

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

PRINTED: 07/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ JUL 29 2011	(X3) DATE SURVEY COMPLETED C 07/08/2011
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NAME OF PROVIDER OR SUPPLIER ROCKINGHAM MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379
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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safeguard 1 of 10 residents (#39) privacy by not closing the medication administration record (MAR) during a med pass. The findings include:</p>	F 164	<p>F 164; Scope and Severity: D Personal Privacy/Confidentiality of records.</p> <ol style="list-style-type: none"> Corrective action for those affected. Resident number 39 was informed that their record was left open. Resident number 39 is alert and oriented times three. Resident 39 stated that there had been no unfortunate events related to this exposure. The nurse that was on the hallway for the resident where the breach of privacy occurred has received inservicing/counseling regarding the record having been exposed by the Director of Nursing on 7/8/11. Corrective action for other residents that may be affected. No other residents noted to have had privacy breaches. Measures put into place to prevent recurrence. All nursing staff have been inserviced regarding the importance of closing or covering patient information. This will apply when staff members are away from areas where resident information is exposed. This inservicing was completed on 7/22/11 by the Director Of Nursing and her designee. 	7/27/11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chad Colby</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/27/11</i>
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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 164	Continued From page 1 Resident #39 was admitted to the facility on 06/16/11 with cumulative diagnosis that included Osteomyelitis, Chronic Pain, Reflux Disease and Anxiety. During an observation of a medication administration pass on 07/07/11 at 8:45 AM , nurse #1 poured resident #39's medications and walked into her room. Nurse #1 did not close or cover the MAR when she went into the resident's room. After administering the medications, nurse #1 left the room and proceeded to answer the call bell for another resident. Nurse #1 came back to the cart after 5 minutes and began to sign the medications for resident #39. The MAR was left uncovered and open for 5 minutes. During an interview with nurse #1 at this time it was revealed "oh I left the MAR open? Oh I forgot."	F 164	4. Monitoring of corrective action to ensure the Deficient practice will not recur. Rounds will be conducted by the DON or her designee to ensure personal privacy and confidentiality of records. The rounds will be completed daily times 2 weeks, then weekly times 4, then monthly times 3, then quarterly until the next annual survey. The process will be reviewed in the QA/Facility Leadership monthly meeting. 5. Completion Date: All appropriate staff were inserviced by July 22, 2011.		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315	F 315; Scope and Severity: E No catheter, prevent UTI, restore bladder. 1. Corrective action for those affected. Residents 57, 12, and 47 had Catheter Securing Devices applied on 7/8/11. 2. Corrective action for other residents that may be affected. All residents with an indwelling and suprapubic catheter were assessed by the DON and ADON	7/22/11	

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F 315	Continued From page 2 by: 1. Based on observations, record review, staff interviews and resident interviews, the facility failed to provide catheter securing devices for 3 of 3 residents (# 57, #12, and #47). Findings include: The facility policy titled "Catheter Care, Indwelling Catheter" updated 01/16/09 indicated under the section "purpose" is written "to prevent infection, to reduce irritation." and under the section "Procedure" is written for # 8. "Anchor/secure catheter tubing to prevent pulling." Resident # 57 was admitted to the facility on 7/27/02 with cumulative diagnoses of multiple strokes with bilateral hemiparesis and currently bedbound in a debilitated state with contractures, atonic bladder and chronic indwelling suprapubic catheter. A review of the Quarterly Minimum Data Set (MDS) assessment of 6/14/11 revealed Resident # 57 was cognitively intact and able to communicate effectively with others. During an interview on 7/7/11 at 11:25 AM, Resident # 57 stated her suprapubic catheter tubing was not secured. Resident # 57 stated, "A long time ago they used tape and I broke out from it. I have not had a catheter strap. I wear briefs and that keeps the tubing in place." Observation of the suprapubic site and tubing revealed nothing was in place to secure the tubing and keep it from pulling. Resident # 57 stated that even with the brief fastened over the tubing, it still pulled at times.	F 315	on 7/9/11. Securing Devices were applied on 7/9/11. The application of device was added to Treatment Administration Record for documentation purposes on 7/9/11. The residents care plans and resident care flow records were also updated regarding securing Catheter Devices. Completion date: 7/22/11. All new admissions will be assessed for Securing Device related to catheters upon admission by the treatment and admitting nurse. This will be monitored daily by DON/ADON/Risk Mgr. during a.m. Nursing meeting. 3. Measures put into place to prevent recurrence. All nursing staff, RN/LPN/CNA, were inserviced on the facility policy and procedure regarding catheter care on 7/22/11 by the Director of Nursing and the Assistant Director of Nursing. 4. Monitoring of corrective action to ensure the Deficient practice will not recur. All residents with catheters will be monitored to ensure that the catheter securing device is in place. The DON or her designee will monitor for the catheter securing device daily times two weeks, then weekly times four, then monthly		

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F 315	<p>Continued From page 3</p> <p>During an interview on 7/7/11 at 12:04 PM, NA # 2 stated "The (Resident # 57) does not have a catheter strap. I don't know that she 's supposed to have one. If she is supposed to have one, no one has told me. If we need one, we get it from the treatment nurse who cleans around it (suprapubic catheter site) every day."</p> <p>During an interview on 7/7/11 at 12:08 PM, 7-3 Nurse # 4 stated she had not seen a catheter strap used in the facility in a long while. Nurse # 4 stated, " If the resident is ambulatory or mobile, we use tape to secure the tubing to prevent it from being pulled out. (Resident # 57) does not have one (to secure the tubing."</p> <p>During an interview on 7/7/11 at 1:44 PM. Nurse # 2 stated she keeps catheter securement devices on the treatment cart. Nurse # 2 provided a butterfly shaped catheter securement device with an adhesive backing to allow device to stick to skin and a velcro strip to hold tubing. Nurse # 2 stated, " If the resident asks for one (the catheter securement device), or a nurse or nursing assistant asks for one, the treatment nurses get it for them. No one has told me (Resident # 57) requested one. No one has asked me for one " .</p> <p>In an interview on 7/7/11 at 2:03 PM, the Director of Nursing (DON) stated it was her expectation that if the facility policy stated that a urinary catheter should be secured then it should be secured.</p> <p>2. Resident #147 was admitted to the facility on 6/7/11 with diagnoses of pressure ulcer, anoxic</p>	F 315	<p>times three, then quarterly until our next annual survey. This process will be reviewed in the next QA/Facility Leadership Meeting.</p> <p>5. Completion Date: July 22, 2011</p>	
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F 315	<p>Continued From page 4 brain damage, and diabetes mellitus.</p> <p>Resident #147's Minimum Data Set (MDS) dated 6/14/11 indicated Resident #147 had both short and long term memory problems and was severely impaired in daily decision making. Resident #147 was total care for all activities of daily living and had an indwelling urinary catheter.</p> <p>In an observation on 7/7/11 at 10:45 AM during wound care, Resident #147 had an indwelling urinary catheter. The urinary catheter was not secured to either leg.</p> <p>In an interview on 7/7/11 at 1:40 PM, nurse #2 stated she did not remember if Resident #147's urinary catheter was secured but she would check.</p> <p>In an interview on 7/7/11 at 2:03 PM, the Director of Nursing (DON) stated it was her expectation that if the facility policy stated that a urinary catheter should be secured then it should be secured.</p> <p>Review of Resident #147's medical record revealed a Nurse's Note dated 7/7/11 at 4:30 PM. The note indicated a catheter securing device had been applied to Resident #147's left upper thigh to secure the urinary catheter. The note was signed by nurse #2.</p> <p>3. Resident #57 was admitted to the facility on 06/02/05 and readmitted on 03/12/08 with cumulative diagnoses that included CVA (stroke) Glaucoma, Hypertension, Anemia, Urinary Retention and a stage 3 pressure ulcer. The resident was coded on the most recent MDS</p>	F 315			

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F 315	Continued From page 5 (minimum data set) dated 02/08/11 as having short and long term memory problems and as being severely impaired in the decision making process. In addition the resident was coded as using a catheter. During an observation of the resident's decubitus ulcer care on 07/07/11 at 11:00 AM , the resident was observed to not have any type of securing device for the catheter. During an interview with nurse #3 at that time it was revealed "I don ' t remember seeing any type of securing strap in this facility" During an interview with the Director of Nursing (DON) on 07/07/11 at 2:05 PM it was revealed "if it is in our policy then we should be doing it. To my knowledge (name of resident) is not capable of refusing the strap. If there was a refusal it should be documented in either the nurse note or the care plan." A review of both the nurse notes and the care plan for the resident did not reveal ay refusal for the use of a catheter strap.	F 315			
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	F 325; Scope and Severity: G Maintain nutrition status unless unavoidable. I. Corrective action for those affected. Resident number 75 was the only resident identified as having been affected. Resident number 75 was assessed by the Dietary Manager on 7/6/11 and recommendations were implemented on 7/6/11. Resident number 75 was then assessed by a Registered Dietitian	7/24/11	

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F 325	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to assess and implement interventions for 1 of 3 residents (Resident #75) with weight loss. The findings include: Resident #75 was admitted to the facility on 9/23/2010 and readmitted on 06/13/2011 following a 5 day hospital stay. The resident ' s cumulative diagnoses included Mild Malnutrition, Gastroesophageal Reflux and Congestive Heart Failure. The Minimum Data Set (MDS) dated 10/20/2010 indicated the resident had short term memory deficits and moderate impairments in daily decision making. The resident required setup assistance only with meals. Record review indicated the resident ' s admission weight on 9/23/2010 was 101 pounds. The resident was started on med pass 2 ounces four times a day with meals on 9/23/2010, and the resident ' s compliance was documented daily on the medication administration record (MAR). Review of the resident ' s care plan initiated on 10/15/2010 indicated the resident was at risk for weight loss and fluid volume deficit. Approaches put in place included "provide 2 ounces med pass four times a day with meals". Med pass 2 ounces 4 times a day was discontinued on 5/04/2011 due to the resident 's refusal. The resident ' s care plan was not updated to reflect the change.	F 325	with a note in the medical record indicating no new recommendations on 7/7/11. The dietitian saw the resident again on 7/20/11. The Registered Dietitian noted that the resident was still in her lower end of the normal BMI range. Resident number 75's care plan was updated on 7/6/11 in regarding discontinuation of supplement. 2. Corrective action for other residents that may be affected. All residents were assessed for 5% weight loss in the past 30 days by the Registered Dietitian and CDM on 7/6/11 through 7/7/11. Recommendations were submitted and orders were obtained by the ADON and noted in the medical record by 7/14/11. Care Plans were reviewed and updated for all appropriate residents. 3. Measures put into place to prevent recurrence. All staff were inserviced on the usage of tri-layer dietary communication slips for dietary orders obtained. This inservice was completed by the DON and the ADON. The 3 copies of the dietary orders will be placed in the medical record, to the dietary department, and to the administrator or designee for review in the AM meeting to		

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F 325	Continued From page 7 The resident 's weight on 06/08/11 was 105 pounds. Records indicated the resident was admitted to a local hospital on 6/08/2011 with admission diagnoses that included Altered Mental Status, Cachexia, Urinary Tract Infection, Severe Malnutrition. The hospital discharge/transfer summary dated 6/15/2011 indicated discharge was discussed with the resident 's responsible party regarding diet that "they have to be on top of things in the nursing home to make sure she eats good ". The summary further indicated the nursing home would have a dietary consult secondary to poor intake. Review of facility admission orders on 6/13/2011 indicated a dietary consult was ordered secondary to poor intake. The order was transcribed on 6/13/2011 to the June 2011 MAR. The resident 's readmission weight on 6/13/2011 was 98.90 pounds . Review of the resident 's clinical record indicated no dietary consult was done as ordered on 6/13/2011. The next recorded weight was 87.10 pounds on 6/20/2011. The facility Dietary Manager was interviewed on 7/6/11 at 3:45PM and indicated the weight on 6/20/11 was 87.10 pounds and that she keyed the weight into the system. She further reported she should have asked for a reweigh at that time, but she did not. She also indicated she did not follow up with the low weight and it was her responsibility to do so. In an interview with the facility Director of Nursing (DON) on 7/6/11 at 4:05PM, it was indicated she was not aware of the 87.10 pound weight until today's date. She indicated weekly audits were done by restorative staff which included the	F 325	assure department head awareness. This was completed on 7/22/11. Care Plans will be updated for all appropriate residents. A log will be kept by the Administrator and the DON and/or their designee. This log will contain all residents that have had an Registered Dietitian consult for. When the Registered Dietitian visits the facility a copy of the log will be given to the Registered Dietitian. 4. Monitoring of corrective action to ensure the Deficient practice will not recur. The DON/ADON, Risk Manger, CDM/Dietary Manager, treatment nurse, MDSC, and the social worker will meet weekly to review residents identified with 5% or more weight loss in 30 days. Recommendations and dietary orders will also be reviewed in the weekly meeting. The DON and/or designee will review 5 charts per week for accurate diet orders and assure follow through to the point where the resident's meal is verified to be matching that of the order. If there was a Registered Dietitian Consult ordered, the DON or her designee will review the record to assure the Registered Dietitian consult has been completed. This will occur weekly		

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F 325	<p>Continued From page 8</p> <p>facility dietary manager, and the resident's low weight should have been reported and followed up.</p> <p>In an interview with the resident 7/6/11 at 4:15PM, the resident reported she did not like the supplement the facility gave, and there were times she refused it. She indicated the supplement made her feel nauseous. She did not recall if any other kind of supplement was suggested, nor did she recall why the supplement was given.</p> <p>The resident was weighed on 7/7/2011 at 9:30 AM by Nursing Assistant #2 (NA #2), a member of the restorative staff. The facility DON was present for the weighing. The weight was done with lift scale. The CNA calibrated the scale to zero prior to weighing. The resident was on her bed wearing a gown. The resident ' s weight was 90.5 pounds.</p> <p>In an interview with restorative NA #2 on 7/7/11 at 9:48AM, it was revealed "There are 4 of us who do the weights, we record them on our weight sheets in the weight books. We give the weights to the Dietary Manager who lets us know if a reweigh is needed. We use both the standing and the lift scale to weigh the residents". She further indicated resident #75 was weighed on both the lift scale and the standing scale depending on when she was weighed.</p> <p>Staff nurse #1 was interviewed on 7/7/11 at 10:40AM and indicated when orders were received from the hospital upon return to the facility, the nurse transcribed the orders to the MAR. She reported the process was " If orders</p>	F 325	<p>times four, then monthly times three, then quarterly until the next annual survey. Care Plans will be reviewed and updated when appropriate. This process will be reviewed in the next QA/Facility Leadership monthly meeting.</p> <p>5. Completion Date: July 24, 2011</p>		

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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 325	Continued From page 9 are given for a dietary consult, the orders are transcribed to a resident 's MAR, and a referral/communication form is filled out and taken to dietary by the nurse who transcribes the order ". The staff nurse indicated she was not the nurse who transcribed admission orders for resident #75 on 6/13/2011 and was uncertain who transcribed them. On 7/07/2011 at 10:50 AM, the facility Dietary Manger indicated it was her responsibility to carry out dietary consults and further indicated no referral form was received in June or July 2011 for a dietary consult for resident #75. In an interview with the facility DON on 7/07/11 at 11:05 AM, it was reported staff was unable to locate a referral form for a dietary consult for Resident #75 done on 6/13/2011. The DON further indicated it was her expectation that orders for a dietary consult were carried out as soon as the orders were received. The DON also reported if there was an abnormal weight, the weight was turned over to the Dietary Manager and the Assistant Director of Nursing both who were in charge of monitoring residents' weights. She also indicated significant weight loss issues were brought to the Quality Assurance (QA) meetings, and that none were brought to the attention of QA for Resident #75 in June or July 2011.	F 325			
F 431 SS-D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	F 431; Scope and Severity: D Drug records, label/store drugs & biological. 1. Corrective action for those affected.	7/12/11	

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

PRINTED: 07/20/2011
FORM APPROVED
OMB NO. 0938-0391

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F 431	<p>Continued From page 10</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to remove outdated items from 1 of 2 medication storage rooms (station 2). The findings include: An observation of the medication room on station</p>	F 431	<p>The outdated medications were removed from the identified medication room immediately. The facility's pharmacy was made aware of outdated IV fluids and a new IV box was exchanged out on the evening on 7/7/11. The DON contacted the Pharmacy Director to inform her that the facility had received IV fluids in an emergency box that were expired upon arrival. The outdated vacutainers were removed immediately. The vacutainers were removed by the ADON.</p> <p>2. Corrective action for other residents that may be affected. The AB medication room, central supply, and medication supply boxes from the pharmacy were inspected and no other expired products were discovered. No residents were affected by any expired over the counter medications, vacutainers, and/or Intravenous Fluids.</p> <p>3. Measures put into place to prevent recurrence. All licensed staff were inserviced on removal of outdated medications, fluids, and vacutainers on 7/22/11. This was conducted by the Director Of Nursing. The central supply clerk was inserviced on removal and appropriate</p>		

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NAME OF PROVIDER OR SUPPLIER ROCKINGHAM MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		
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F 431	<p>Continued From page 11</p> <p>2 was done on 07/7/11 at 2:00PM. An "IV (intravenous) start box" with a label dated 04/26/11 was observed. The box contained a liter bag of Dextrose/.45 Normal Saline with 20 meq (millequivalents) of Potassium with an expiration date of 05/2011, a 250 ml(milliliter) bag of Dextrose5%/Water with an expiration date of 06/2011 and 2 100ml bags of Dextrose 5%/water with an expiration dates of 06/2011. During an interview with the Assistant Director of Nursing (ADON) at this time it was revealed "the pharmacy changes out the IV box monthly."</p> <p>Also observed in the medication room were 2 bottles of Calcium 500 mg (milligram) tablets with an expiration date of 05/2011, 1 bottle of Calcium 500 mg tablets with an expiration date of 05/2010 and a bottle of Folic Acid 400 mg tablets with an expiration dated of 06/2011. During an interview with the ADON at this time it was revealed "the stock person is the one who stocks the room. She should check the expiration dates but the nurses should also be checking them." During an interview with the Director of Nursing (DON) on 7/07/11 at 3:30 PM it was revealed "I would expect the pharmacy to check the IV solutions for outdated items and I would expect the supply person to check for outdated supplies when she is stocking the room. "</p> <p>During and observation of the supply room on the unit at 3:00PM on 07/07/11, 3 yellow top vacutainer tubes (used to draw blood) were found with an expiration date of 11/2010.</p> <p>During an interview with the DON on 07/07/11 at 3:30 PM it was revealed "the vacutainer tubes are brought to us by the hospital and we should</p>	F 431	<p>disposal of outdated OTC medications and vacuainers on 7/22/11. This was conducted by the Director of Nursing.</p> <p>4. Monitoring of corrective action to ensure the Deficient practice will not recur. The DON or her designee will inspect all medication rooms will be for appropriate removal of medications, IV fluids, and vacutaners 5 days per week for 2 months then weekly times 5 weeks and continue until next annual survey. This will be completed by DON,ADON, and Risk Manager. This process will be reviewed in the next QA/Facility Leadership monthly meeting.</p> <p>5. Completion Date: July 22, 2011</p>		

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NAME OF PROVIDER OR SUPPLIER ROCKINGHAM MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		
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F 431	Continued From page 12 be checking them to be sure they are not outdated." At 3:50 PM the ADON brought a "pharmacy consult form" dated 06/24/11 that indicated that all the medication rooms were checked and outdated items were removed. The ADON stated "but they must have missed those things."	F 431			

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345378	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/8/2011
NAME OF PROVIDER OR SUPPLIER ROCKINGHAM MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 280	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of interested persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on family and staff interview and record review, the facility failed to invite the family of 1 of 15 residents (#130) to the care planning meeting. The findings include:</p> <p>Resident #130 was admitted to the facility on 10/01/09 with cumulative diagnoses that included Failure to Thrive, Dementia and Hypertension.</p> <p>During a interview with a family member on 07/05/11 at 12:30 PM it was revealed "I don ' t know what a care plan is and I have never been invited to a meeting to discuss her care."</p> <p>A review of the medical record revealed a "Care Plan Review" form. The form listed the care plan dates of 11/24/10, 02/17/11 and 05/19/11. For the dates 11/24/10 and 02/17/11 there is no documentation for the question "family invited" or "family attended". There is a section to circle Y/N (indication yes or no). For the date 05/19/11 for the question "family invited" a Y is circled and for the question "family attended" a N is circled.</p> <p>During an interview with the Social Worker (SW) on 07/07/11 at 1:35 PM it was revealed "I could not find any documentation to indicate that (name of family member) was invited to any of the care plan meetings". The SW indicated that if the family member is in the facility, the invitation is given in person, if not then the invitation is sent in writing. The SW indicated that the letter gives instruction to call the facility to let them know if the time of the meeting is convenient. The SW stated "if there is no documentation on the form that means that (name of family member) was not invited to the meeting."</p>		

Submitted as a condition of participation in the Part 1848, XVIII & XIX programs.
 undersigned does not constitute an admission that the deficiencies existed and/or were correctly cited and/or require correction. Rather it is being submitted as a condition of participation in the Part 1848, XVIII & XIX programs.

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

The above isolated deficiencies pose no actual harm to the residents

**Rockingham Manor
Plan of Correction
July 27, 2011**

**F 280; Scope and Severity: A
Right to participate planning care/revise CP.**

- 1. Corrective action for those affected.**
A care plan was held for resident 130 on Friday July 8th at 11 AM. This was conducted by the MDS Coordinator and the Social Worker.
- 2. Corrective action for other residents that may be affected.**
A letter was sent to all responsible parties and given to all residents that are on the interviewable list outlining the care plan process and that they are invited to come to the care plan meeting.
- 3. Measures put into place to prevent recurrence.**
All new admissions will be monitored for Care Plan invite upon admission daily during the AM meeting. Once identified, the Responsible Party and/or resident will be placed on a schedule corresponding with the resident's MDS, to ensure Care Plan invite and participation. This will be managed by the MDS Coordinator and Social Facility Social Worker. Residents that will be having their care plan meeting for each week will be reviewed in the morning meeting. This process will be reviewed in the next QA/Facility Leadership monthly meeting.
- 4. Monitoring of corrective action to ensure the Deficient practice will not recur.**
All Care Plan invitation letters will be initialed by the administrator/designee in the morning meeting weekly times four, monthly times three, then quarterly until the next annual survey.
- 5. Completion Date:**
July 26, 2011

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