

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 345288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2020
NAME OF PROVIDER OF SUPPLIER COMPASS HEALTHCARE AND REHAB ROWAN, LLC		STREET ADDRESS, CITY, STATE, ZIP 1404 S SALISBURY AVENUE SPENCER, NC 28159	
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 0559 Level of harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, and family interviews the facility failed to provide written notice of a room change for 1 of 1 resident reviewed for room change (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] and was discharged to a local hospital on [DATE]. The resident 's [DIAGNOSES REDACTED]. Review of Resident #1's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 3/31/20. Review of the assessment revealed the resident was coded as moderately cognitively impaired. An interview and record review were conducted with the facility Social Worker (SW) on 7/6/20 at 11:38 AM. She stated she was the person responsible for notifying family members and residents about room changes or roommate changes. She stated Resident #1 received a new roommate on 4/8/20. The SW stated she had not remembered notifying the family of Resident #1 about him receiving a new roommate on 4/8/20. The SW reviewed the progress notes for Resident #1 and said she had not documented information regarding Resident #1 receiving a new roommate and she had not documented information regarding having notified the resident 's family about Resident #1 receiving a new roommate. The SW explained she was unable to provide a reason as to how come she had not notified the family of Resident #1 about him receiving a roommate. The SW further explained she should have notified the resident 's family and she should have documented the notification in the progress notes. An interview was conducted with Resident #1's family member on 7/6/20 at 3:50 PM who stated she had not been notified verbally or through written notification regarding her father receiving a new roommate on 4/8/20. During a second interview with Resident #1's family member on 7/16/20 at 3:50 PM she stated she had not become aware of her father having a new roommate until 4/11/20 when she was notified via a phone call. During an interview with the Administrator on 7/16/20 at 3:01 PM she stated it was her expectation for the resident and/or the resident 's family member to be made aware of a new roommate coming to a resident 's room. The Administrator further stated the facility had been conducting several room changes and unfortunately, in this circumstance the proper notification was not completed.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE (X6) DATE	

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.