STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		5/11/18

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

Electronically Signed | 04/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to treat 1 of 18 residents in a dignified manner by not answering call bells for a resident who needed toileting assistance which resulted in incontinent episodes for a continent resident (Resident #6). Findings included: Review of the medical record revealed Resident #6 was admitted to the facility on 11/27/2006 with diagnoses which included Heart Disease and overactive bladder. Review of the Quarterly Minimum Data Set (MDS) assessment dated 1/8/2018 indicated Resident #6 was cognitively intact and always continent of bowel and bladder. The MDS specified the resident was unsteady and required assistance of 1 staff member to move on and off the toilet. An observation and interview was conducted with Resident #6 on 4/3/2018 at 10:53 AM. The resident was in her room, sitting in a wheelchair. The resident was alert, oriented and well kempt. Resident #6 stated, at times she waited an hour for assistance after she used her call bell. There was a clock in the resident's room. Resident #6 stated she knew when she needed to go and could wheel herself into the bathroom, but was unable to transfer independently from the wheelchair to the toilet. Resident #6 indicated there were times she would have to wet herself because her bell was not answered in time for her to get on the toilet. The resident reported there	F 550	Ayden Court Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. Ayden Court Nursing and Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Ayden Court Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through the Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 550 The process that led to this deficiency was determined to be the failure of nursing staff to answer call bells timely, resulting in Resident #6 having an incontinent episode and not being treated in a dignified manner. On 4/24/18, an interview was conducted by the Social Worker (SW) with 100% of alert and oriented residents to include Resident #6 to determine if call bells had	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 550	Continued From page 2	F 550		

were at least 3 different times when the urine soaked her chair and puddled from the bathroom where she was sitting into her room. The resident stated she felt bad when it happened and she would apologize to the staff. Resident #6 stated twice during the interview that it was a terrible feeling to know you needed to go to the bathroom, could not go by yourself and wet yourself due to having to wait for assistance. Resident #6 also reported at times the staff came in her room, cut the call bell off and told her they would return. The resident indicated it was a long time before they came back to assist.

An interview was conducted with Nurse #10 on 4/3/2018 at 2:31 PM. The nurse verified she was the nurse responsible for Resident #6. The nurse reported she was employed with a staffing agency and worked at the facility often. The nurse stated she worked all shifts and was familiar with Resident #6. The nurse indicated the resident was continent and called for assistance when she needed to use the toilet. The nurse reported there were times the call bells were not answered timely and she recalled the resident wetting herself waiting for staff to assist her.

An interview was conducted with NA #10 on 4/6/2018 at 3:56 PM. NA # 10 verified she worked with Resident #6 often and was familiar with her care needs. NA #10 reported most days it was difficult to get the call lights answered timely due to the unavailability of facility staff. NA #10 stated Resident #6 was continent. NA #10 recalled times the resident's call light was not answered in time for the resident to be toileted and the resident would wet herself. NA #10 indicated she was unsure of the exact date, but the last time she was unable to get to the resident before she wet

been answered in a timely manner to ensure dignity and prevent incontinence for those residents who are continent. All identified areas of concern were immediately addressed by the Director of Nursing (DON) to include additional staff training and increased monitoring of resident rooms.

On 4/23/18, an in-service was initiated for all facility and agency staff by the Staff Facilitator (SF) regarding answering call bells in a timely manner to maintain dignity to prevent incontinence for those residents who are continent. If a staff member is unable to directly address the resident's need, the call bell should remain on and the staff member should immediately find a clinical staff member who can assist the resident, to include with toileting assistance. The in-service will be completed by 5/11/18. All newly hired staff to include agency will be in-serviced by the SF during orientation regarding the need to answer call bells in a timely manner to maintain dignity. This will include advising staff members unable to directly address the resident's need on leaving the call bell on and immediately finding a clinical staff member that can directly assist the resident to include with toileting assistance.

The Nursing Supervisor, Quality Improvement (QI) Nurse, and SF will conduct call bell audits for 10% of residents five times weekly, on various shifts, for 4 weeks, then two times weekly, on various shifts, for 4 weeks, and finally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 550	Continued From page 3 herself was within the last week. An interview was conducted with the Director of Nursing (DON) on 4/6/2018 at 4:21 PM. The DON stated the expectation was for call lights to be answered in a timely manner in order to ensure the dignity of all residents.	F 550	weekly, on various shifts, for one month to ensure dignity is maintained by call bells, including call bell for Resident #6, being answered in a timely manner using a QI Call Bell Audit tool. Any concerns will be immediately addressed by the Nursing Supervisor, QI Nurse, and SF with retraining of staff. The Director of Nursing (DON) will review and initial the QI Call Bell Audit tool weekly for 8 weeks, then monthly for 1 month to ensure compliance. The SW will interview 10% of alert and oriented residents, including Resident #6, weekly for 8 weeks, then monthly for 1 month to determine if call bells are being answered in a timely manner including to prevent incontinence for resident who are continent using a QI Resident Care Questionnaire. The DON will review the results of the audit and initial weekly for 8 weeks then monthly for 1 month to ensure compliance. Any identified areas of concern will be immediately addressed by the DON, Nursing Supervisor, QI Nurse, or Staff Facilitator (SF) with retraining of staff. The administrator and/or the DON will review and present the findings of the audits and questionnaires to the Executive Quality (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 550	Continued From page 4	F 550	monitoring. The administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 558 SS=G	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and resident interviews, the facility failed to maximize a resident's potential for mobility and physical conditioning for 1 of 1 residents (Resident #1) assessed as needing a specialty order wheelchair, which resulted in the loss of mobility and decrease of physical conditioning. Findings included: Review of Resident # 1's medical record indicated that she was admitted to the facility on 11/01/17. Her admitting diagnoses included: Atrial Fibrillation, Acute Embolism, and Thrombosis of Unspecified Deep Veins of left lower extremity, Morbid Obesity, Difficulty Walking and Generalized Muscle Weakness. The Quarterly MDS (Minimum Data Set) dated 1/10/18 revealed the resident had adequate speech, hearing and vision, could understand and	F 558	The process which led to this deficiency was determined to be the facility failed to maximize the potential for mobility and physical conditioning for Resident #1. Resident #1 was assessed by therapy as needing a specialty order wheelchair, which was not received timely resulting in the loss of mobility and decreased physical conditioning. On 12/14/17, the rehab department submitted a request for a wheelchair measuring 46 x 32 for Resident #1. On 12/21/17, a purchase order for a 46 wheelchair, categorized as nursing equipment, was obtained by the supply clerk. On 2/2/18, a 46 wheelchair was ordered for Resident #1 by the supply clerk.	5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 558	Continued From page 5 be understood. She was cognitively intact and had not demonstrated any behaviors of rejection of care. Her functional status was determined as requiring extensive, two-person physical assistance with bed mobility, transfer activity occurred only once or twice with one-person physical assist, walking in room and locomotion on/off the unit did not occur. Additionally, she required extensive, one-person physical assistance with dressing, eating and toileting and totally dependent with one-person physical assistance for bathing. Review of the resident's Care Plan dated 01/10/18 addressed the area of immobility with the use of half rails (bed rails) to assist the resident with turning and repositioning. Consultation notes revealed the resident was seen by an Orthopedic physician on 01/17/18. The orthopedic doctor's report stated he had no recommendations, and "If she was in therapy before I see no reason why she cannot try to continue." Investigation of the resident's mobility was initiated on 04/02/18. The chart review revealed an order for Physical Therapy (PT) written by the SDC (Staff Development Coordinator). The PT order the order was dated 04/04/18 at 09:30. On 04/02/18 at 07:50 am, an observation was made of Resident #1. She was lying in the bed eating breakfast. On 04/03/18 at 03:36 pm, a second observation was made of the resident. She was lying in bed watching TV. On 04/04/18 at 07:57 am, an interview was conducted with Resident # 1. She stated she received a wheelchair in January or before. She also stated, "The lift was cutting into my leg, so I	F 558	On 3/21/18, the facility made an inquiry as to the delivery status of the wheelchair for Resident #1. The reply to the inquiry indicated that the wheelchair for Resident #1 would be delivered on 4-16-18, with an 8-10 week lead time. On 4/4/18, a physical therapy referral was submitted for Resident #1 by the Staff Facilitator (SF) due to observation of decreased mobility. On 4/4/18, Resident #1 was added to the physical therapy caseload to improve strength, endurance, and balance for transfers and bed mobility. On 4/16/18, the supply clerk followed up regarding the delivery status of the wheelchair for Resident #1. The supply clerk received the response that stated there was an 8-10 week lead time from the date of 4/16/18. On 4/26/18, the supply clerk contacted the supplier to follow up with status of wheelchair for Resident #1. The supply clerk was informed that the wheelchair would ship on 4/27/18. On 4/26/18, a 100% audit of all residents to include Resident #1 was initiated by the Staff Facilitator (SF), Nurse Supervisor, and/or the Quality Improvement (QI) Nurse in regards to mobility devices to include specialty ordered wheelchairs, walkers, beds, and lifts to ensure all residents had the appropriate mobility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 558	Continued From page 6 didn't get settled in it; they put me back in bed." She added she has not been up since her "therapy was cut off" in January. She, then pointed to the wheelchair that was previously ordered and stated it fit within the door frame but it was too small for her. Resident # 1 stated she wondered if the new wheelchair would fit through the doorframe. She stated she was awaiting another wheelchair that had been ordered. On 04/04/18 at 08:00 am, the Maintenance Director was asked the width of residents' doorframes. He replied he was not sure but thought it was 44 inches. On 04/04/18 at 08:08 am, an observation was made of the Maintenance Director measuring the width of the doorframe of Resident # 1's room. When asked what the measurement was, he stated it measured 44 inches. On 04/04/18 at 11:05 am, a facility staff member provided a copy of a document from rehab requesting a wheelchair measuring 46"x 32". It was dated 12/14/17. A review of email correspondence, dated 12/19/17, revealed a request from the facility to its supply company for a price quote. On 12/21/17, a purchase order for a 46" wheelchair, categorized as nursing equipment, was obtained. Subsequent email correspondence, dated 02/01/18 at 04:55 pm, revealed a request from the supplier to verify wheelchair measurements. Email correspondence, dated 03/21/18 at 09:40 am, revealed an inquiry as to the delivery status of the wheelchair. The reply, on the same date at 11:05 am, indicated the delivery would be "4-16-18 8-10 WK LEAD TIME."	F 558	devices in place per the care plan, care guide, and/or therapy recommendations. The audit will be completed by 5/11/18. All areas of concern identified during the audit will be immediately addressed by the SF, Nurse Supervisor, and/or the QI Nurse, to include re-evaluation by therapy, updating of care plans, obtaining the appropriate mobility devices, and/or additional staff training. On 4/26/18, a 100% audit of progress notes and therapy recommendations for the past 90 days was initiated by the facility nurse consultant, the SF, Nurse Supervisor, and the QI Nurse for mobility of residents to include Resident #1 to ensure any resident with a change in mobility was assessed for cause of change in mobility and appropriate interventions were initiated to include, but not limited to, therapy referrals as indicated or obtaining appropriate mobility devices (specialty wheelchairs, lifts, or walkers). The audit will be completed by 5/11/18. All areas of concern will be immediately addressed by the DON, to include submission of therapy referrals as indicated and obtaining the appropriate mobility equipment. On 4/27/18, a 100% audit of all medical equipment orders for the past 90 days to include Resident #1 wheelchair, was initiated by the supply clerk to ensure all medical equipment ordered for residents was received in a timely manner to include specialty wheelchairs, walkers, beds or lifts. The audit will be completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 558	Continued From page 7 On 04/04/18 at 5:04 pm, a third observation was made, and the resident was lying in bed watching TV. During an interview with the Physical Therapy Aide (PTA) at 09:16 am, on 04/05/18, the PTA revealed the extent of services rendered was sitting the resident on the side of the bed "because we didn't have the right equipment." He also stated she was discharged from Physical Therapy (PT) by her insurance and stated "She was maxed out with what we could do because, again, we didn't have the right stuff. She did the best that she could." Regarding mobility, the PTA stated the resident needed a larger wheelchair and she had not received it. At 09:43 am on 04/05/18, a telephone interview was done with a representative of the company where the facility ordered the wheelchair. She stated a quote was requested on 12/19/17. She stated the order was held due to the cost of the wheelchair requiring approval on three levels. She identified the three levels as Administrator, Regional Vice President of Operations (RVPO) and Chief Executive Officer (CEO). She added the final approval was not obtained until 02/02/18, and it usually took eight to ten weeks to make a special ordered wheelchair. On 04/05/18 at 10:15 am, an interview with the Admissions Coordinator was conducted. She indicated she was the person who admitted Resident # 1, but the process of admissions was once a referral is received from the hospital, it was given to the Director of Nursing (DON) for her to determine if the resident's needs can be met at the facility. If the DON agreed to the admission, the referral was given to the	F 558	by 5/11/18. All areas of concern will be immediately addressed by the administrator and/or the DON to include follow up on medical equipment orders and/or additional staff training. On 4/27/18, an in-service was conducted by the facility nurse consultant with the administrator, Director of Nursing (DON), and admissions coordinator to ensure all residents are thoroughly reviewed and discussed during the admissions process to determine if the facility is able to accommodate the resident□s needs, including orders for medical equipment such as specialty wheelchairs. This in-service also discussed the need to conduct an onsite visit with the potential resident if indicated prior to admission. All newly hired administrators, DONs, and admissions coordinators will be in-serviced by the facility nurse consultant during orientation regarding ensuring all residents are thoroughly reviewed and discussed during the admissions process to determine if the facility is able to accommodate the resident□s needs. This in-service will also discuss the need to conduct an onsite visit with the potential resident if indicated prior to admission. An audit of 10% of residents to include Resident #1 will be completed by the Quality Improvement (QI) Nurse, Staff Facilitator (SF), and/or the Nurse Supervisor utilizing the Mobility Equipment Audit Tool weekly for 8 weeks, then monthly for one month to ensure all residents to include Resident #1 have the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 558	Continued From page 8 Bookkeeper to review the payor source. Upon agreement between the Bookkeeper and DON, the paperwork was returned to the admission's office, and a bed offer is made. During an interview with the DON on 04/05/18 at 10:40 am, she stated she did not do an onsite assessment of Resident # 1 prior to admission to the facility. She stated that she reviewed the discharge summary and it stated the resident could stand. The DON stated that she was told by the Vice President of Operations (VPO) the resident could walk but she had gotten weaker. She further added she told the Admissions Coordinator she was "not for the idea" of admitting the resident. She stated she told the Admissions Coordinator the facility had a Bariatric bed available. The DON stated the resident's decreased mobility was because she had pain in her left knee and would not do PT. She also stated the resident said her knee was sliding out of joint. The DON stated an Orthopedic appointment was made but there were no negative findings. The DON stated the resident's admission was anticipated for therapy only, but she knew it was going to be long term. During an interview on 04/05/18 at 10:47 am with the Supply Clerk (identified by the DON as responsible for ordering equipment), revealed she told the DON the facility could not accommodate the resident because there was not a wheelchair, mechanical lift or shower bed big enough. She stated it took a while to order some things, because the facility must obtain a price quote, write a purchase order and get approval from the home office. During an interview on 04/05/18 at 11:10 am with	F 558	appropriate mobility equipment in place to include specialty wheelchairs, walkers, and lifts and that resident does not have a decreased in mobility. Any areas of identified concern will be immediately addressed by the DON during the audit to include therapy referrals as indicated, obtaining appropriate mobility equipment and education of staff. The Administrator will initial the Mobility Equipment Audit Tool weekly for 8 weeks, then monthly for one month to ensure all areas of concern were addressed. An audit of 10% of progress notes will be reviewed by the Quality Improvement (QI) Nurse, Staff Facilitator, and/or the Nurse Supervisor utilizing a Resident Mobility Accommodation Audit tool weekly for 8 weeks, then monthly for 1 month, to ensure any resident including Resident #1 with a change in mobility was assessed for cause of change in mobility and appropriate interventions were initiated to include, but not limited to, therapy referrals as indicated or obtaining appropriate mobility devices (specialty wheelchairs, lifts, or walkers). All areas of concern will be immediately addressed by the DON, to include submission of therapy referrals as indicated, updating of care plans and care guides, and obtaining the appropriate mobility equipment. The Administrator will initial the Resident Mobility Accommodation Audit tool weekly for 8 weeks, then monthly for one month to ensure all areas of concern were addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 558	Continued From page 9 the VPO, she revealed Resident # 1 was a former employee at another facility. She stated she instructed staff to look at admitting the resident and added "How could we not take her?" She also stated at the time of the referral, the resident was walking. She further stated "The failure to obtain the wheelchair has been a calamity of errors. We thought it was approved." On 04/05/18 at 11:39 am, an interview was conducted with the Administrator. He stated he got involved with admissions when there was no secondary insurance. He added if there were concerns about the staff's ability to take care of the resident, it was discussed prior to admission. When asked if he had any knowledge about Resident # 1's wheelchair, he stated he had just followed up and it was coming on or before the 16th. He added "we thought she was walking" before she came to the facility. He also stated when the wheelchair came, PT would start. When asked about the difference in the wheelchair width and the width of Resident # 1's doorframe, he replied that she would be transported to PT by stretcher as was done previously. When asked about the resident's ability to get out of the room, he added he would look at it when the time came. During an interview with a former Admissions Coordinator on 04/05/18 at 11:43 am, she revealed she was in that role at the time of Resident # 1's admission. She stated she did not do an onsite visit to see the resident prior to admission. She confirmed the current Admissions Coordinator's account of the facility's admissions process. On 04/05/18 at 03:15 pm, an interview was conducted with the Medical Director. He stated	F 558	10% of all medical equipment ordered to include specialty wheelchairs and mobility equipment will be audited by the supply clerk utilizing Medical Equipment Order Audit tool weekly for 8 weeks, then monthly for 1 month, ensuring all medical equipment is received timely. Any areas of concern identified during the audit will be immediately addressed by the administrator to include follow up The Administrator will forward the results of the Resident Mobility Accommodation Audit tool, Mobility Equipment Audit tool, and the Medical Equipment Order Audit tool to the Executive QI Committee monthly for 3 months. The Executive QI Committee will meet monthly for 3 months and review the Resident Mobility Accommodation Audit tool, Mobility Equipment Audit Tool, and the Medical Equipment Order Audit tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 558	Continued From page 10 the resident has "declined so much because she hasn't gotten up." He stated he referred the resident to an orthopedic doctor, but there was no problem. The Medical Director ordered a MRI (Magnetic Resonance Image), but it couldn't be done due to the resident's size. He demonstrated the resident's previous ability to move her left knee and leg at an approximate 45-degree angle and stated, "now she cannot." In addition to decreased knee and leg flexibility, the Medical Provider stated that there had been a decrease in the resident's ability to bear weight on both legs. The Medical Provider was asked if not getting the resident up caused her decline, and he replied "yes, to a certain extent." During an interview with the Physical Therapist at 11:48 am on 04/06/18, the therapist revealed physical therapy restarted on 04/05/18, and the resident was being assisted to sit on the side of the bed. She stated the previous PT sessions ended due to maximum progress was made. She stated the resident declined due to being mostly in bed. The therapist added the resident now had increased fluid in her thighs that was not there before. The medical record indicated the resident had a history of DVT (Deep Vein Thrombosis [deep vein blood clots]) which could be caused by impaired circulation secondary to immobility or bed confinement. The therapist stated the right leg is weaker now due to inactivity. She added that there was a decrease in weight bearing tolerance of both legs.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must	F 561		5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 561	Continued From page 11 promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to honor residents' choices by not providing showers as scheduled for 2 of 18 residents (Resident #70 and Resident #20). Findings included: 1-Record review revealed Resident #70 was admitted to the facility on 3/15/2018 with diagnoses which included cerebral infarction	F 561	The process that led to this deficiency was determined to be the nursing staff failed to honor choices for Resident #70 and Resident #20 by not providing showers as scheduled. On 4/27/18, a questionnaire for all alert and oriented residents was completed by the Social Worker (SW) on residents bathing preferences to include Resident #70 and Resident #20, receiving showers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 561	Continued From page 12 (stroke) and congestive heart failure. Review of the Admission Minimum Data Set (MDS) dated 3/22/2018 revealed Resident #70 was cognitively intact and required the limited assistance of 1 person for all activities of daily living (ADLs) and total assistance with bathing. The MDS also revealed it was very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath. Review of Resident #70's care plan dated 3/23/2018 included a focus of assistance with activities of daily living. Interventions included staff support as appropriate to maintain or achieve the highest practical level of functioning. An observation and interview was conducted with Resident #70 on 4/3/2018 at 9:45 AM. Resident #70 was alert, oriented and well kempt. The resident indicated she preferred showers but was not offered showers at the facility. The resident reported she asked for a shower the day before and the staff told her they would give her one today. The resident indicated her first shower since her admission to the facility was the morning of the interview. A review of the Bath/Shower Schedule located at the Nurses Station revealed Resident #70's shower days were Tuesdays and Fridays on the 3:00 PM to 11:00 PM shift. A review of the documentation for completed showers was reviewed from the date of Resident #70's admission until 4/3/2018. The documentation revealed, since admission on 3/15/18, the resident received a shower on 4/3/2018 on the 7AM-3PM shift.	F 561	as scheduled. All areas of concern identified during the questionnaire were immediately addressed by the Director of Nursing (DON) and/ or the Minimum Data Set (MDS) Nurse to include updating care plans, care guides, and/ or providing additional staff training. On 4/27/18, a questionnaire for all alert and oriented residents was completed by the SW to determine if residents choices, including Resident #70 and Resident 20, were being honored to include providing showers as scheduled. Any areas of concern identified during the interview were immediately addressed by the DON to include providing additional staff training. On 4/27/18, a 100% audit was initiated by the facility nurse consultant of all bathing and shower documentation reviewed for the past 30 days to ensure showers were provided as scheduled per resident preference, to include Resident #70 and Resident #20. The audit will be completed by 5/11/18. Any areas of concern identified during the audit will be addressed by the DON immediately to include additional staff training. On 4/24/18, an in-service for all licensed nurses and nursing assistants, including agency, was initiated by the Staff Facilitator (SF) regarding honoring residents choices, to include providing showers as scheduled. The in-service completion date will be 5/11/18. Any newly hired licensed nurses and nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 561	Continued From page 13 An interview was conducted with Nurse #10 on 4/3/2018 at 2:31 PM. The nurse reported she was employed with a staffing agency and worked at the facility often. The nurse stated she worked all shifts and was familiar with Resident #70. The nurse indicated the resident was alert and oriented and could make her needs known. The nurse indicated there were days the scheduled showers were not completed due to the unavailability of staff. The nurse indicated she did not recall Resident #70 getting a shower. An interview was conducted with NA #11 on 4/6/2018 at 3:56 PM. NA # 11 verified she worked with Resident #70 often and was familiar with her care needs. NA #11 stated she worked the 3AM-11PM shift. NA #11 reported there many were times the showers were not completed due to the unavailability of facility staff. NA #11 stated she did not recall ever giving Resident #70 a shower. NA #11 indicated there were days she was so busy she did not look at the shower schedule. NA #11 confirmed she was the NA assigned to the resident on the prior Friday for the 3PM-11PM shift and indicated she did not give the resident a shower because she did not have time. An interview was conducted with the Director of Nursing (DON) on 4/6/2018 at 4:21 PM. The DON stated the expectation was for showers to be completed twice a week. The DON further stated the expectation was for the nurses to be notified if showers were not given so documentation could be completed.	F 561	assistants to include agency will be in-serviced by the SF during orientation regarding honoring residents choices, to include providing showers as scheduled. 10% of all alert and oriented residents will be interviewed to include Resident #70 and Resident #20 by the SW weekly for 8 weeks, then monthly for 1 month, utilizing the Resident Preference Audit tool to determine if residents preferences are being honored to include receiving showers as scheduled. Any areas of concern identified during the audit will be immediately addressed by the DON to include providing additional staff training. 10% of residents to include Resident #70 and Resident #20 will be reviewed by the Quality Improvement (QI) Nurse, the Nurse Supervisor, and/or the SF weekly for 8 weeks, then monthly for 1 month, utilizing a Resident Shower Documentation tool to ensure residents choices are honored by providing showers as scheduled. Any areas of concern identified during the audit will be immediately addressed by the QI Nurse, the Nurse Supervisor, and/or the SF to include providing additional staff training. The DON will review and initial the audit tools to ensure accuracy and completion weekly for 8 weeks, then monthly for 1 month. The administrator will forward the results of the audit tools to the Executive QI Committee monthly for 3 months. Any issues, concerns, and/or trends identified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 561	Continued From page 14 2. A review of medical records revealed Resident #20 was admitted 1/12/2018 with diagnoses of Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, respiratory failure, shortness of breath, low back pain, osteoarthritis and right arm pain. The Admission Minimum Data Set (MDS) dated 1/19/2018 noted Resident #20 to be intact for cognition and needed extensive to total assistance for all Activities of Daily Living (ADL) with the physical help of one to two persons. The MDS indicated Resident #20 stated it was very important to her to choose between a tub bath, shower and a bed bath or sponge bath. The Care Area Assessment noted a focus of Resident #20 needing assistance with ADL function and this area went to care plan. On 4/3/2018 at 9:34 AM, in an interview, Resident #20 stated she got a shower sometimes and that her showers were scheduled for Saturdays. Resident #20 said "It has been awhile since I got a shower, a couple of weeks. I really like my shower and I am disappointed when I don't get one." A review of the schedule revealed Resident #20 was to receive her shower on Saturdays. The schedule also showed Nursing Assistant (NA) #1 was scheduled to work Resident #20's hall on 3/24/2018 and 3/31/2018. Documentation by staff of bath type was reviewed for March, 2018. That documentation revealed Resident #20 had one shower on 3/10/2018. Resident #20 was noted to have no shower on 3/24/2018 and that it was because it was not scheduled. The bath type on 3/31/2018 was	F 561	will be addressed by implementing changes as necessary, to include continued frequency of monitoring. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 561	Continued From page 15 noted to be full bed bath. In an interview on 4/6/2018 at 2:15 PM, NA #1 stated she did not know why the bath was documented as a bath when it was her shower day. NA #1 stated Resident #20 sometimes refused but indicated she did not document a refusal. On 4/6/2018 at 2:45 PM, Resident #20 stated she likes her shower and does not remember ever refusing them. The Director of Nursing (DON) was interviewed on 4/6/2018 and stated she expected residents to get their showers.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life	F 565		5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 565	Continued From page 16 in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and concerns voiced from residents in the resident council meeting, the facility failed to resolve grievances that were reported in the resident council meetings for 5 of 5 consecutive months. Findings included: Observation of a Resident Council Meeting was conducted on 4/4/2018 at 3:00 PM and revealed an issue with the resolution of grievances. The residents in the meeting reported call light response time had been an ongoing issue for several months. The Activities Director (AD) reported during the meeting the Director of Nursing requested the AD inform the council members that the facility was in the process of hiring additional staff which hopefully would resolve the issue with call light response time. Several of the council members indicated the AD explained during the meetings that the issues	F 565	The process that led to this deficiency was the facility failed to resolve grievances that were reported in the resident council meetings for 5 of 5 consecutive months. On 4/27/18, a 100% audit of all grievances reported during resident council meetings for the past 5 months was initiated by the facility nurse consultant utilizing the Resident Council Grievance Audit Tool to ensure all grievances voiced during resident council meetings were addressed timely and resolution to the grievance reviewed with resident council. The audit will be completed by 5/11/18. Any grievance that does not have a written grievance resolution will be immediately addressed by the administrator and/or the Director of Nursing (DON) and a written grievance resolution completed and presented to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 565	Continued From page 17 were passed along to the appropriate staff to ensure resolution of the issues and each month the AD reported the resolution from the prior month. The resident council members indicated the call light response time was not improved. Review of the Resident Council Meeting minutes from September 2017, October 2017, January 2018 and February 2018 were reviewed. There was documentation of the resident council members choosing not to have a Resident Council meeting for the months of November 2017 and December 2017 due to the holidays. Review of the Resident Council minutes dated September 27, 2017 indicated the residents voiced concern the response to call lights was a continued problem. Review of the Resident Council minutes dated October 26, 2017 indicated the residents reported the concerns of call light response time continued to be a problem. The response to the issue included in the meeting minutes indicated the Director of Nursing addressed the concern and the action taken was 2 nursing assistants sat at the nursing station and patrolled the length of time from call light initiation to response time. Review of the Resident Council minutes dated January 25, 2018 indicated the residents reported continued concerns of call light response time. There was no documentation of any attempted resolution. Review of the Resident Council Meeting minutes dated Feb. 22, 2018 revealed the residents voiced concerns with the call light response time	F 565	resident council for review. On 4/20/18, the DON reviewed the grievance by the resident council on timeliness of call bell response time and provided a written resolution to the resident council to include implementation of interventions of staff training and increased monitoring and assistance by the DON, Quality Improvement (QI) Nurse, and Nurse Supervisor of licensed nurses and nursing assistants on halls to ensure call bells are answered timely. On 4/30/18, the Administrator, Director of Nursing, Social Worker and Activities Director were in-serviced by the facility nurse consultant in regards to the Resident Grievance Policy. All newly hired administrators, DONs, Social Workers, and activities directors will be in-serviced during orientation by the Staff Facilitator (SF) regarding the Resident Grievance Policy, which includes the following: 1. The Social Worker will complete Resident Council Grievance Follow Up form for all areas of concern voiced during resident council meeting and forward to the Administrator immediately following the resident council meeting. 2. The Administrator will review all grievances and forward to appropriate Department Head for resolution of grievance. 3. Once the Department Head has addressed the concern it will be returned	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 565	Continued From page 18 which they indicated was not resolved. There was no response to the prior month's concern. An interview was conducted with the Activities Director (AD) on 4/4/2018 at 4:20 PM. The AD indicated copies of the monthly Resident Council Meeting minutes were given to the departments with concerns monthly after the meeting. The AD reported prior to the next month's meeting, the responses to the concerns were given to her so she could report the resolutions. The AD indicated she was aware of the ongoing issue with the call light response time and hoped the issue would be resolved with the addition of new hired staff. An interview was conducted with the Director of Nursing (DON) on 4/5/2018 at 11:53 AM. The DON the expectation was the grievances and concerns from the Resident Council would be addressed and resolution be accomplished to the satisfaction of the residents.	F 565	to the Administrator for final review. 4. Resident concerns should be addressed timely (within 3 days). 5. The Social Worker will review with resident council resolutions to all grievances the next scheduled resident council meeting or sooner if indicated. 6. Any resolution that does not meet resident council satisfaction will be given to the Administrator for further review/follow up. 10% of all grievances received during monthly resident council meetings will be reviewed by the DON utilizing the Resident Council Grievance Audit Tool monthly for 3 months to ensure a written resolution of all grievances/concerns were reviewed with and meet expectations of resident council, to include any concerns regarding call light response time. Any areas of identified concern will be immediately addressed by the administrator during the audit to include completing grievance form, written resolution response to the resident council and/or additional staff training. The administrator will forward the results of the Resident Council Grievance Audit Tool to the Executive QI Committee monthly for 3 months. The Executive QI Committee will meet monthly for 3 months and review the Resident Council Grievance Audit Tool to determine trends and/or issues that may need further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 565	Continued From page 19	F 565	interventions put into place and to determine the need for further and/or frequency of monitoring. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 580	Continued From page 20 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and record review, the facility failed to notify the family/responsible party when a resident's feeding tube came out and needed to be replaced for one of one residents reviewed for a change in status (Resident #33). Findings included: A review of the medical record revealed Resident #33 was admitted 12/8/2017 with diagnoses of Dementia without behaviors, Congestive Heart Failure, Atrial fibrillation and Osteoarthritis. The Quarterly Minimum Data Set (MDS) dated 2/8/2018 indicated Resident #33 was severely impaired for cognition and needed extensive to total assistance for all Activities of Daily Living with the help of one to two persons.	F 580	The process that led to this deficiency was determined to be that the licensed nurse failed to notify the Resident Representative (RR) when the feeding tube for Resident #33 became displaced and required replacement. On 4/6/18, the licensed nurse was in-serviced by the Director of Nursing (DON) regarding notifying the RR for any acute change in a resident□s condition to include when a feeding tube becomes displaced that may require replacement or repair. On 4/11/18, the facility nurse consultant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 580	Continued From page 21 The care plan dated 9/22/2016 noted a focus of feeding tube requirement for assisting resident in maintaining or improving nutritional status related to dysphagia. The goal was the resident would have no complications through the next review. Interventions included tube feeding and water flushes as ordered by the physician; maintain function of feeding tube by application of a binder to prevent self-dislodgement of the tube. Check for patency with flushes and monitor to ensure binder is in place. Monitor for signs and symptoms of infection at feeding tube site and notify physician. A review of progress notes revealed on 2/25/2018 a Nursing Assistant (NA) found Resident #33's feeding tube lying beside the Resident in bed. The progress notes indicated the feeding tube was temporarily replaced with a #16 catheter with a 10 cubic centimeter (cc) balloon to secure it. Nurse #2 also documented the tube was checked for placement, balloon was inflated with normal saline and the tube was flushed and would be monitored. A progress noted written on 2/27/2018 noted the physician in to see Resident #33. Routine visit. Order for Complete Blood Count (CBC). Responsible Party (RP) will be notified. In an interview on 4/5/2018 at 2:15 PM, the RP for Resident #33 stated she received a call on 3/27/2018 from a Gastro-Intestinal physician's office asking if she could come there to sign a consent to have Resident #33's feeding tube replaced. The RP stated she had not been informed the feeding tube had been dislodged. The RP indicated she called the facility and filed a grievance about not being notified. A review of grievances revealed the grievance filed by the RP, which was dated 3/27/2018, in regard to not being notified when the feeding tube	F 580	completed an audit of 100% nursing progress notes, risk management reports, and physician□s orders for the past 30 days to ensure the RR was notified, to include for Resident #33, for all acute changes in residents□ conditions including displaced feeding tubes that may require replacement or repair. All identified areas of concern were immediately addressed by the DON and/or the Nurse Supervisor to include notification of the RR and additional staff training. On 4/11/18, the Staff Facilitator (SF) initiated an in-service for 100% of licensed nurses to include agency on RR notification for acute changes in residents□ condition to include displaced feeding tubes that may require replacement or repair. This in-service will be completed by 5/11/18. Any newly hired licensed nurses including agency will be in-serviced by the SF during orientation regarding RR notification for acute changes in residents□ condition to include displaced feeding tubes that may require replacement or repair. 50% of all nursing progress notes, risk management reports, and physician□s orders will be reviewed by the Quality Improvement (QI) Nurse, Nurse Supervisor, and/or the SF utilizing a RR Notification Audit tool 3 times weekly for 4 weeks, twice weekly for 4 weeks, then weekly for 4 weeks to ensure the RR was notified of the acute change in resident□s condition, including for Resident #33, to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 580	Continued From page 22 came out. On 4/6/2018 at 4:45 PM, the facility physician was interviewed and stated he was not sure if he was notified when Resident #33's feeding tube came out. The Director of Nursing was present and informed the physician Resident #33's feeding tube was replaced with a catheter. The physician stated it was in the communication book. A review of the communication book, used to inform the physician about residents when the physician is not in the facility, indicated the physician was notified on 3/2/2018. On 4/6/2018 at 4:50 PM, the Director of Nursing stated her expectation was the physician and the RP would be notified of any change with a resident. On 4/16/2018 at 9:15 AM, in a telephone interview, Nurse #2 stated she replaced the feeding tube when it was found to be dislodged on 2/25/2018. Nurse #2 indicated she did not notify the RP because it was about 3 AM when she replaced the tube. Nurse #2 stated she probably wrote it on the 24 hour report sheet and the nurse coming on the following shift would notify the RP.	F 580	include displaced feeding tubes that may require replacement or repair. Any identified areas of concern will be immediately addressed by the QI Nurse, Nurse Supervisor, and/or the SF to include RR notification and additional staff training. The DON will review and initial the RR Notification Audit tool weekly for 12 weeks to ensure accuracy and completion. The administrator and/or the DON will review and present the results of the audit tools to the Executive QI committee meeting monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC	F 585		5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 585	Continued From page 23	F 585		

facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 585	Continued From page 24	F 585		

conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 585	Continued From page 25 result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to provide written responses to grievances for 2 (Resident #56 and Resident #33) of 2 residents reviewed for grievances. Findings included: 1.Record review revealed Resident #56 was admitted 6/30/2017 with diagnoses which included Cerebral Hemorrhage (bleeding in the brain) and convulsions. Review of the quarterly Minimum Data Set (MDS) dated 12/13/17 indicated Resident #56 was rarely/never understood and required total care for all his activities of daily living (ADLs). An interview was conducted with Resident #56's family member on 4/2/2018 at 12:01 PM. The family member reported grievances were filed on the resident's behalf in December 2017 and January 2018. The family member indicated there were no written responses received with the resolution to the grievances. Record review of grievances indicated Resident #56's family member filed a written grievance on 12/15/2017. The grievance was investigated by the Director of Nursing (DON) on 12/15/2017. The grievance form listed the grievance as resolved on 12/18/2017 and indicated the investigation findings were reported in person to the family member. The documentation revealed	F 585	The process that led to this deficiency was the facility failed to provide the resident or Resident Representative (RR) with written responses to grievances for Resident #33 and Resident #56 per the Resident Grievance Policy and per Resident Concern and Grievance guidelines. On 4/27/18, a 100% audit of all grievances for the past 5 months was initiated by the facility nurse consultant to ensure all residents or resident representatives to include Resident #33 and Resident #56 were provided a written grievance summary per the Resident Grievance Policy and per Resident Concern and Grievance guidelines. The audit will be completed by 5/11/18. Any grievance that does not have a written grievance summary will be immediately addressed by the administrator and a written grievance summary completed and mailed to the resident or resident representative. On 4/25/18, the Social Worker (SW) sent a written grievance summary to Resident Representative of resident #56 via mail for grievance dated 12/15/17, 12/26/17 and 1/16/18. On 4/25/18, the SW sent a written grievance summary to Resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 585	Continued From page 26 the grievance was completed by the facility's Social Worker who was listed as the facility's Grievance Officer. There was no evidence of a written response. Record review of grievances indicated Resident #56's family member filed a written grievance on 12/26/2017. The grievance was investigated by the Director of Nursing (DON) on 12/27/2017. The grievance form listed the grievance as resolved on 12/27/2017 and indicated the investigation findings were reported in person to the family member. The documentation revealed the grievance was completed by the facility's Social Worker who was listed as the facility's Grievance Officer. There was no evidence of a written response. Record review of grievances indicated Resident #56's family member filed a written grievance on 1/16/2018. The grievance was investigated by the Director of Nursing (DON) on 1/16/2018. The grievance form listed the grievance as resolved on 1/16/2018 and indicated the investigation findings were reported in person to the family member. The documentation revealed the grievance was completed by the facility's Social Worker who was listed as the facility's Grievance Officer. There was no evidence of a written response. An interview was conducted with the facility Social Worker (SW) on 4/5/2018 at 10:23 AM. The SW confirmed he was the facility Grievance Officer. The SW indicated he preferred to handle the facility grievances. The SW reported the goal was to have the grievances resolved within 72 hours. The SW also reported he was aware written responses were required for grievances but he	F 585	Representative of resident #33 via mail for grievance dated 12/21/17, 1/16/18 and 3/27/18. On 4/19/18, the Administrator, Director of Nursing (DON), and the SW were in-serviced by the Vice President of Clinical Services in regards to the Resident Grievance Policy and guidelines to include the Administrator□s responsibility to assure the resident or resident representative is provided with a written grievance summary results upon completion of the grievance investigation. 10% of resident grievances to be reviewed weekly for 8 weeks, then monthly for one month by the DON to ensure written notification of grievance results and decisions were provided to the resident and/or resident representative, utilizing the Grievance Summary Audit Tool. Any areas of identified concern will be immediately addressed by the DON during the audit to include notification of the resident or resident representative and/or additional staff training. The administrator will review and initial the Grievance Summary Audit Tool weekly for 8 weeks, then monthly for 1 month for completion. The administrator will forward the results of the Grievance Summary Audit Tool to the Executive QI Committee monthly for 3 months. The Executive QI Committee will meet monthly for 3 months and review the Grievance Summary Audit Tool to determine trends and/or issues that may	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 585	Continued From page 27 was new in the SW position and was trying to get things in order. The SW stated if there was not a copy of a written response attached to the grievance, there was not written notification of the resolution provided to the person who filed the grievance. In an interview on 4/6/2018 at 4:01 PM, the Administrator stated the expectation was the person who filed the grievance be provided a written copy of the grievance summary response upon resolution of the grievance. 2. A review of the medical record revealed Resident #33 was admitted 12/8/2017 with diagnoses of dementia, congestive heart failure, atrial fibrillation and osteoarthritis. The Quarterly Minimum Data Set (MDS) dated 2/8/2018 indicated Resident #33 was severely impaired for cognition and needed extensive to total assistance for all activities of daily living with the help of one to two persons. The MDS noted Resident #33 had a feeding tube. A review of a grievance filed by the Responsible Party (RP) on behalf of Resident #33 and dated 12/21/2017, concerned new pressure areas found on Resident #33 and was processed by the Director of Nursing (DON). The grievance was confirmed by the DON, but there was no documentation regarding whether or not a written resolution was provided to the RP. A grievance dated 1/16/2018 was filed by the RP on behalf of Resident #33, concerning Resident #33 not being changed in a timely manner. The grievance was confirmed by the DON and there was no documentation regarding whether or not a written resolution was provided to the RP. A review of two grievances dated 3/27/2018 for Resident #33 were filed by the RP. The description of the grievances indicated the	F 585	need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 585	Continued From page 28	F 585		

Responsible Party (RP) was not notified of an incident concerning Resident #33's feeding tube and about two nebulizer machines being in the room. There were steps taken, but no documentation regarding whether or not a written resolution was provided to the RP.
In an interview with Resident #33's RP on 4/15/2018 at 2:15 PM, the RP stated she had called the facility to file a grievance about not being notified regarding separate things that had happened to Resident #33 on 3/27/2018. The RP stated she did not receive a written resolution to that grievance (3/27/2018), or to the grievance dated 12/21/2017 regarding pressure ulcers, nor had she received a written resolution to the grievance on 1/16/2018 regarding Resident #33 being changed in a timely manner.
On 4/5/2018 at 2:45 PM, in an interview, the Social Worker stated he had been in the position a short period of time, and was trying to make sure the regulations were being followed. The Social Worker stated he received the resolution from the department head the grievance was given to when they had resolved them. The Social Worker indicated he had not given written resolutions to the RP of Resident #33 for the 12/21/2017, 1/16/2018 and 3/27/2018 grievances, and was working toward making sure everyone who filed a grievance got a written resolution. The Social Worker stated he was aware of the regulation and the requirement that a written resolution be provided for the grievance. The Social worker was asked why the written grievance resolutions were not given and he replied he was working on it.
The Administrator was interviewed on 4/6/2018 at 4:10 PM and stated he expected a written resolution would be given to anyone who filed a grievance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 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 observation, resident interviews and record review, the facility failed to provide nail care for 1 of 18 residents reviewed for activities of daily living (Resident #55). Findings included: A review of the medical record revealed Resident #55 was admitted 10/26/2007 with diagnoses of heart failure, osteoarthritis, hemiplegia (paralysis affecting one side of the body), anxiety and depression. The Annual Minimum Data Set (MDS) dated 12/13/2017 noted Resident #55 to be moderately intact for cognition and total assistance was needed for all activities of daily living (ADL) with the physical assistance of one to two persons. The MDS noted Resident #55 had impairment on one side of the upper and lower extremities. The Care Area Assessment dated 12/13/2017 noted a focus of ADL function and this area went to care plan. The care plan dated 12/4/2017 was comprehensive for ADL care and the interventions included: One person total assist for bath, provide total care to comb hair, apply make-up, wash and dry face, hands and perineum. On 4/3/2018 at 11:25 AM, Resident #55 stated she had already had a bath that day. Resident #55 had long fingernails on her right hand with polish. The nails on Resident #55's right hand	F 677	The process which led to this deficiency was determined to be that the nursing staff failed to provide nail care for Resident #55. On 4/6/18, Resident #55 received nail care to include trimming by the Director of Nursing (DON). On 4/27/18, a 100% audit of all residents to include Resident #55 was completed by the Quality Improvement (QI) Nurse and the Nurse Supervisor to ensure nail care was provided as evidenced by clean, trimmed nails. All areas of concern identified during the audit were immediately addressed by the QI Nurse and/or Nurse Supervisor to include providing nail care for the involved resident and additional staff training. On 4/3/18, an in-service for all licensed nurses and nursing assistants to include agency was initiated by the Staff Facilitator (SF) regarding providing nail care for dependent residents. The in-service emphasized checking residents nails while providing bath care to ensure nails were trimmed and clean and to provide nail care when nails were observed to be long and dirty. The	5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 677	Continued From page 30 were shaped and she stated she liked them that way. Her left hand was flaccid, and was observed to have very long fingernails, approximately ¾ inch, which curved under on the sides, appearing tubular in shape and were thick. Resident #55 stated staff did not trim her nails on her left hand, and she thought they could use trimming. On 4/4/2018 at 9:30 AM observation was made of Resident #55 having a bath. The restorative Nursing Assistant (NA) was helping NA #2 give the bath. NA #2 finished the bath, gave mouth care, changed the linen and dressed Resident #55 in clean clothes. Nails remained long and untrimmed on the left hand. On 4/5/2018 at 10:30 AM, Resident #55 was observed in bed, without the splint, and nails on the left hand remained ¾ inches long and not trimmed. On 4/5/ 2018 in an interview at 2:11 PM, NA #2 stated there was not always enough staff and if there wasn't, she could not get everything done, including nail care. NA #3 was interviewed on 4/5/2018 at 2:35 PM, and stated she did not have trouble getting her resident care done, including nail care. NA #1 stated, in an interview on 4/5/2018 at 2:15 PM, she always got everything done for her residents, a bath every day and mouth care and nail care. NA #1 stated she did not work on the hall where Resident #55 resided. Nurse #3, who was caring for Resident #55, came into the room and was shown the long, tube shaped fingernails on 4/5/2018 at 2:50 PM. Nurse #3 stated Resident #55's nails were too long. On 4/6/2018 at 4:15 PM, the Director of Nursing (DON) stated she had gone into Resident #55's room and trimmed her nails. The DON stated her expectation was when baths were given, nail care would be provided also.	F 677	in-service will be completed by 5/11/18. All newly hired licensed nurses and nursing assistants to include agency will be in-serviced by the SF during orientation regarding providing nail care for dependent residents, including checking residents nails while providing bath care to ensure nails were trimmed and clean and to provide nail care when nails were observed to be long and dirty. 10% of all residents to include Resident #55 will be audited by the QI Nurse, Nurse Supervisor, and/or the SF weekly for 12 weeks utilizing a Resident Nail Care Audit tool to ensure nail care is provided when indicated, as evidenced by clean, trimmed nails. Any areas of concern identified during the audit will be immediately addressed by the QI Nurse, Nurse Supervisor, and/or the SF by providing nail care for the involved resident and additional staff training. The DON will review and initial the Resident Nail Care Audit tool weekly for 12 weeks for accuracy and completion. The administrator or DON will forward the results of the audit tools to the Executive QI Committee meeting monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. The administrator and DON will be responsible for the implementation of corrective actions to include all 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 677	Continued From page 31	F 677	audits, in-services, and monitoring related to the plan of correction.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews, and record reviews, the facility failed to provide activities including 1:1 and group activities to meet the individual needs for 1 of 1 resident reviewed for activities (Resident #56). Findings included: Record review revealed Resident #56 was admitted 6/30/2017 with diagnoses which included Cerebral Hemorrhage (bleeding in the brain) and convulsions. Review of the quarterly Minimum Data Set (MDS) dated 12/13/17 indicated Resident #56 was rarely/never understood and required total care for all his activities of daily living (ADLs). Review of Resident #56's Care Plan with a revision date of 3/14/2018 included a focus of an	F 679	The process which led to this deficiency was determined to be that the activities coordinator failed to provide 1:1 and group activities to meet the individual need of Resident #56. On 4/5/18, the Activities Director (AD) and the Activities Assistant (AA) were in-serviced by the facility nurse consultant on providing 1:1 activities to meet residents individual needs. On 4/6/18, Resident #56 was provided with 1:1 activities by the AD. On 4/24/18, the facility nurse consultant in-serviced the AD and the AA on ensuring all residents attend scheduled activities that wish to participate. The AD and AA must also ensure that 1:1 activities are	5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 679	Continued From page 32 alteration in supervised/organized recreation characterized by little or no involvement and lack of attendance related to cognitive impairment, impaired communication and impaired mobility. Interventions included the resident would participate in activities per week, 1:1 individualized activities programming, engage resident in group activities and transport resident to activities. An observation of Resident #56 along with an interview of Resident #56's family member was conducted on 4/2/2018 at 12:01 PM. The resident was observed in his room in a wheelchair and the family member was seated beside the resident. The family member reported the resident did not attend activities and she did not recall any one from the activity department providing 1:1 activities with the resident. An interview was conducted with Nurse #5 on 4/4/2018 at 4:02 PM. Nurse #5 confirmed she was the nurse responsible for the resident most days and was very familiar with his care needs. Nurse #5 indicated the activity staff would take Resident #56 to activities occasionally, but not often. Nurse #5 stated she was unaware if 1:1 activities were provided for the resident. Nurse #5 stated she did not recall a time she witnessed individual activities conducted with the resident. An interview was conducted with the Activity Director (AD) on 4/5/2018 at 11:27 AM. The AD indicated she was familiar with Resident #56 and his activity Care Plan. The AD reported she conducted 1:1 visits with the resident, and when he was up in his chair she would take him to singing activities. The AD indicated when the resident was not out of bed she did not tell the	F 679	provided and communicate all scheduled activities for the day in the morning meeting and prior to the activity in order that residents can be assisted to the activity. The administrator or the Director of Nursing (DON) are to be notified by the AD for any issues with providing activities so it can be addressed immediately. Any newly hired Activities Directors or Activities assistants will be in-serviced during orientation by the Staff Facilitator (SF) on ensuring all residents attend scheduled activities that wish to participate. The AD and AA must also ensure that 1:1 activities are provided and communicate all scheduled activities for the day in the morning meeting and prior to the activity in order that residents can be assisted to the activity. The administrator or the Director of Nursing (DON) are to be notified by the AD for any issues with providing activities so it can be addressed immediately. On 4/27/18, a 100% audit of all 1:1 and group activity documentation for all residents to include Resident #56 was initiated by the facility nurse consultant from November 1, 2017 to present to ensure all residents individual needs were met by receiving 1:1 and/or group activities. The audit will be completed by 5/4/18. Areas of concern identified will be immediately addressed by the administrator to include additional staff training. 10% of all residents to include Resident #56 will audited by the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 679	Continued From page 33 staff he needed to get up for an activity. The AD stated the resident needed 1:1 visits weekly but that was not accomplished due to the number of residents who required 1:1 activities. The AD indicated she was not able to get to all the residents who required in room activities and the Activity Assistant only helped part-time. The AD reported she had not informed the Administrative Staff of the issues with completing activities with residents who required 1:1. The Activity Director presented the Activity Participation Record for Resident #56. The following were the documented activities per month provided for the resident since November 2017: -November 2017=No activities documented for the resident -December 2017=1 Social Event -January 2018=1:1 activity documented 1/12/2018 and 1:1 documented 1/26/2108 -February 2018=1:1 activity documented on 2/2/2018 and 2/9/2018 and a Social Event on 2/14/2018 -March=No activities documented for the resident -April 2018=No activities documented through 4/5/2018 An interview was conducted with the Director of Nursing (DON) on 4/5/2018 at 11:44 AM. The DON stated she expected to be notified if any resident was not receiving on-going activities. The DON stated she was unaware of any concerns with activities not being completed with Resident #56 or any other residents in the facility. The DON stated the expectation was for all residents in the facility to receive activities to	F 679	Improvement (QI) Nurse, the Staff Facilitator (SF), and/or the Nurse Supervisor utilizing a Resident Activity QI Audit tool, weekly for 8 weeks, then monthly for 1 month. The audit will ensure activities are provided for 1:1 and/or group activities as indicated on the residents care plan by observing the resident participating in an activity and by reviewing documentation in the electronic health record (PCC). The DON will review and initial the Resident Activity QI Audit tool weekly for 8 weeks, then monthly for 1 month for accuracy and completion. The Administrator will present the findings of the Resident Activity QI Audit tool to the Executive QI Committee monthly for 3 months. The Executive QI Committee will meet monthly for 3 months and review the Resident Activity QI Audit tool and the Resident Activity QI Audit tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 679	Continued From page 34 enhance their quality of life.	F 679		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews and record review, the facility failed to provide consistent splint application for three of eighteen residents reviewed for restorative care (Resident #55, Resident #8, and Resident #56). Findings included: 1. A review of the medical record revealed Resident #55 was admitted 10/26/2007 with diagnoses of heart failure, osteoarthritis, hemiplegia (paralysis affecting one side of the body), anxiety and depression. The Annual Minimum Data Set (MDS) dated 12/13/2017 noted Resident #55 to be moderately intact for cognition and total assistance was	F 688	The process which led to this deficiency was determined to be that the nursing staff failed to provide consistent splint applications for Resident #55, Resident #8, and Resident #56. On 4/26/18, an audit from 3/1/18 to present of all residents documentation receiving restorative services to include splint application for Resident #55, Resident #8, and Resident #56 was initiated by the facility nurse consultant to ensure all residents on restorative caseload received restorative services to	5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 688	Continued From page 35 needed for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons. The MDS noted Resident #55 had impairment on one side of the upper and lower extremities. The care plan dated 10/18/2017 noted a focus of Resident #55 requires assistance to maintain maximum function for mobility regarding positioning and the Resident's left sided hemiplegia. The goal was Resident #55 would not acquire further contractures of the left upper extremity through next review. Interventions included: Apply elbow extension orthotic to left elbow 4-6 hours daily, 6 to 7 days per week. Place towel roll in lower forearm strap of the elbow extension orthotic for increased comfort. Monitor skin integrity under applied splint daily. On 4/3/2018 at 11:29 AM, Resident #55 was observed in bed with left upper extremity supported on a pillow. There was no splint in place. Resident #55 stated she had received her bath that morning, but the Nursing Assistant (NA) had not applied her splint yet. Resident #55 was observed having a bath on 4/4/2018 at 9:30 AM. The bath was given by two restorative aides who also did range of motion with the Resident. After the bath, Resident #55's splint was applied. A review of the Restorative Nursing task documentation revealed daily checklists for splint application. The documentation was reviewed from 3/1/2018 to 4/1/2018 and noted eleven days with no splint application documented for Resident #55. On 4/5/2018 at 11:21 AM, in an interview, the Restorative Aide stated she was often pulled to work the hall as an NA, therefore, she did not do restorative tasks. The Restorative Aide stated when she had to work as an NA, the other NAs	F 688	include splint application as indicated on the care plan. The audit will be completed by 5/11/18. Any areas of identified concern will be immediately addressed during the audit by the Director of Nursing (DON) to include additional staff training. On 4/18/18, an in-service with all licensed nurses was initiated by the Staff Facilitator (SF) to include the restorative nurse was to ensure residents assigned to the restorative caseload receive restorative services daily to include splint application. The licensed nurse will also ensure documentation of minutes and type of restorative service is present in the resident□s electronic health record (PCC). The in-service will be completed by 5/11/18. All newly hired licensed nurses to include restorative nurses and agency will be in-serviced by the SF during orientation regarding the licensed nurse□s responsibility to ensure residents assigned to the restorative caseload receive restorative services daily to include splint application. The licensed nurse will also ensure documentation of minutes and type of restorative service is present in the resident□s electronic health record (PCC). On 4/18/18, an in-service for all restorative aides and nursing assistants trained in providing restorative services was initiated by the SF regarding providing restorative services on all residents assigned to restorative caseload to include splint application. The in-service also added that all restorative aides and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 688	Continued From page 36 know they have to do their own splints and range of motion. On 4/5/2018 at 2:32 PM, in an interview, NA #9 stated she did not have to apply splints, because restorative did that. In an interview on 4/5/2018 at 11:35 AM, the Quality Improvement (QI) nurse stated the facility had trained NAs for range of motion and splint/brace application. The QI nurse then checked her records and stated NA #9 was an agency NA and had not received training for restorative tasks. On 4/5/2018 at 2:45 PM, in an interview, the Director of Nursing stated her expectation was splints would be applied according to the care plan and NAs would apply splints and range of motion when the restorative aides were working as NAs on the hall. 2. Resident #8 was admitted to the facility on 4/28/2015 with diagnoses that included: malaise, adult failure to thrive, muscle weakness, contracture right elbow, left elbow, right wrist, right hand, left hand, aphasia, and contracture of the left knee. The most recent Minimum Data Set, a Quarterly Review, was dated 1/9/2018. The assessment noted the resident was totally dependent on facility staff for all care and had numerous contractures on both upper and lower contractures. It assessed the resident as requiring splint application in 6 of the past 7 days. The Plan of Care dated 1/9/2018 for Resident #8 noted the resident would receive left elbow splint to the left upper extremity and right T-bar splint to right hand up to 6 hours daily for 6-7 days of the week with a goal of preventing the contractures from getting worse. Resident #8 was observed on 4/4/2018 at 3:40pm. The resident was observed to be lying in	F 688	nursing assistants trained in providing restorative services would be expected to provide documentation in the residents electronic health record (PCC). The in-service will be completed by 5/11/18. All newly hired restorative aides and nursing assistants trained in providing restorative services will be in-serviced by the SF during orientation regarding providing restorative services on all residents assigned to restorative caseload to include splint application. Additionally, the in-service will state that restorative aides and nursing assistants trained in providing restorative services will be expected to provide documentation in the residents electronic health record (PCC) 10% of all residents on restorative caseload, including Resident #55, Resident #8, and Resident #56, will be audited by the Quality Improvement (QI) Nurse, Nurse Supervisor, and/or the SF, utilizing a Restorative Service QI Audit tool weekly for 8 weeks, then monthly for 1 month, to ensure all residents on restorative caseload received restorative services to include splint application as indicated on the care plan. Any areas of identified concern will be immediately addressed by the QI Nurse, Nurse Supervisor, and/or the SF by providing additional retraining. The DON will review and initial the Restorative Service QI Audit tool. The administrator will present the findings of the Restorative Service QI Audit tool to the Executive QI Committee monthly for 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 688	Continued From page 37 bed with the head of the bed in an up position. The resident's left hand was outside of the cover and did not have a splint in place. The resident's other hand was beneath the bed covers and could not be seen. Resident #8 was observed on 4/5/2018 at 10:25am and was lying in bed with both hands out from under the covers. There was no splint in place on either hand. Resident #8 was observed on 4/5/2018 at 2:50pm. The resident was lying in bed and with her left hand out from under the covers. The left hand did not have a splint in place. Staff interview with one of the facility restorative aides was completed on 4/5/2018 at 2:58pm. The restorative aide reported they are responsible for placing splints and braces in place for residents in the facility. She reported she worked full time as a restorative aide except when she is "pulled" to work as a nursing assistant when there are not enough nursing assistants on the shift. If that happens, she stated the nursing assistant who works with the resident is responsible for putting the splint or brace in place and documenting that it was completed. When asked what time Resident #8 is supposed to have her splint applied, she stated there is no specific time as to when the splint is placed on and removed for the resident. The restorative aide stated she had worked the entire month of March 2018 and one entire week of April 2018 as a nursing assistant, having been pulled from the restorative aide assignment. Record review of the documentation of the restorative aide completed for Resident #8 revealed from 1/31/2018-2/15/2018, there were 8 blanks or days when there was no documentation that the splints were placed for Resident #8. From 2/16/2018-3/1/2018, there were 6 blanks	F 688	months. The Executive QI Committee will meet monthly for 3 months and review the Restorative Service QI Audit tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 688	Continued From page 38	F 688		

where the restorative aide documentation should have been. Documentation from 3/1/2018-3/16/2018 revealed 6 blanks where there was no documentation Resident #8's splints were applied. And review of the sheets dated 3/21/2018-4/5/2018 revealed 6 days had been left blank. During the interview with the restorative aide, she reported if the dates were left blank, the splints were either not put in place for the resident or the nursing assistant failed to complete the documentation.

3-Record review revealed Resident #56 was admitted to the facility on 6/30/2017 with diagnoses which included cerebral hemorrhage (stroke) and convulsions.

Review of the Minimum Data Set (MDS) dated 12/13/2017 revealed Resident #56 was rarely/never understood and required total care with all activities of daily living (ADLs).

Review of Resident #56's Care plan revised on 1/18/2108 included a focus of assistance for positioning related to the development of contractures. Interventions included a splint would be applied to the resident's left arm/elbow/wrist every day except Sunday. The interventions indicated if the resident did not participate in the splint/brace therapy to document the reason for nonparticipation.

An observation of Resident #56 was conducted on 4/2/2018 at 12:24 PM. The resident was observed in bed with no splint to the left upper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 688	Continued From page 39	F 688		

extremity.

An observation of Resident #56 was conducted on 4/3/2018 at 11:52 AM. The resident was observed sitting up in his wheelchair at the nurse's station. No splint was observed to the left upper extremity.

An observation of Resident #56 was conducted on 4/4/2018 at 2:05 PM. The resident was observed sitting up in his wheelchair at the nurse's station. No splint was observed to the left upper extremity.

An interview was conducted with Nursing Assistant (NA) #9 on 4/4/2018 at 2:10 PM. NA #9 confirmed she was the NA assigned to Resident #56. NA #9 indicated she was assigned to the resident often. NA #9 reported the resident did not have splints and if he did, the Restorative Aide was responsible for the splinting.

An interview was conducted with Nurse #5 on 4/4/2018 at 2:31 PM. Nurse #5 confirmed she was the nurse responsible for Resident #56 regularly. Nurse #5 stated the resident was supposed to wear a splint to his left upper extremity daily. Nurse #5 indicated the Restorative Aide was responsible for the application of the splint. Nurse #5 further indicated if the Restorative Aide was on a hall assignment, the Nursing Assistant was responsible for the splinting.

An observation of Resident #56 was conducted on 4/5/2018 at 8:52 AM. The resident was observed sitting up in his wheelchair at the nurse's station. A splint was observed to the left upper extremity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 688	Continued From page 40	F 688		

An interview was conducted with the Restorative Aide (RA) on 4/5/2018 at 9:35 AM. The RA stated Resident #56 was on the splinting schedule daily except Sundays. The RA indicated she was responsible for the splint application. The RA indicated when she was pulled to the hall to work an assignment, the resident's nursing assistant was responsible for the application of the splint. The RA stated if there was no documentation for the splint application, they were not applied. The RA stated she was pulled to the hall sometimes several days a week. The RA stated the resident did not refuse the splints.

A review of Resident #56's Restorative Nursing documentation from 3/1/2018 to 4/3/ 2018 was completed. The documentation revealed there were 14 days with no documentation of splint/brace application.

An interview was conducted with the Occupational Therapist (OT) on 4/5/2018 at 2:55 PM. The OT stated she was familiar with Resident #56 and his splinting needs. The OT reported she worked with the resident when he was admitted to the facility for his splinting needs. The OT indicated once all the splints were fitted and the resident tolerated the splinting therapy with no issues, he was discharged from the therapy department. The OT stated prior to the discharge, the staff who worked with the resident were educated on the splint application and schedule for splinting. The OT presented documentation of the resident's discharge from therapy dated 10/2/2017 and the training/education sheet with staff signatures also dated 10/2/2017.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 688	Continued From page 41 An interview was conducted with the Director of Nursing (DON) on 4/5/2018 at 10:39 AM. The DON stated the expectation was for splints to be applied per the Care Plan by the Restorative Aide. The DON indicated if the Restorative Aide was assigned to a hall, the expectation was the splints would be applied by the Nursing Assistants.	F 688		
F 690 SS=D	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 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.	F 690		5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 690	Continued From page 42 §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, staff and resident interviews and record review, the facility failed to anchor catheter tubing to prevent excessive tension on the catheter for 2 of 5 residents with catheters (Resident #20 and Resident #33). Findings included: 1. A review of medical records revealed Resident #20 was admitted 1/12/2018 with diagnoses of Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, respiratory failure, shortness of breath, low back pain, osteoarthritis and neurogenic bladder. The Admission Minimum Data Set (MDS) dated 1/19/2018 noted Resident #20 to be intact for cognition and needed extensive to total assistance for all Activities of Daily Living (ADLs) with the physical help of one to two persons. The Care Area Assessment noted a focus of urinary incontinence and indwelling catheter and this area went to care plan. The care plan dated 1/25/2018 noted a problem of altered pattern of urinary elimination with indwelling catheter. The goal was Resident #20 would be free from Urinary Tract Infection (UTI) through next review. The Interventions included: Catheter care per facility protocol. Empty catheter bag at end of each shift and record output. Ensure adequate fluids are provided. Observe for	F 690	The process that led to this deficiency was determined to be the nursing staff failed to anchor the catheter tubing to prevent excessive tension for Resident #20 and Resident #33. On 4/5/18, Resident #20 indwelling catheter was changed by the Director of Nursing (DON) and the Staff Facilitator (SF) to include applying a security anchor to the leg to prevent excessive tension. On 4/5/18, Resident #33 indwelling catheter was changed by the Treatment Nurse to include applying a security anchor to the leg to prevent excessive tension. On 4/6/18, an audit for 100% of residents with indwelling catheters to include Resident #20 and Resident #33 was completed by the DON to ensure all indwelling catheters were attached securely with an anchor to the leg, preventing excessive tension. There were no further concerns identified at the time of the audit. On 4/24/18, an in-service for 100% of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 690	Continued From page 43 signs and symptoms of UTI. Labs as ordered. A review of orders noted an order on 1/22/2018 for catheter to be changed monthly and when needed. An observation was made on 4/3/2018 at 9:50 AM of Resident #20 in bed with catheter draining clear, yellow urine into drainage bag that was not covered. Tubing into bag was not secured to any part of Resident #20's leg. On 4/4/2018 at 10:49 AM, an observation was made of catheter care by NA #1 and of the NA finishing Resident #20's bath. There was no observation of a strap or other device to secure tubing to the Resident. NA #1 maintained good technique and Resident #20 tolerated the care with no problem. Resident #20 remarked she had tape holding the tubing at one time, but it came off and was not replaced. Resident #20 also stated the tubing pulled and that was uncomfortable when it was not secured. NA #1 stated she did not know anything about a strap for the tubing. On 4/4/2018 at 2:00 PM, Resident #20 was observed in bed with tape securing the catheter tubing to her leg. Resident #20 indicated she felt much better with the tubing secured. The catheter bag was noted to be covered at this time. In an interview on 4/4/2018 at 4:00 PM, the Director of Nursing (DON) stated catheter care and securing catheters was part of orientation for new staff (NAs and nurses) and if in-service was done for catheter care, it was part of the in-service. The DON stated her expectation was that catheter tubing would always be secured. 2. A review of medical records revealed Resident #33 was admitted 12/8/2017 with diagnoses of Dementia without behaviors, Congestive Heart Failure, hematuria (blood in urine), atrial	F 690	licensed nurses to include agency was started to ensure all licensed nurses place a security anchor to the resident□s leg upon insertion of a new indwelling catheter to prevent excessive tension. If the security anchor is missing or becomes unattached to the resident□s leg, the nurse must immediately replace the security anchor to prevent excessive tension. The in-service will be completed by 5/11/18. All newly hired licensed nurses to include agency will be in-serviced during orientation by the SF to ensure all licensed nurses place a security anchor to the resident□s leg upon insertion of a new indwelling catheter to prevent excessive tension. If the security anchor is missing or becomes unattached to the resident□s leg, the nurse must immediately replace the security anchor to prevent excessive tension. On 4/24/18, an in-service for 100% of nursing assistants to include agency was started by the SF regarding checking for the security anchor on the resident□s leg during care to ensure it is intact. Any resident with an indwelling catheter that is missing a security anchor or security anchor has become unattached must be reported to the nurse immediately. The in-service will be completed by 5/11/18. All newly hired nursing assistants to include agency will be in-serviced on checking for the security anchor on the resident□s leg during care to ensure it is intact. Any resident with an indwelling catheter that is missing a security anchor or security anchor has become unattached must be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 690	Continued From page 44 fibrillation and neurogenic bladder. The Quarterly Minimum Data Set (MDS) dated 2/8/2018 noted Resident #20 to be severely impaired for cognition and needed extensive to total assistance for all Activities of Daily Living (ADLs), with the physical help of one to two persons. The MDS noted Resident #33 had an indwelling urinary catheter. The care plan dated 11/21/2017 noted a problem of altered pattern of urinary elimination with an indwelling catheter and a goal of Resident #33 would be clean, dry and free from odor or skin breakdown through next review. Interventions included: Catheter care per facility protocol. Empty drainage bag at the end of each shift and observe and record output. Ensure that drainage tubing is secured with anchoring device, i.e. leg strap. Observe for signs and symptoms of Urinary Tract Infection (UTI). A review of orders noted on 1/25/18 an order for change indwelling catheter monthly and when needed. On 4/4/2018 at 9:28 AM, an observation was made of the catheter tubing lying on the floor, disconnected from the catheter. Nurse #3 went into Resident #33's room, stated staff was not to leave tubing and bag on the floor when the leg bag was used. Nurse #3 showed me the leg bag was on, but there was no strap securing the leg bag. On 4/4/2018 at 10 AM, the Director of Nursing (DON) went into the room, and was observed to check the leg bag was on. The DON stated there was no strap on to secure the bag. The DON stated, in an interview on 4/4/2018 at 4:00 PM, catheter care and securing catheters was part of orientation for new nursing staff, both NAs and nurses and, if in-service was done for catheter care, it was part of the in-service. The	F 690	reported to the nurse immediately. All residents with indwelling catheters, to include Resident #20 and Resident #33, will be reviewed weekly for 8 weeks, then monthly for 1 month by the Treatment Nurse utilizing a Catheter Tubing Security Audit tool. Any areas of concern identified during the audit will be immediately addressed by the Treatment Nurse and/or the DON to include replacement of the security anchor and attaching the security anchor to the involved resident□s leg and/or additional staff training. The DON will review and initial the Catheter Tubing Security Audit tools weekly for 8 weeks, then monthly for 1 month, to ensure completion. The administrator will present the findings of the Catheter Tubing Security Audit tools to the Executive QI committee monthly for 3 months. The Executive QI Committee will meet monthly for 3 months and review the Catheter Tubing Security Audit tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 690	Continued From page 45 DON stated her expectation was that all catheter tubing would be secured.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to provide sufficient nursing staff by not providing showers as scheduled for 2 of 18 residents (Resident #70	F 725	The process that led to this deficiency was the facility failed to provide sufficient nursing staff by not providing showers as scheduled for Resident #70 and Resident	5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 725	Continued From page 46 and Resident # 20), failed to treat resident in a dignified manner by not answering call bells for a resident who needed toileting assistance which resulted in incontinence episodes for a continent resident (Resident # 6), and failed to provide consistent splint application for 3 of 18 residents reviewed for restorative care. (Resident #55, Resident #8, and Resident #56) 1. This citation is cross referenced to F561-Based on observations, record review, resident and staff interviews the facility failed to honor residents' choices by not providing showers as scheduled for 2 of 18 residents (Resident #70 and Resident #20). 2. This citation is cross referenced to F550-Based on record review, observations, resident and staff interviews, the facility failed to treat 1 of 18 residents in a dignified manner by not answering call bells for a resident who needed toileting assistance which resulted in incontinent episodes for a continent resident (Resident #6). 3. This citation is cross referenced to F 688-Based on observation, resident interviews and record review, the facility failed to provide consistent splint application for three of eighteen residents reviewed for restorative care (Resident #55, Resident #8, and Resident #56). Staff interview with the person responsible for scheduling nurses and nurse aides was completed on 4/6/2018 at 2:30 PM. The staffing coordinator reported there are times when staff who are scheduled to work call in and do not report to work. She stated on those days, she contacts other facility staff who are not scheduled to see if they are available to work. She reported if facility staff cannot fill the openings in the	F 725	#20, failed to treat resident #6 in a dignified manner by not answering call bells for a resident who needed toileting assistance which resulted in incontinence episodes for a continent resident, and failed to provide consistent splint application Resident #55, Resident #8, and Resident #56. On 4/24/18, the Director of Nursing (DON) and the Administrator reviewed the clinical staffing schedule to ensure that sufficient staff were on duty to meet the care needs of the residents, to providing showers to include for Resident #70 and Resident #20, answering call bells for residents needing toileting assistance to include Resident #6, and providing splint application for Resident #55, Resident #8, and Resident #56. There were no concerns noted during this review. The DON will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to ensure that clinical staff are on duty to meet the needs of the residents. The weekly case mix index will be reviewed weekly to ensure the acuity of the residents is taken into account with the clinical staffing patterns to meet the needs of the residents, including the needs of Resident #70, Resident #20, Resident #5, Resident #55, Resident #8, and Resident #56. On 4/27/18, the Facility Nurse Consultant in-serviced the Administrator and the DON in regards to Sufficient Staff to include:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 725	Continued From page 47 schedule, she will contact staffing agency. She reported at times she calls the staffing agency every day of the week and sometimes she will only need to call the agency 3 times during the week. The staffing coordinator also confirmed there are frequent times when the restorative aides are pulled from their assignments to work on the hall as a nursing assistant. The staffing coordinator reported on an ideal day in the facility on day shift, there would be 8 nursing assistants on the floors plus 2 restorative aides. Staff interview with the facility director of nursing on 4/6/2018 at 3:23 PM revealed on an ideal day for day shift, there would be 6 nursing assistants plus the 2 restorative aides. Ideally on the evening shift, there would be 5 nursing assistants and on the night shift she would want to always have 4 nursing assistants. She reported that administrative nursing staff always fills in when staff have called in and do not report to work. She stated that staffing in the facility is based on resident acuity and that is re-assessed on a daily basis. Documentation in the facility assessment noted staffing is assessed based on resident acuity and explained resident acuity changes from day to day. The director of nursing reported she believed all residents get the baths and showers that are needed because administrative nursing staff help out and complete resident baths and showers. The director of nursing confirmed that restorative nurse aides are pulled from their assignments to work on the floor as a nursing assistants. The director of nursing stated she felt like the staffing in the facility is adequate to provide care for their residents. An interview with a facility registered nurse, Staff member # 12, was completed on 4/6/2018 at 3:40 PM. That nurse reported the facility is short	F 725	1. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24 hour basis to provide nursing care to all residents in accordance with resident care plan. 2. The determination of sufficient staff will be made based on the staff□s ability to provide needed care to residents that enable them to reach their highest practicable physical, mental, and psychosocial well-being. The facility has hired additional licensed nurses and nursing assistants to fill the vacant position in the current schedule. The facility will utilize agency staffing to ensure daily staffing is sufficient according to the acuity level of the residents and to ensure the needs of residents are met including for Resident #70, Resident #20, Resident #5, Resident #55, Resident #8, and Resident #56. The scheduling coordinator will be notified of night and weekend call-ins and no shows promptly. The scheduling coordinator will make necessary arrangements to ensure adequate staff are on duty. If the scheduling coordinator is unable to obtain adequate staff or if it is outside the of the scheduling coordinators normal working hours, the nurse on call or the DON will be notified promptly the facility administrator and DON will provide ongoing monitoring daily to ensure that there is adequate clinical staff on duty to provide needed care to residents that enable them to reach their highest	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 725	Continued From page 48	F 725		

staffed at times and she thinks there are times when all resident care cannot be completed because the facility is short-staffed. She reported response to call bells were sometimes longer because staffing is not ideal.
An interview was conducted with nursing assistant #10 on 4/6/2018 at 3:56 PM. The nursing assistant works the evening shift and reported most days it was difficult to get the call lights answered timely due to the unavailability of facility staff. The nursing assistant #10 recalled times the residents' call lights were not answered in time to be toileted and the residents would wet themselves.
An interview was conducted with nurse #10 on 4/3/2018 at 2:31 PM. The nurse verified she was the nurse responsible for Resident #6. The nurse reported she was employed with a staffing agency and worked at the facility often. The nurse stated she worked all shifts. The nurse reported there were times the call bells were not answered timely due because there was not enough staff to answer the lights and provide the care needed.
Review of the facility staffing sheets revealed there were numerous days on all shifts the staffing numbers documented were less than the "ideal numbers" reported by the director of nursing. The staffing schedule sheets also indicated there were less than the facility desired numbers and also there were times there were only half of what the facility considered to be ideal.
Review of the minutes from the Resident Council Meeting on 9/27/2017 revealed some old business was: "Response to call lights continue to be a problem." In the 1/25/2018 Resident Council Meeting minutes, it was noted in the "New Business" section that residents complained of call bell assistance is taking too long. During the

practical physical, mental and psychosocial wellbeing.

On 4/30/18, all licensed nurses and nursing assistants were in-serviced that that the scheduling coordinator is the first point of contact for any and all scheduling issues that arise while on shift and procedure for notifying on call nurse or DON after hours and on weekends for further scheduling issues. The scheduling coordinators contact information will be posted in designated employee areas and will include subsequent points of contact which will be available 24/7 to avoid a single point of failure. All newly hired licensed nurses and nursing assistants will be in-serviced during orientation by the Staff Facilitator that the scheduling coordinator is the first point of contact for any and all scheduling issues that arise while on shift and procedure for notifying on call nurse or DON after hours and on weekends for further scheduling issues. Copy of contact information for schedule related issues will be posted in designated areas.

The Administrator and/ or the DON will audit staffing schedule at the beginning of each shift to include nights and weekends x 4 weeks then twice weekly x 4 weeks then monthly x 1 month utilizing the Sufficient Staff Audit Tool to ensure sufficient staff to meet the needs of the residents, including Resident #70, Resident #20, Resident #6, Resident #55, Resident #8, and Resident #56, based upon the acuity level as identified by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 725	Continued From page 49 2/22/2018 Resident Council Meeting a concern was mentioned that had been discussed at an earlier meeting but residents did not feel had been resolved. This was the concern of nursing assistants taking "too long" to respond to call bells. At the 2/22/2018 Resident Council Meeting, the residents discussed a concern that they did not feel there were enough nursing assistants, they were not getting their ice water pitchers refilled "in a timely manner."	F 725	Case Mix index score assuring the residents reach their highest practicable physical, mental and psychosocial well-being. All areas of concern will be immediately addressed by the DON/Administrator to include use of administrative nurses pulled to the hall to meet resident care needs. The Administrator will initial the Sufficient Staff Tool daily to ensure the staffing patterns are appropriate to meet the needs of the resident care identified by their acuity level from the Case Mix Index Report. The Administrator will forward the results of Sufficient Staff Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Sufficient Staff Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		5/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 812	Continued From page 50 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to allow all dishes to air dry and increased the opportunity for cross-contamination in five of five breakfast meal observations. The findings include: 1. On Monday, 4/2/2018 at 6:19am observation in the facility kitchen, it was noted that the residents' breakfast meal trays had been pre-set for the breakfast meal. The breakfast meal trays were noted to have silverware, condiments, clear plastic tumblers, straws already in place. Twelve of the plastic tumblers were noted to have moisture droplets in the inside of the tumblers that had been turned upside down on the trays. The morning cook in the kitchen reported the breakfast meal trays are pre-set by the evening staff and all of the items on the trays at this time had been put in place by the evening dietary staff. 2. On Tuesday, 4/3/2018 at 6:45am it was observed there were 15 clear plastic tumblers that had moisture droplets remaining on the	F 812	The process that led to this deficiency was the facility failed to allow all dishes to air dry and increased the opportunity for cross-contamination in 5 of 5 breakfast meal observations. On 4/6/18, a 100% audit of all utensils was completed by the Dietary Manager and all utensils to include plastic tumblers that had moisture or were not completely air dried were removed from service and replaced with appropriate air dried utensils. On 4/9/18, a 100% in-service with all dietary staff was initiated by the Dietary Manager in regards to Cleaning Procedures-Warewashing to include: 1. Dishes and other reusable components of meal service, pots and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 812	Continued From page 51 inside of the tumbler that had been turned upside down on the residents' breakfast meal trays. Dietary staff in the kitchen reported the breakfast meal trays had been pre-set by the evening dietary staff in an effort to decrease the work load of the morning staff who prepared and served breakfast to the residents. 3. On Wednesday, 4/4/2018 at 7:05am it was observed that 10 of the clear plastic tumblers that had been placed on the resident trays upside down, still had moisture droplets on the inside of the tumbler. Dietary staff in the kitchen reported the tumblers were placed upside down on the meal trays by the evening dietary staff the night before. 4. On Thursday, 4/5/2018 at 7:35am, there were 12 clear plastic tumblers turned upside down on pre-set resident meal trays that had moisture droplets on the inside of the tumblers. Dietary staff reported the trays had been pre-set by the evening staff. 5. On Friday, 4/6/2018 at 7:35am revealed breakfast trays that had been pre-set and 18 clear plastic tumblers that were placed on the tray upside down that still had moisture droplets on the inside of the tumblers. Dietary staff confirmed the tumblers were placed on the trays by the evening staff in an effort to assist the morning dietary staff. In interview with the dietary manager on 4/6/2018 at 7:45am revealed the trays were pre-set by dietary staff from the night before. She reported the night shift should have used a second set of clear plastic tumblers that were available and would already be air dried. The dietary manager expressed an understanding about the need for utensils and dishware to air dry to decrease the opportunity of cross contamination.	F 812	pans, will be washed using the proper temperature, correct chemicals, and then air-dried completely. 2. China or glassware, which is chipped or has lost its glaze will be discarded. 3. Notification of Maintenance Supervisor in the event of dish machine does not maintain proper temperatures or sanitizing solution. 4. How to dispose paper, plastic and other disposable items when removed from the trays. 5. Washing, rinsing, sanitizing of pots/pans/utensils to include air dry completely. 6. Alternate methods of sanitizing. 7. Cleaning of wash machines. All newly hired dietary staff will be trained during orientation by the Dietary Manager on Cleaning Procedures-Warewashing to include: 1. Dishes and other reusable components of meal service, pots and pans, will be washed using the proper temperature, correct chemicals, and then air-dried completely. 2. China or glassware, which is chipped or has lost its glaze will be discarded 3. Notification of Maintenance Supervisor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 812	Continued From page 52	F 812	in the event of dish machine does not maintain proper temperatures or sanitizing solution. 4. How to dispose paper, plastic and other disposable items when removed from the trays. 5.Washing, rinsing, sanitizing of pots/pans/utensils to include air dry completely. 6. Alternate methods of sanitizing. 7. Cleaning of wash machines. On 4/12/18 an extra glass drying rack was ordered by the Dietary Manager to promote improved air-drying time for tumblers. 4/17/18 the Dietary Manager ordered an additional glass drying rack due to original rack being the incorrect size. 4/19/18 the new glass drying rack was received and noted to be of the appropriate size. 4/21/18 the Dietary Manager ordered an additional 6 glass drying racks to promote appropriate air-drying for all utensils to include tumblers. 4/23/18 all glass drying racks received by the facility and use of extra glass drying racks initiated by the Dietary Manager. On 4/24/18, the Cleaning Procedures-Warewashing dietary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 812	Continued From page 53	F 812	in-service was completed with 100% of all dietary staff by the Dietary Manager. The Dietary Manager will audit utensils to include tumblers during breakfast, lunch, and dinner 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 1 month utilizing the Dietary Audit Tool to ensure all utensils are appropriately cleaned, sanitized and air-dried completely per facility protocol. All areas of concern will be immediately addressed by the Dietary Manager to include immediate removal of utensils that are not appropriately cleaned, sanitized, and air-dried, and also additional staff training if indicated. The Administrator will initial the Dietary Audit Tool weekly for 8 weeks, then monthly for one month to ensure all areas of concern were addressed. The Quality Improvement (QI) Nurse will forward the results of the Dietary Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Dietary Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	**128 SNOW HILL ROAD AYDEN, NC 28513**

(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