STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345311	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roxboro Healthcare & Rehab Center	901 Ridge Road Roxboro, NC 27573

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on observations, family and staff interviews, and record review, the facility failed to ensure a resident's nails were clean for 1 of 4 residents (Resident #89) who were reviewed for Activities of Daily Living (ADLs). The findings included: Resident #89 was admitted to the facility on [DATE] from a hospital. Her cumulative diagnoses included a history of cerebral infarction (a type of stroke which occurs when blood flow to the brain is disrupted) and recurrent urinary tract infarctions (UTIs). An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #89 had severely impaired cognition. No behaviors nor rejection of care were reported. The assessment indicated Resident #89 required partial to moderate assistance for eating with substantial/maximal assistance from staff for toileting, bathing, dressing, and personal hygiene. The resident's care plan included the following area of focus, in part: I have an ADL self-care performance deficit related to limited mobility (Initiated on 8/5/24). An observation was conducted on 8/11/24 at 9:54 AM of Resident #89 as she was lying in her bed with her left arm bent at the elbow and her left hand holding the call light button up in the air. The call light outside her doorway was lit at the time of the observation. The resident's nails on her left hand were observed to be 1/8 inch () to 1/4 long with a dark brown/black substance present underneath each of the 5 fingernails on that hand. At the time of this observation, Resident #89's Nurse Aide (NA) entered the room, asked the resident what was needed, and closed the door to provide care. Another observation was conducted on 8/12/24 at 11:48 AM of Resident #89. The resident was observed sitting in a wheelchair in her room with a family member sitting next to her while attempting to feed Resident #89 her noon meal. Only three (3) fingers of the resident's right hand were visible at the time of this observation. A dark brown/black substance was observed underneath each of the three right hand fingernails observed. Resident #89's fingernails were again observed during a Medication Administration Observation conducted on 8/13/24 at 9:14 AM. All 5 fingers on each hand could be viewed at that time. The fingernails varied from 1/8 to 1/4 in length. Each of the fingernails on both hands had a dark brown/black substance under the nail which was noted during the initial observations made on 8/11/24 and 8/12/24. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation was conducted on 8/13/24 at 11:34 as the resident's family member was visiting Resident #89 in her room. The resident was lying in bed with her right hand placed on top of her bed covers. Her fingernails were clean at that time. When the resident's family member was asked if someone had been in to clean Resident #89's fingernails, the family member stated, I did it. I can't stand to see them so dirty. The family member reiterated that she herself had just cleaned the resident's fingernails on both hands. The observation made at that time confirmed the resident's fingernails were clean and the dark brown/black substance previously observed under her nails was gone. On 8/13/24 at 2:47 PM, Nurse Aide (NA) #1 was interviewed. NA #1 was identified as the first shift nurse aide who was assigned to care for Resident #89 on 8/13/24. During the interview, the NA was asked when a resident's fingernails were cleaned. NA #1 stated she would clean the resident's nails whenever she noticed they needed it. Upon further inquiry, she reported the nails would also be cleaned on bath/shower days (twice weekly). When the NA was informed of the family member cleaning her nails earlier that morning because she didn't like seeing them so dirty, the NA reported she had not noticed the resident needed to have her nails cleaned. NA #1 stated that if she had noticed the fingernails were dirty, she would have cleaned them. An interview was conducted on 8/13/24 at 3:51 PM with the facility's interim Director of Nursing (DON) in the presence of the 100/200 Hall Unit Manager. During the interview, the concern regarding the multiple observations of Resident #89's dirty fingernails was discussed. The DON was also informed of Resident #89's family member's interview and involvement in cleaning the resident's fingernails because they were dirty. In response, the DON reported her expectation was for nail care to be done on each resident's shower days and as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38077 Based on record review, staff and consultant pharmacist interviews the facility failed to: 1) Maintain documentation of the pharmacist's Monthly Medication Reviews (MMRs) within the facility and readily available for review; and 2) Retain documentation of the physician's review and response to the pharmacist's findings / recommendations in the resident's medical record. This occurred for 2 of 5 residents reviewed for Unnecessary Medications (Resident #26, and Resident #30). Findings included: 1a. A review of Resident #26's electronic medical record was conducted and included the Pharmacy Progress Notes with the monthly Medication Regiment Review (MRR) completed by the facility's consultant pharmacist. This review revealed MRRs were documented as completed during the past year on each of the following dates: 9/21/23, 10/23/23, 11/16/23; 12/18/23,1/22/23, 2/4/24 and 2/19/24 (upon the resident's re-admission to the facility), 3/18/24, 4/22/24, 5/24/24, 6/18/24 and 7/15/24. Resident #26's electronic medical record did not include the monthly MRRs for 1/22/24 and 5/24/24 recommendations nor the signed provider's review and response (documented on a Note to Attending Physician/Prescriber) for any pharmacist's findings / recommendations generated on these dates. 1b. A review of Resident #30's electronic medical record was conducted and included the Pharmacy Progress Notes with the monthly Medication Regiment Review (MRR) completed by the facility's consultant pharmacist. This review revealed MRRs were documented as completed for the following dates: 1/18/24 (initial review for admission to the facility), 1/23/24, 2/20/24, 3/19/24, 4/23/24, 5/26/24, 6/19/24, and 7/24/24. Resident #30's electronic medical record did not include the monthly MRRs for 2/20/24 and 5/26/24 recommendations nor the signed provider's review and response (documented on a Prescriber Recommendation Form) for any pharmacist's findings / recommendations generated on these dates. A telephone interview was conducted on 8/14/24 at 3:35 PM with the facility's consultant pharmacist. The Pharmacist stated all recommendation after their monthly MMR were sent in an email to the Director of Nursing (DON), Administrator and Pharmacy Nurse Consultant. The Pharmacist stated these recommendations were placed in the DON's office. She further stated that the previous DON was asked multiple times to place the documentations / recommendations and the signed provider's review and response (documented on a Note to Attending Physician/Prescriber) from any pharmacist's findings / recommendations in the resident's electronic records. These have not been uploaded in the electronic records. The recommendations were sent as pending the following month due to no availability of the documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24 at 12:11 PM, the Director of Nursing (DON) indicated she was interim and was hired 7/18/24. The DON stated when she was hired, she was made aware by the Nurse Consultant about the concerns expressed by the Pharmacy. The Pharmacy had notified the facility that the resident's medication recommendations were not in the medical records. The DON indicated a plan of correction was put in place for the identified concern. The Pharmacy would emailed the recommendations to the DON. The nurses would go through the nursing recommendations and the DON would forward the Physician recommendations to the Physician. The Physician would reviewed the recommendations with approval or denial of the recommendations and would resend them back to the DON. The DON stated she would reviews the signed documentation and ensured that the recommendations were followed. The documentation was given to the Health Information Manager (medical record staff) and would be uploaded in the resident's electronic medical record. The DON indicated that prior to the Plan of correction these processes were not happening. The documents were kept in folders in the DON's office. These documents were not 100% reviewed by the Physician and they were inconsistent. She was unsure if the previous DON was forwarding the recommendations to the Physician. Some of the recommendations were also missing. The DON stated on 7/25/24 a root cause analysis was started, and audits and education was also in process. All Nurse supervisors, and DON were educated by the Nurse Consultant. The education was on the topic on Pharmacy Consults - procedure regarding handling monthly pharmacy recommendations and reports. All the staff completed the education on the 7/25/24. Weekly 3 residents records were randomly selected and monitored for any pharmacy recommendations. The DON stated that two weeks of audits were completed and there were no issues. The DON further stated the Pharmacy start their monthly medications reviews on 20th of each month and recommendation would be sent to the DON. All the procedure would be followed to ensure compliance. Audits would be conducted weekly for 3 weeks and monthly for 2 months. All audits will be discussed in Quality Assurance. If any issues/ concerned occurred than monitoring would happen more often and would continue until there was no error. The plan of correction compliance date was 8/1/24. The DON stated she was unable to find Resident #26's 1/22/24 and 5/24/24 recommendations and Resident #30's 2/20/24 and 5/26/24 recommendations. During an interview on 8/15/24 at 12:28 PM, Nurse Consultant indicated in July she was made aware by the Consultant Pharmacist regarding the recommendations provided by the pharmacy to the facility. The Nurse Consultant further indicated she had a discussion with the Administrator, Physician, Interim DON and Nurse Supervisor regarding the concern brought up by the pharmacy. The Nurse Consultant stated she was not aware if there were any issues with the previous DON regarding following up with the recommendations. The root cause analysis was completed, and plan of correction was put in place. All resident's records were audited to identity any missing recommendations. DON and Nurse Supervisors were educated, and audit tools were put in place. The Nurse Consultant stated the DON was conducting weekly audits to ensure there was no errors. During an interview on 8/15/24 at 12:33 PM, the Administrator stated the Nurse Consultant had notified her about the pharmacy concerns. A plan of corrections was immediately started. All residents' records were audited to identify any concerns. The Physician was also made aware. Plan of corrections and audit tools were put in place. The Administrator stated the monitoring would continue until there was no error and in compliance. The audit results would be discussed in QA meeting. The Pharmacy documentations were now scanned in resident's electronic medical records. The plan of correction did not include corrective action for Resident #26 and Resident #30. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24 at 12:11 PM, the Director of Nursing (DON) stated she was unable to find Resident #26's pharmacy recommendations for 1/22/24 and 5/24/24 and Resident #30's 2/20/24 and 5/26/24 recommendations.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38077 Based on observations and staff interviews, the facility failed to prevent a buildup of dust on, and condensation on and around the kitchen Heating Ventilation and Air Conditioning (HVAC) vent, which resulted in moisture damage to the ceiling in the kitchen. These practices had the potential to affect food served to all residents. Findings included: A. An observation of the kitchen on 8/13/24 at 11:40 AM revealed a puddle of water on the floor which was approximately the size of a golf ball. The puddle was observed in the kitchen walkway in front of the table where the juice dispenser, iced tea maker, and coffee maker were placed. Observation of the ceiling above the puddle of water revealed an HVAC vent which had a buildup of condensation, and the condensation was dripping onto the floor, contributing to the puddle of water on the floor. The HVAC vent was approximately 2 feet by 2 feet and had a brownish black color around the edges with a visible buildup of dust. Further observation revealed an area extending approximately 6 inches around the perimeter of vent was discolored as if it were a water stain. During an interview on 8/13/24 at 11:44 AM, the Dietary Manager stated the water dripped from the HVAC vent when there was a lot of humidity in the air. The water would drip out of the vent some days and would not drip other days. She indicated the vent was dripping water for past few months and the facility Administrator was aware of it and she had not reported it to maintenance. The dietary Manager stated maintenance staff were responsible for cleaning the dust on the vent. B. An observation of the kitchen's ceiling on 8/13/24 at 11:40 AM revealed approximately 18 to 24 inches (L X W) area of paint, next to the vent, had come loose from the ceiling and the paint was beginning to sag down adjacent to the vent. The loose area of paint was above the table where the juice dispenser, iced tea maker, and coffee maker were placed. The observation revealed visible condensation on the ceiling and water puddle in front of the table. A brownish black color remained around the edges of the vent with a visible buildup of dust. During an interview on 8/13/24 at 11:44 AM, the Dietary Manager indicated the ceiling was usually wet but had not noticed the paint was loose and peeling. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/24 at 11:51 AM, the Maintenance Manager stated he was recently hired. He indicated he did not receive any work orders nor was he notified about the vent dripping water or the paint on the ceiling paint coming loose. The Maintenance Manager stated a few weeks ago the Administrator was discussing a plan for work to be done in the kitchen regarding painting and patching the walls, redoing the floors, and installing a new refrigerator. The Maintenance Manager explained there was no discussion about the ceiling or the vent. The Maintenance Manager stated the dietary staff had the kitchen air conditioning thermostat set at 65 degrees which resulted in the air conditioning equipment running nonstop as it could not reach that temperature. The kitchen was usually hot because of the cooking and the kitchen staff were also keeping the back door open, resulting in increased moisture in the kitchen, causing further condensation on the vent. He indicated the condensation was causing the ceiling to be wet and the paint started to peel. He explained the thermostat setting was changed to 72 degrees on 8/13/24. He said when the thermostat was set at a moderate temperature, the air conditioning would not have to run continuously which would prevent the condensation. The Maintenance manager stated on 8/13/24 he had cleaned the vent and patched the ceiling. During a third interview on 8/14/24 at 12: 00 PM, the Dietary Manager stated depending on the outside temperature, the HVAC vent would drip water, especially when there was a lot of humidity outside. The Dietary Manager stated she did not recall the date, but a few months ago she did report to the previous Maintenance Manager about the vent dripping water. The Administrator was also made aware about the vent dripping water and ceiling being wet. The ceiling was repaired previously; however, it had deteriorated a few days ago. The Dietary Manager indicated the vent was cleaned on 8/13/24. During an interview on 8/14/24 at 12:34 PM, the Administrator stated the HVAC vent had condensation due to the thermostat being set at a very low temperature, the air conditioning ran constantly, and there was increased humidity in the kitchen due to staff frequently opening the back door. The buildup of condensation at the HVAC vent resulted in the ceiling being wet. The Administrator indicated the ceiling paint near the vent may have become loose due to the condensation.