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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE NURSING & REHAB	**300 NORTH MAIN STREET RICH SQUARE, NC 27869**

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/20/2023 through 02/23/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #HW7J11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 02/20/2023 through 02/23/2023. Event ID# HW7J11. The following intakes were investigated NC00198146 and NC00198149. 11 of the 11 complaint allegations did not result in deficiency.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		3/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/15/2023

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 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean and sanitary homelike environment by failing to clean tube feeding poles, and floor near tube feed poles for 2 of 2 residents reviewed for receiving tube feedings. (Resident #42, and #5). The findings included: On 2/22/23 at 9:30 AM an observation of room 201 Bed B revealed the tube feeding pole legs had 5-6 dime size drops of a dried tan substance. On 2/23/23 at 9:39 AM an observation of room 201 Bed B revealed the tube feeding pole legs had 5-6 dime size drops of a dried tan substance and the floor surrounding the pole had multiple	F 584	F584-Safe/Clean/Comfortable/Homelike Environment: 1 The following corrective actions have been accomplished for the identified deficiency: The feeding pump poles for resident□s in room 201a and 201B were immediately cleaned by housekeeping staff on 02/23/2023 2. All residents with tube feeding has the potential to be affected by the deficient practice:	

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F 584	Continued From page 2 drops of a dried tan substance. On 2/22/23 at 10:23 AM an observation of room 201 Bed A revealed the tube feeding pole legs had 2 fifty cent size drops of dried tan substance. The tube feeding pole had a dried tan substance down the pole and was sticky to touch. On 2/23/23 at 9:41 AM an observation of room 201 Bed A revealed the tube feeding pole legs had 2 fifty cent size drops of a dried tan substance. The tube feeding pole had a dried tan substance down the pole and was sticky to touch. An interview on 2/23/23 at 10:00 AM the Director of Nursing indicated the tube feeding poles and floor should be cleaned daily and she would have the areas cleaned right away. An interview on 2/23/23 at 10:05 AM housekeeping staff #1 revealed he cleaned resident rooms daily and frequently checked the tube feeding poles.	F 584	The housekeeping supervisor and Administrator did a walk thru to identify all residents with tube feeding poles to ensure cleanliness of each tube feeding pole on 02/23/2023. 3. The following measures have been put into place to prevent the deficient practice: Licensed Nurses were in-serviced on cleaning tube feeding poles when leaks are noted on 3/10/2023. Housekeeping staff were in-serviced in regards to the cleaning of the tube feeding poles on 03/10/2023. Housekeeping Daily Cleaning schedule for tube feeding poles were initiated to ensure that all residents remain in clean/comfortable/homelike/environment on 3/13/23. Housekeeping Director or designee will conduct a weekly audit that will include checking all resident rooms with tube feeding poles for cleanliness. Monitoring will continue 5 days a week for 4 weeks then 3 days a week for 4 weeks and weekly for 4 weeks. The findings will be reported to the Quality Assurance Performance Improvement Committee on a monthly basis X3 months.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		3/17/23

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F 688	Continued From page 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, record review, Rehabilitation Director, and staff interviews, the facility failed to place hand splint to left hand for contracture management for 1 of 2 residents observed for range of motion (Resident #10). Findings included: Resident #10 was admitted to the facility on 11/22/13 with diagnoses which included stroke and left-hand contracture. Review of the Occupational Therapy Discharge Summary dated 9/14/22 revealed a restorative program was established for splint and brace program for Resident #10. The Restorative Nursing Transfer Form dated 9/12/22 revealed Resident #10's treatment plan	F 688	F688- Increase/Prevent Decrease in ROM/Mobility (D) 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #10 reassessed by therapy department for splinting needs on 03/14/2023 Resident #10 Care plan updated on 03/15/2023 to reflect splinting schedule. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	

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F 688	Continued From page 4 included splinting with resting hand splint 5-6 times a week for 6 hours daily for contracture management. A nursing progress note dated 10/26/22 revealed Resident #10 was transferred to the hospital for cough and congestion. Resident #10 was admitted to the hospital and returned to the facility on 10/31/22. A physician order dated 11/01/22 for splint left hand, every day shift for preventive, protective covering. Monitor for redness/irritation before applying to left hand and every evening shift monitor for redness/irritation left hand upon removal of splint. Resident #10's care plan last reviewed November 2022, revealed a restorative care plan for splint/brace related to contracture to left hand with interventions which included to apply resting splint to left hand after morning care, wear for up to 6 hours per day, remove by end of first shift, and to check hand and splint area for any redness or irritation before applying and after removing splint. The Quarterly Minimum Data Set (MDS) Assessment dated 11/26/22 revealed Resident #10 had severe cognitive impairment and had upper and lower extremity impairment. Resident #10 was not coded for rejection of care. Resident #10's Point of Care Resident Detail report (no date) revealed a resting splint for left hand was to be applied after morning care and wear up to 6 hours per day. The Point of Care Resident Detail report was a guide to the Nursing Assistant's for the care required by the resident.	F 688	actions will be taken: All residents who wear splints have the potential to be affected by this same practice. A complete audit of all residents with active splints to ensure that each care plan, physician order, and splints were completed on 03/14/2023. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Restorative Nurse and Licensed therapist education was initiated on process of implementing splints per therapy and MD orders by the Director of Nursing (DON) on 3/10/23. Licensed Nurses were educated on Splint schedules by Director of Nursing(DON)on 3/10/23. Restorative aide education initiated on Implementation process of splints and splinting schedules by the Director of Nursing on 3/10/23. Therapy Director or designee will provide new hire restorative nursing staff training on splinting and ROM. 4. How the corrective actions will be	

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F 688

Continued From page 5

There was no place on this report that required the NA to document application of the resting splint for Resident #10's left hand.

A review of the Medication Administration Record from 11/01/22 through 2/20/23 revealed nursing staff documented the skin was monitored for redness/irritation before and after the splint was used.

An observation on 2/20/23 at 2:14 pm revealed Resident #10 did not have a splint on her left hand. Two blue hand splints were observed on the bedside table.

An observation on 2/21/23 at 9:23 am, 12:27 pm, and 3:17 pm revealed Resident #10 did not have a splint on her left hand. Two blue hand splints were observed on the bedside table.

An observation on 2/22/23 at 12:36 pm revealed Resident #10 did not have a splint on her left hand.

During an interview on 2/22/23 at 12:45 pm Nurse #1 revealed she was required to assess her hand for redness and/or irritation before and after the splint was used, but the Restorative Nurse Aide was responsible to apply the hand splint to Resident #10's left hand.

An interview on 2/22/23 at 1:58 pm the Restorative Nurse Aide revealed she no longer placed the hand splint on Resident #10 because she did not know she was still on the restorative therapy splint list. She stated when a resident was placed on restorative therapy, she received paperwork with directions for what type of care was ordered and the time frame of the care that

F 688

monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Director of Nursing or designee will audit all residents with active splint orders for use of splints 3 times a week for 4 weeks 2 times a week for 4 weeks and 1 time a week for 4 weeks.

QAPI committee will review the Splint/ROM audit to ensure that compliance is met monthly x3 months

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F 688	Continued From page 6 she would document the care provided. The Restorative Nurse Aide stated the splinting required documentation of its application and there was no such documentation required for Resident #10, so she did not put the splint on. During an interview on 2/22/23 at 2:27 pm the MDS Nurse revealed the physician order for splinting to Resident #10's left hand was in place when she returned from the hospital on 10/31/22, so she continued the restorative care plan for left hand splint. She stated the information for the hand splinting was on the Point of Care Resident Detail report and the plan of care for Resident #10 and the Restorative Nurse Aide was able to access the information. During an interview on 2/23/23 at 10:47 am the Director of Nursing (DON) revealed Resident #10's left hand splint order may have been renewed automatically when she returned from the hospital, but she was not sure if Resident #10 was still on restorative therapy for the left hand splint. The DON was unable to state why Resident #10 would not have continued with restorative therapy for contracture management of the left hand when she returned to the facility. An interview was conducted on 2/23/23 at 12:12 pm with the Rehabilitation Director who revealed Resident #10 was ordered restorative therapy for left hand splinting, but she was unable to state if she was still on the restorative program since her return from the hospital. The Rehabilitation Director was unable to state if therapy was required to reassess Resident #10 upon her return from the hospital to continue the splinting program or if it would just continue as part of the management of her contracture.	F 688		

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F 688	Continued From page 7 During an interview on 2/23/23 at 12:29 pm the Administrator revealed nursing management was responsible to ensure the order for left hand splinting for Resident #10 was confirmed and implemented as ordered. The Administrator was unable to state why the splinting for Resident #10 was not completed as ordered.	F 688		