STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING ______ B. WING ______	03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOWAN RIVER NURSING AND REHABILITATION CENTER	**1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932**

(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 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to apply splints as care planned to a resident's upper extremities for 1 (Resident #56) of 3 residents reviewed for range of motion. Findings included: Resident #56 was admitted to the facility on 5/1/12 and readmitted on 7/25/14 with diagnoses which included CVA (Cardiovascular Accident)/stroke, epilepsy, aphasia, dysphagia and diabetes. The quarterly Minimum Data Set (MDS) dated 1/26/15 revealed he was severely cognitively impaired and totally dependent on staff for all Activities of Daily Living (ADLs) with 2 or more physical assistance. He had functional impairment on both sides of the upper and lower extremities. The MDS also revealed the resident received passive range of motion (ROM) by the restorative nursing program. The care plan dated 2/9/15 revealed that Resident #56 required assistance to restore or maintain maximum function of mobility due to having limited ROM in BUE (bilateral upper extremities) due to CVA. The interventions were to: apply a splint to bilateral hands/wrist every day; remove splint both hands/wrist each day;	F 318	Resident #56 was referred to therapy on 3/30/15 by the Assistant Director of Nursing (ADON) for evaluation to ensure splint/brace remains appropriate for resident. Resident remains on OT case load for upper extremity ROM and splint/brace management as of 4/6/15. 100% audit conducted comparing all residents care plans and rehab communication to nursing to actual observations of all residents to include resident # 56 was completed on 4/7/15 by the ADON to ensure services being provided regarding splint/braces were in accordance with the written care plan. Any areas of concern regarding splints/ braces was immediately addressed by ADON with referral to therapy as needed and or immediate splint application. 100% in-service to be conducted on or before April 20, 2015, by ADON, Staff Development Coordinator (SDC), and Director of Nursing (DON) for all licensed nursing staff and Restorative Aids, to include Nurse #1, to check Medication	4/20/15

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

Electronically Signed | | 04/10/2015

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 318	Continued From page 1 monitor skin integrity under applied splint/brace every shift; and if resident did not participate in splint/brace program document reason. The goal was documented as resident will not have worsening of contractures to upper extremities through next review. An observation of Resident #56 on 3/25/15 at 9:37 AM revealed Physical Therapy Assistant (PTA) #1 was in with the resident. The resident was in bed dressed in a shirt and pants. There was a leg brace in place on the left leg. There were no splints on his upper extremities. During an interview on 3/25/14 at 9:40 AM PTA #1 stated she was completing the weekly measurements of the resident's leg contractures. She stated ROM to the resident's lower extremities was completed daily by Physical Therapy prior to placing the brace on his left leg and that Occupational Therapy (OT) or restorative worked with his upper extremities and applied braces for the upper extremities. On 3/25/15 at 12:20 PM the resident was observed in bed wearing a shirt and pants. He was watching TV. There was a leg splint on his left leg but no splints were present on his upper extremities. Splints were observed on his bedside table. On 3/25/15 at 4:50 PM the resident was observed in bed dressed in a hospital type gown. He was not wearing splints on his arms or on his left leg. During an interview on 3/25/15 at 5:01 PM NA #1 stated she had worked together with NA #4 to get Resident #56 to bed. She stated they removed the splint from the resident's left leg but that the wrist/hand wrap splints were not on when they arrived to prepare him for bed. She added that she had seen him with splints on his upper extremities but could not remember the last time she had observed him wearing the hand/wrist	F 318	Administration Records(MARs) of assigned hall at the beginning of the shift to review list placed on the MAR identifying residents requiring splint/braces to ensure splint, applications, splint removal and documentation in the electronic medical record as per plan of care. 100% in-service to be conducted on or before April 20, 2015 by the ADON, SDC, and DON with all Restorative Aides and Certified Nursing AssistantKs(CNAKs) to include CNA #1 and CNA #4 regarding application/removal of splints/braces to be conducted by licensed nursing staff. All new licensed nursing staff to be in serviced during orientation by SDC regarding need to review list place on MAR of assigned hall to identify residents requiring splint/braces to ensure splint applications, splint removal, and documentation in the electronic medical record as per plan of care. All new CNAs will be in-serviced by SDC during orientation that application/removal of splints/braces to be conducted by licensed nursing staff only. A list of all residents with splint/brace application to include residents #56, was placed in front of each units MAR on 1/14/2015 by the ADON. When new residents are referred to nursing for splint/brace application by the rehabilitation department/or resident splint/braces are discontinued the ADON will update the list of each residents requiring splint/brace application found on the MAR. Licensed floor nurses should	

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F 318	Continued From page 2 splints. On 3/26/15 at 12:01 the Occupational Therapy Assistant (OTA/L) #1 stated a communication form was used when a resident was no longer receiving occupational therapy (OT) services and was started on Restorative Nursing services. He stated resident #56 was discontinued from OT recently. He stated he had educated the nurse on duty during the day shift on how to properly place the splints to Resident #56's wrist and hands on both sides. He stated the splints were needed to prevent further contractures of the hands, to prevent wrist flexion and to prevent skin breakdown in the palm of the hand due to the fingers digging into the palm. He added the nurse was instructed how to perform the ROM and then how to place the splint. On 3/26/15 at 12:01 PM OTA/L #1 provided a form titled Rehab. Communication to Nursing. The form revealed the date to begin restorative services was 3/5/15. The treatment approaches were documented as exercise to include; "Pt to receive PROM to BUEs (all joints/planes) prior to donning splints" and splinting as; "Pt (patient) is to wear bilateral hand splints daily during 7-3 shift." The short term goal was listed as "To maintain current ROM with bilateral UES (upper extremities) to prevent further contractures and to maintain skin/joint integrity." The form was signed by OTA/L #1, Nurse #1 on 2/27/15 and by the ADON on 3/6/15. During an interview on 3/25/15 at 4:22 PM the ADON stated she and the floor nurse were notified whenever a resident was started on the restorative therapy program. She stated the resident's nurse was responsible for doing the ROM and applying splints. She stated therapy service completed the training with the bedside nurse for that resident. She reported she	F 318	check MARs when coming on duty for the list identifying any residents requiring application of splints/braces. The licensed floor nurse is responsible for applying and removing splint/brace as per care planned instructions with documentation of task in the electronic medical record. The ADON, Quality Improvement Nurse (QI Nurse), Minimum Data Set Nurse (MDS Nurse), Treatment Nurse and SDC will monitor to sustain solution by completing resident rounds to include resident #56 using QI splint/brace audit tool 5 X per week x 4 weeks, then 2 x weekly X 4 weeks, then weekly X8 weeks to ensure residents have splint/braces applied in accordance with the written plan of care. The ADON, QI Nurse, MDS Nurse, Treatment Nurse, and SDC address any identified areas of concern immediately by ensuring interventions are in place and training with the appropriate staff member. The DON will review and initial the QI splint/brace audit tools weekly X 8 weeks then monthly X2 months for completion and ensure all identified areas of concern were addressed The results of the QI Splint/Brace Audit Tool will be compiled by the QI Nurse and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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F 318	Continued From page 3 received the orders afterwards and completed the paperwork and documentation. She also stated the orders for the therapy were written in the resident's Medication Administration Record (MAR) and on the resident's Plan of Care (POC). A record review on 3/26/15 at 1:30 PM revealed the MAR for March 2015 which was written, "Apply splint to BUE QD (daily) on 7-3, off 3-11 Doc. (document) in POC (Plan of Care)." The BUE was marked though and hand written in the same box was "Both hands/wrist." Nurse #1's initials were present for 3/25/14 and 3/26/14 indicating that the splints were applied on the 7-3 shift on both days. On 3/26/15 at 2:28 PM Nurse #1 stated she thought she saw the splints on. She stated if applying the splint was on the MAR it should be done. She also stated that someone from therapy did show her how to place the hand splint including that the splint on the left went through the hand and around the wrist. During an interview with the DON and administrator on 3/26/15 at 2:35 PM the DON stated her expectation was that the bedside nurse put the splints on. She stated that Resident #56 could have further contractures, pain and additional loss of use.	F 318		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		4/20/15

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F 371	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the temperature of pudding at or below 41 degrees Fahrenheit during operation of the trayline. The findings included: On 3/25/15 at 12:28 PM a tray cart holding trays of individual dessert plates of carrot cake and individual sauce dishes of pudding was observed directly to the right of the steam table. No method of keeping the pudding chilled was observed. At this time the temperature of the pudding was checked with a calibrated thermometer and found to be 39 degrees Fahrenheit. At 12:56 PM while the tray line was still in process, the temperature of a dish of pudding that had just been placed on a tray was checked and found to be 49 degrees Fahrenheit. The pudding was removed from the tray. Prepackaged pudding was substituted. During an interview on 3/25/15 at 1:00 PM, the Dietary Manager (DM) indicated that the pudding should have been held on a tray filled with ice to keep the temperature at 40 degrees or lower. The DM explained that pudding and fruit were usually held on ice but it was an oversight due to nervousness.	F 371	The pudding checked that was found to have a temperature increase to 49 degrees on 3/25/15 was thrown away by Dietary Manager and not served to the residents. Temperatures were obtained on all other foods being served on the tray line, by the cook, on 3/25/15 and reviewed by the Dietary Manager prior to serving to residents and found to be within acceptable temperature range. 100% in-service of all dietary staff including the Dietary Manager conducted by the administrator to be completed on or before April 20, 2015 regarding checking temperatures of all foods, to include pudding, at the beginning, middle, and end of tray line, to ensure proper temperatures maintained and need to use pans filled with ice to keep cold desserts, to include pudding at the proper temperature while serving and not to serve any food that is not within acceptable temperature ranges. All new hires will be in serviced by the Dietary Manager during orientation regarding checking temperatures of food, such as pudding, at the beginning, middle, and end of tray line, to ensure proper temperatures maintained and need to use ice pans to keep cold desserts, such as, pudding at the proper temperature while	

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F 371	Continued From page 5	F 371	serving and not to serve any food that is not within acceptable temperature ranges On 3/26/15 the administrator and Dietary Manager implemented the use of pans filled with ice to be used on the tray line for desserts that are required to be 41 degrees and below. Desserts will be placed in pans filled with ice within 5 minutes of serving meals on the tray line. Additional desserts will be kept cold in a cooler and placed in the ice pans for serving when space in pans become available. The dietary aide will take temperatures of all foods to include deserts, such as puddings, at the beginning, middle and end of tray line and record the temperatures on the QI Temperature Audit Tool 7 days a week, to include weekends, x4 weeks, 2 x weekly, 4 weeks, and then monthly x 2 months. Dietary Manager and/or head cook will follow up immediately for any potential temperature concerns with appropriate staff member as necessary The Administrator will review the results of the QI Temperature Audit Tool and initial weekly x 8 weeks then monthly x 2 months with follow up with Dietary Manager as necessary. The Results of the QI Temperature Audit Tool will be gathered by the Dietary Manager and taken to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and pharmacist interview, the facility failed to have an antihypertensive medication available for 1 (Resident #17) of 5 residents observed at medication administration pass. The findings included: A review of the physician orders for March 2015 revealed an order for Valsartan (a high blood pressure medicine) 320 milligrams (mg) via feeding tube daily for hypertension. On 3/25/2015 at 9:59 AM, a medication administration pass was observed with Nurse #1. The nurse stated that Resident #17's valsartan	F 425	Physician was notified of medication not being available for resident # 17 on 3/25/17 by Staff Development Coordinator (SDC). Orders were obtained to give Valsartan 320 milligrams (mg) x 1 now on 3/25/15. Valsartan was obtained from back up pharmacy on 3/25/15 and administered by Nurse #1 as ordered and documented on Medication Administration Record(MAR). 100% audit of all medication carts, to include medication cart for Nurse #1, was	4/20/15

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F 425	Continued From page 7 was unavailable. A review of the March 2015 Medication Administration Record (MAR), revealed documentation on 3/24/2015 and 3/25/2015 with the nurse initials circled, for Resident #17's valsartan. On 3/25/2015 at 11:58 AM, an interview was conducted with Nurse #1. The nurse stated Resident #17's blood pressure medicine box was not in the medicine drawer yesterday, and she had expected it to be available to give to the resident today. She stated she did not give the medicine on 3/24/2015 and she did not call the pharmacy on 3/24/2015. The nurse stated that she had planned to call the pharmacy today, to see if the medicine was available, so she could give the medicine. The nurse stated it was the floor nurse's responsibility to reorder medicine's when they were running low. She also worked with the resident on 3/18/2015 and 3/19/2015, but could not remember if she saw the reorder label, or if she had reordered the medicine. On 3/25/2015 at 12:54 PM, an interview was conducted with Nurse #2. The nurse stated that she worked on 3/23/2015, and she gave the last blood pressure medicine that was in the box. She stated the reorder label was already gone from the box, so she assumed the medicine had already been reordered, and she threw the box away. She stated she normally reorders medicines when there are 3 pills left in the box. She also worked with the resident on Friday 3/20/2015, but could not remember if she had seen the label that day, or if she had reordered the medicine. On 3/25/2015 at 2:39 PM, an interview was conducted with the pharmacist. The pharmacist stated the prior refill history for the blood pressure medicine was on 3/6/2015, and 14 pills were sent	F 425	conducted by Treatment Nurse and SDC, Assistant Director of Nursing (ADON), Minimum Data Nurse (MDS), and Quality Improvement Nurse (QI) on 3/25/15 and on 3/30/15 comparing Medication Administration Records (MARs) to medications in the medication cart to ensure all residentsK, to include resident #17, prescribed medications, such as Valsartan, were available. Any medications found to be missing or low were immediately addressed by ADON, SDC by ordering medication from the pharmacy. 100% of licensed nursing staff, including Nurse # 1, in serviced by Director of Nursing(DON) on need to reorder medications, such as Valsartan, from the pharmacy, when last dose removed above the Red Reorder Divider found in unit dose packages, and/or if in punch packs the nurse removes the does with a red reorder arrow beside it. Medications are reordered by pulling reorder sticker found on each medication pack and faxing to pharmacy per pharmacy manual. If any medications is not available on the medication cart, the nurse should first check to see if medication is stocked in emergency drug box. If medication not stocked in emergency drug box the nurse should then contact the pharmacy who in turn will call medication into back up pharmacy. If for any reason the medication cannot be obtained the nurse should contact the physician for further orders and make DON award that medications not available. In-service completed on 4-1-2015. Newly hired	

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F 425	Continued From page 8 to the facility. He stated that if that medicine had been ordered too early and rejected, the computer would generate a fax to the facility with the correct reorder date on it. He stated there was no fax generated on that medicine, and that meant it could not have been ordered early and rejected. He stated the pharmacy had not received a reorder for that medicine. He stated if a medicine was ordered before 2 PM on one day, the facility would receive the medicine the next day. On 3/25/2015 at 3:35PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that it was her expectation that the medicines were ordered within 3 days of running out, and the nurse should check to see if the medication was available within the time it was reordered. On 3/25/2015 at 3:49 PM, an interview was conducted with the Director of Nursing (DON). She stated it was her expectation for nurses to follow the facility protocol for reordering medications. She stated when the nurses see the reorder tab in the medicine box that was time to reorder.	F 425	licensed nurses will be in-serviced by the SDC on need to reorder medications, such as Valsartan, from the pharmacy, when last does removed from above the red cardboard divider found in unit does packages, and/or if in punch packs the nurse removes the does with a red reorder arrow beside it. Medications are reordered by pulling the reorder sticker found on each medication pack and faxing to pharmacy per pharmacy manual. If any medication is not available on the medication cart, the nurse should first check to see if medication is stocked in emergency drug box. If medication not stocked in emergency drug box the nurse should then contact the pharmacy who in turn will call medication into back up pharmacy. If for any reason the medication cannot be obtained, the nurse should contact the physician for further orders and make DON aware that medication not available. The licensed nurses on each shift, including nurse #1 will check their assigned medication cart to ensure availability of all prescribed medications for their shift are present for each resident, to include resident # 17. Any discrepancy will be immediately addressed by initiating the process of checking to see if the prescribed medication, such as Valsartan, is stocked in emergency drug kit. If medication not stocked in emergency drug kit the nurse should then contact the pharmacy who in turn will call medication into back up pharmacy. If for any reason the	

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F 425	Continued From page 9	F 425	medication cannot be obtained, the nurse should contact the physician for further orders and make DON aware that medication not available. The ADON, QI Nurse, SDC, MDS Nurse, and Treatment Nurse will audit medication carts using the QI Medication Availability Audit Tool weekly x 4 weeks then bimonthly x 4 weeks then monthly x 2 months to ensure availability of all prescribed medications for each resident and address any concerns with the appropriate nurse with reeducation on protocol as needed. The DON will review and initial the completed QI Medication Availability Audit Tool weekly x 4 weeks then bimonthly x 4 weeks then monthly x 2 months and address any concerns with appropriate nurses as needed. The DON will compile the results of the QI Medication Availability Audit Tools and present to the Quality Improvement Committee monthly x 4. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	