

removed.

3.Education to all licensed nurses provided by the Director of Nursing and/or the Unit Manager. This education to be complete by 10/18/19. This training will also be provided to all licensed nurses upon hire during orientation.

4.Ongoing audits by the DON or Staff Development Coordinator to validate residents with an indwelling catheter have a diagnosis/clinical condition for the use of an indwelling catheter and/or have the indwelling catheter removed. These audits will be conducted 5 days per week for two weeks, then weekly for two weeks, then monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.

5.The Administrator and DNS is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 30, 2019.

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F 690	Continued From page 21	F 690		

an assessment for continued need of catheter at least quarterly.

On 9/23/2019 at 10:31 AM an interview was conducted with Resident #27 who stated she did not know why she had the catheter, but it was necessary because she couldn't walk to the bathroom. The resident was unaware of any issues or complications she experienced from having the indwelling catheter.

On 9/25/2019 at 12:27 PM an interview was conducted with Nurse #1 who cared for Resident #27. The Nurse stated she thought Resident #27's catheter was for urinary retention, but she did not know of a voiding trial that had been done for Resident #27. The nurse stated a urine sample had recently been sent for a culture to see if Resident #27 had a UTI, but the results were not available yet.

On 9/26/2019 at 11:36 AM, an observation of catheter care was observed for Resident #27 with nursing assistant #5. No bruising or skin tears were noted at or around insertion site.

On 10/2/2019 at 3:47 PM, an interview was conducted with MDS nurse #2 who stated she did not have a diagnosis for the catheter for Resident #27 when she was working on the MDS assessment and she made the previous Director of Nursing (DON) aware of the need for a diagnosis. The MDS nurse stated she only had a family interview for the reason for the catheter of resident comfort and that was the information she included in the Care Area Assessment (CAA).

On 10/2/2019 at 3:57 PM, an interview was conducted with Unit Manager (UM) #1, who

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F 690	Continued From page 22 stated she made an appointment with the Urologist for resident #27 for 10/15/2019. The UM stated when a resident was admitted without a clinical need for an indwelling catheter the resident would be sent to the urologist for further instruction. The UM stated she was not the UM for Resident #27's unit but made the urologist appointment because she saw there was not follow up ordered for the catheter. On 9/26/2019 at 12:50 PM, an interview was conducted with the Director or Nursing (DON) who stated she started working at the facility approximately one month ago and could not find a diagnosis for Resident #27's catheter, or an order for a trial removal. The DON stated she could not find any assessments for the catheter since admission. The DON stated she expected the admitting nurse to obtain an order for the diagnosis and need for a catheter when the resident was admitted.	F 690		
F 867 SS=B	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification survey of 9/27/18. This was for one	F 867	1.Residents in the facility have the potential to be affected by the alleged deficient practice. The facility□s Quality Assessment and Assurance committee failed to maintain procedures and monitor the interventions that the committee put in	10/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING ______ B. WING ______	C 10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

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F 867	Continued From page 23 deficiency which was recited during the recertification survey of 9/26/19 regarding Notice of Requirements before Transfer/Discharge, F-623. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This citation is cross referenced to: F-623 Based on staff interviews and medical review the facility failed to provide written notice of reason for discharge to hospital to resident representative for 1 of 1 resident reviewed for hospitalization. (Resident #75) F-623 was originally cited on 9/27/18 for failing to notify the responsible party (RP) in writing of the reason for transfer to the hospital for 3 of 3 residents reviewed for hospitalization. During an interview on 9/26/19 at 2:40 PM, the Administrator revealed the facility had a new team and none of the staff in the facility this year were in the facility last year. She revealed in reference to the corrections from last year, they have a template with goals and interventions to meet the goals. She stated before a resident was discharged to the hospital the medical doctor was called and the next day they had stand up meeting and a form was completed and mailed. She revealed she did not know about the form so she could not keep it going, but she knew about the ombudsman log and she kept it up, but she did not know about the letter that was supposed to be sent to family member after a resident was discharged to the hospital, otherwise she would	F 867	place on September 27, 2018. The Quality Assurance Performance Improvement (QAPI) team notified Medical Director on 10/11/19 and held a discussion with the QAPI team regarding the findings of the recertification survey. An Ad Hoc QAPI team meeting was held on 10/11/19 regarding the plan of correction and the involvement of the QAPI team to ensure the identified concern is corrected and maintained in compliance. 2.Residents in the facility have the potential to be affected by the alleged deficient practice. 3.The Quality Assurance Performance Improvement Committee will ensure that Discharge Summaries are completed regarding the Notice of Requirements before Transfer/Discharge F-623. Education completed regarding the Notice of Requirements before Transfer/Discharge by 10/18/19 to the admission coordinator and Social Worker. 4.The QAPI Committee will review results of written notice of reason for discharge audits during the monthly meetings. Audits will be completed on 3 discharged residents weekly x 8 weeks to ensure written notice of reason for discharge to hospital to resident representative have been issued; then 2 discharged residents weekly x 4 weeks: the 1 discharged resident monthly thereafter. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued	

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F 867	Continued From page 24 have kept it up.	F 867	compliance. 5.The Administrator and DNS is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 30, 2019.	