

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/06/2019
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNT REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804		
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E 000	Initial Comments	E 000			
F 000	INITIAL COMMENTS	F 000			
F 641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) Assessment for insulin injections and Pre-Admission Screening and Resident Review (PASRR) for 2 of 26 residents whose MDS was reviewed (Resident #206 and #61). The findings included:</p> <p>1. Resident #206 was admitted to the facility on 6/22/18 and had a diagnosis of diabetes mellitus.</p> <p>Review of the Medication Administration Record (MAR) for 12/1/18 through 12/31/18 revealed an entry on the MAR for Basaglar KwikPen Solution pen-injector 100 units per milliliter. Inject 20 units subcutaneously in the evening for diabetes mellitus. Basaglar is a long acting insulin given for the treatment of elevated blood sugar for people with diabetes mellitus. The start date was</p>	F 641	<p>Resident # 206 no longer resides in the facility and resident # 61 MDS was modified on 6/5/2019 to reflect Pre-Admission Screening and Resident Review level correction.</p> <p>Root cause: MDS Nurse #1 and MDS Nurse # 2 failed to accurately code the MDS assessment during the look back period.</p> <p>A 100% audit of the residents' most current MDS Assessments was conducted by the facility MDS Nurse Manager to ensure there were no similar findings on 6/14/2019. The DON conducted education to MDS staff regarding coding accuracy on the MDS assessment to include accurate coding of</p>	6/28/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/14/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	<p>Continued From page 1</p> <p>12/12/18 at 6:00 PM. The MAR revealed a check mark and initials to indicate the insulin was given every evening at the scheduled time from 12/12/18 through the end of the month.</p> <p>Review of the MDS with the assessment reference date (ARD) of 12/19/18 revealed Section N0300 Injections read: "Number of days that injections of any type were received during the last 7 days." The number 0 was entered as the answer. Section N0350 A. Insulin injections read: "Record the number of days that insulin injections were received during the last 7 days." The question was not answered on the MDS.</p> <p>On 6/6/19 at 8:42 AM an interview was conducted with MDS Nurse #1 who was observed to review the MDS and the MAR for Resident #206. The MDS Nurse stated the MDS should be coded as injections and insulin given 7 days.</p> <p>On 6/6/19 at 11:58 AM an interview was conducted with the Director of Nursing, the Administrator and MDS Nurse #2 who completed the MDS for Resident #206 with the ARD 12/19/18. MDS Nurse #2 was unable to explain why the MDS was not coded accurately for injections or insulin. The Administrator stated she expected the MDS to be accurate.</p> <p>2. Resident #61 was admitted to the facility on 1/16/2016 with diagnoses to include schizoaffective disorder, bipolar type.</p> <p>Resident #61's Pre-Admission Screening and Resident Review (PASARR) dated 4/26/2016 revealed a Level II PASARR.</p> <p>A review of Resident #61's annual Minimum Data (MDS) assessment dated 10/1/2018 revealed in</p>	F 641	<p>injections and PASRR's on the MDS.</p> <p>10% of current residents completed MDS assessments will be reviewed by the RN, Staff Development Coordinator and/or the Director of Nursing to ensure accurate coding of the MDS assessments to include injections and proper PASRR coding. This audit will be conducted utilizing a Resident MDS Accuracy QI Tool weekly for 8 weeks, then monthly for 4 weeks. Any identified areas of concern will be immediately addressed by the DON to include additional training and modifications to the MDS assessment as indicated. The DON will review and initial the MDS Accuracy QI Tool weekly for eight weeks and then monthly for 4 weeks for accuracy and to ensure all areas of concerns have been addressed.</p> <p>The DON will forward the results of the MDS Accuracy QI Tool audit to the facility's monthly QAPI committee meeting for 3 months. The QAPI Committee will meet monthly for 3 months to review the results of the MDS Accuracy QI Tool audit. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include frequency of monitoring.</p>		

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F 641	Continued From page 2 Section A1500 a "No" answer to the question which read: has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and /or mental retardation or a related condition. Section I6000 of the MDS assessment included schizophrenia as a diagnosis. On 6/5/2019 at 11:39 AM, an interview was conducted with the MDS nurse who stated she knew Resident #61 had a Level II PASARR determination. The MDS nurse stated Resident #61's annual assessment was wrong and should have been coded as a Level II. On 6/5/2019 at 3:30 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected the MDS to be coded accurately.	F 641			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral	F 693		6/28/19	

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F 693	<p>Continued From page 3</p> <p>means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interviews the facility failed to check placement of a gastrostomy tube prior to administering nutrition for 1 of 3 residents (Resident #30) reviewed for gastrostomy tubes.</p> <p>The findings included:</p> <p>A review of the facility policy titled "Verifying Gastrostomy Tube Placement" and revised on 8/23/2016, included under the category of Auscultation: position stethoscope against abdomen, inject 20 cubic centimeters (CC) of air into the tube, listen for sounds such as "whooshing" to verify tube placement.</p> <p>Resident #30 was admitted to the facility on 6/23/2018 with diagnoses to include stroke, percutaneous endoscopic gastrostomy (feeding) tube and hemiplegia.</p> <p>Resident #30's quarterly Minimum Data Set (MDS) assessment date 4/1/2019 revealed his cognition was moderately impaired for decision making with short and long-term memory loss. He received more than 51% of nutrition and fluids via a feeding tube and had no weight loss.</p> <p>A review of Resident #30's Physician orders for June 2019 included: 1. Osmolite (a balanced liquid nutrition) 1.5 calorie bolus of 240 milliliters</p>	F 693	<p>Nurse #2 was immediately in-serviced on 6/5/2019 re: appropriately checking for placement prior to administering nutrition and/or medications via gastrostomy tube. Resident #30's gastrostomy tube was checked for placement by the Director of Nursing on 6/5/2019 with no concerns.</p> <p>Root Cause: Nurse failed to properly follow policy and procedure re: checking for gastrostomy tube placement prior to administering nutrition.</p> <p>100 % of residents with gastrostomy tubes were assessed and the tubes were checked for placement by the Director of Nursing on 6/5/2019 with no concerns identified.</p> <p>The RN Staff Development Coordinator and/ or Director of Nursing will inservice 100% Licensed Nurses to include Nurse # 2 re: appropriately checking for gastrostomy tube placement prior to administering nutrition and/or medications by 6/24/2019.</p> <p>A Gastrostomy Tube QI Audit Tool will be utilized by the RN SDC, Unit Managers and Treatment Nurse with observation of 10% of Licensed Nurses include Nurse # 2, to ensure proper placement of</p>		

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F 693	<p>Continued From page 4</p> <p>(ML) per feeding tube every 4 hours; 2. Free water flush 150 ML every 4 hours; 3. Flush feeding tube with 10 ML of water at the beginning and ending of feedings after residual check and before and after medications every shift.</p> <p>An observation was conducted on 6/5/2019 at 2:24 PM with Nurse #2 as she conducted a bolus nutrition administration via the feeding tube for Resident #30. The nurse inserted a large syringe into Resident #30's feeding tube and left the plunger on the bedside table. The nurse placed her stethoscope on the resident's abdomen near the feeding tube site and listened while holding the syringe in the tube. The nurse did not inject air while listening. The nurse then removed the syringe, inserted the plunger, checked the residual, flushed the tube, administered the nutrition and water flush, and cleaned up and exited the room.</p> <p>Immediately following the observation on 6/5/2019 at 2:41 PM, an interview was conducted with Nurse #2. The nurse stated she checked placement of the feeding tube prior to administering nutrition by placing the stethoscope on the resident's abdomen and listening to the whoosh of air going in. The nurse stated she did not inject air into the tube because the air was free flowing in thru the syringe and that was what she listened to.</p> <p>On 6/5/2019 at 3:24 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected nurses to check for placement of the feeding tube prior to administering nutrition by placing the stethoscope on the resident's abdomen and pushing air in and listening to see if they could hear the air being</p>	F 693	<p>Gastrostomy placement prior to administering nutrition and/or medications. The audit will include 3 shifts weekly for 8 weeks, then monthly for 1 month. Immediate retraining will be conducted with the Licensed Nurse for any issues observed during the Gastrostomy tube QI audits by the DON/RN SDC. The DON will review and initial the Gastrostomy Tube QI Audit Tool for completion and appropriate Gastrostomy Tube placement checks for residents with Gastrostomy tubes to include resident # 2 and to ensure areas of concern were addressed for 3 shifts weekly for 8 weeks, and then monthly for 1 month.</p> <p>The DON will forward the results of the Gastrostomy Tube QI Audit Tool audit to the facility's monthly QAPI committee meeting for 3 months. The QAPI Committee will meet monthly for 3 months to review the results of the Gastrostomy Tube QI Tool audit. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include frequency of monitoring.</p>		

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F 693	Continued From page 5 pushed into the stomach.	F 693			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to lock medications in the medicine cart before leaving the medicine cart unattended for 1 of 2 medication carts observed on the 400 hall. The findings included:	F 761	Nurse #1 was immediately inserviced by the Director of Nursing on 6/5/2019 re: ensuring that medications are appropriately secured in the cart before leaving any medicine unattended. Root Cause: Nurse failed to follow proper	6/28/19	

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F 761	<p>Continued From page 6</p> <p>On 6/5/2019 at 7:46 AM, an observation of the 4 upper west medication cart was conducted while the cart remained parked and unattended in the 400 hall. A medication cup containing multiple pills was on top of the unattended medication cart, as well as a medication cup with blue liquid, and a medication bottle containing drops.</p> <p>Nurse #3 walked to the medication cart and stated the cart was not hers, but she would look for the nurse. Shortly after the Director of Nursing (DON) walked to the cart and stated she would stay with the cart until the nurse was found. At 7:48 AM on 6/5/2019, nurse #1 came out of a room next to the cart.</p> <p>Nurse #1 was interviewed immediately upon her return to the medication cart. The nurse stated she was preparing medications for a resident when a red call bell rang, and she left her cart to answer it. Nurse #1 stated she did not realize she left medications on the cart unattended. The nurse counted and stated there were 11 medications in the cup, the blue liquid was a mouthwash, and the drops were eye drops.</p> <p>On 6/5/2019 at 9:19 AM, an interview was conducted with the Director of Nursing (DON) who stated she expected the nurse to lock her medications in her cart if she had to leave the cart.</p> <p>On 6/6/2019 at 8:24 AM, an interview was conducted with the Administrator who stated she expected staff to lock medications in the cart before leaving the cart unattended.</p>	F 761	<p>protocol re: ensuring medications were locked up securely in the medication cart while leaving the medication cart unattended.</p> <p>100% audit of medication carts was completed on 6/7/2019 to ensure no medications were left unattended on the medication cart by the Director of Nursing. No issues were identified during the audit. 100% Licensed nurses to include Nurse #1 to be inserviced by the RN, Staff Development Coordinator re: ensuring that medications are locked or appropriately secured in the medication cart prior to leaving medication cart unattended by 6/24/2019.</p> <p>The RN, SDC, Unit Managers, Treatment Nurse and weekend Supervisor will audit medication carts to ensure medication is appropriately secured and not left unattended utilizing a Medication Storage QI Audit Tool weekly for 8 weeks, then monthly for 1 month. The licensed nurses will be reeducated by the RN, SDC, Unit Managers, Treatment Nurse and Weekend Supervisor for any areas of concern during the audit. The Director of Nursing will review and initial the Medication Storage QI Audit Tool weekly for 8 weeks, then monthly for 1 month for completion and to ensure all areas of concern were addressed.</p> <p>The DON will forward the results of the Medication Storage Audit Tool audit to the facility's monthly QAPI committee meeting for 3 months. The QAPI Committee will</p>		

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

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F 761	Continued From page 7	F 761	meet monthly for 3 months to review the results of the Medication Storage QI Tool audit. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include frequency of monitoring.		