STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOWAN RIVER NURSING AND REHABILITATION CENTER	1341 PARADISE RD P O BOX 666 EDENTON, NC 27932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to document offered vision services, and failed to document the legal representative decline for vision services to be completed for 1 of 1 resident with visual impairment (Resident #2). Findings included: Resident #2 was admitted into the facility on 11/29/10. Diagnoses included Macular Degeneration of the Retina, Cataract, and Glaucoma. The quarterly minimum data set completed on 11/22/12 indicated Resident #2 decision making skills was moderately impaired. There was no rejection of care, and vision was indicated as moderately impaired. A review of the care plan dated 12/13/12 identified as a focus problem "Inability to focus on objects, discriminate color; adjust to changes in light and dark characterized by pain, decreased/impaired vision related to: macular	F 313	**Response Preface** Chowan River Nursing & Rehabilitation Center 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. The Plan of Correction is submitted as a written allegation of compliance. Chowan River'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, Chowan River reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deanna C Hall	Administrator	1-14-13

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

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F 313	Continued From page 1 degeneration and cataracts." A vision consult as per ordered and as necessary was indicated as an intervention. A review of the most recent eye consultation report signed 10/31/08 indicated as a recommendation Resident #1 was to have a complete eye exam in 6 months. Glaucoma was listed as a finding. A review of the nurses notes for 2012: January, February, March, April, May, June, July, August, September, October, November, and December revealed no documented refusal that Resident #2 refused to be seen, or that the legal representative declined for Resident #2 not to be evaluated by the eye doctor. A review of the physician progress notes dated 2/6/12, 4/17/12, 6/26/12, 8/21/12, 10/6/12, and 12/8/12 revealed no documentation that supported Resident #2 or the legal representative refused eye services to be rendered. A review of the medication administration record for January 2013 revealed eye medications ordered included: · Lumigan solution 0.03% one drop each eye daily for macular degeneration · Genteal gel 0.3% to each eye at bedtime for macular degeneration On 1/23/13 at 12:00 noon Resident #2 was observed with no visual eyewear. Upon questioning, Resident #2 would not respond verbally.	F 313	Social Worker made an appointment for Resident #2 with a local eye doctor for 2-14-13. Responsible party and resident notified of appointment. 100% audit was done on all residents in the building regarding eye exams by our QI nurse using form #1 on 1-31-2013. Any resident found without a confirmed visit to the eye doctor in the past year will be set up with the on-sight eye clinic on their next visit. Administratuve QI nurse will communicate those that need exams to the scheduler for inclusion with on-sight next visit. During the admission process the admission coordinator will interview the resident/RP family member concerning eye care, previous and future visits and document on a QI tool (Form #2) This tool will be forwarded to the QI nurse for follow up. This process was implemented in the facility on 2-1-13.	2-1-13 1-31-13 2-4-13

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
	345164	A. BUILDING _____ B. WING _____	01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 313	Continued From page 2 In a telephone interview on 1/24/13 at 8:15 am, onsite services eye representative #1 stated Resident #2 had not been seen by the eye doctor due to on admission it was indicated that Resident #2 did not want to be seen. The representative added there was no documentation that supported who indicated that Resident #2 was not to be seen, nor the time, or the date of the notation. The representative concluded she was not able to print the document she was reading from; to be faxed over for review, but would continue to search for other documentation that supported why Resident #2 had not been seen recently by the eye doctor. In an interview on 1/24/13 at 8:18 am, the Director of Nursing (DON) stated residents were usually evaluated onsite twice a year by the eye doctor, unless the resident or the legal representative declined services. The DON concluded she was not sure why Resident #2 records did not specifically reflect why Resident #2 had not been seen by the eye doctor. In an interview on 1/24/13 at 10:22 am, the social worker revealed she was not aware that Resident #2's legal representative declined for the resident to be seen by the eye doctor, or that Resident #2 refused to be evaluated. In an interview on 1/24/13 at 10:29 am, the assistant director of nursing indicated if Resident #2 or the legal representative refused for services to be provided by the eye doctor, her expectation was that the medical record documentation reflected such. There was no additional documentation provided	F 313	Monitoring will be completed by the administrative nursing staff and any concerns will be corrected at that time utilizing the QI [illegible] tool. These checks will be done weekly x4 weeks for all new residents then monthly thereafter. The administrative staff will follow up as indicated for any potential concern. The results of the audits will be reviewed by the Executive QI committee quarterly for any potential trends and for follow up as deemed appropriate and to determine the need for frequency of continued QI monitoring.	2-4-13 2-4-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/24/2013

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F 313	Continued From page 3 from onsite eye service representative #1 that supported why Resident #2 had not been evaluated by the eye doctor, during the completion of the annual recertification survey on 1/24/12.	F 313		

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FORM APPROVED
OMB NO. 0938-0391

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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
	345164	A. BUILDING 01 - MAIN BUILDING 01 MAR 11 2013 B. WING	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOWAN RIVER NURSING AND REHABILITATION CENTER	1341 PARADISE RD P O BOX 586 EDENTON, NC 27932

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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 02/14/2013 there are unprotected ceiling fans and recessed lights fixtures in the ceiling that are not protected. Facility has a rated ceiling. 42 CFR 483.70 (a)	K 012	Recessed lights will be covered with sheetrock boxes that are fire retardant. Wires for the c ceiling fans will be placed in conduit Maintenance will check all lights and ceiling fans to ensure they are in fire retardant boxes and the ceiling fan wires in conduit. Maintenance will take all non-compliant issues to the fire and safey meeting.	3-30-13 3-30-13 3-30-13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 02/15/2013 the door to the soiled linen room was blocked in the open position and could be closed. B. The door to the clean linen side of the laundry failed to close and latch. Clean and soiled areas are not separated	K 029	Maintenance removed milk crate from the soiled linen room and in-serviced laundry staff on not propping open the soiled li linen door for residents safety and infection control. Automatic closures were placed on the Laundry room door between the dirty and clean linen room so that it will automatically close and latch. In-service held for all staff about not propping doors open because of resident safety. Informed staff that Maintenance and administrative staff will monitor doors for compliance	2-4-13 2-22-13 3-30-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2-28-13

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cD

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	345164	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/14/2013

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K 029	Continued From page 1 42 CFR 483.70 (a)	K 029	Maintenance will take all non-compliant issues to the Fire and Safety Meeting	3-30-13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation 02/14/2013 thetampper alarm on the PIV near the main. office falled to give a signal. 42 CFR 483.70 (a)	K 062	The non working tamper alarm on the PIV near the main was re-placed with new one on 2-22-13 Sunland also checkd the other tamper alarm on the PIV and found it to be working correctly Maintenance will take all non-compliant issues to the Fire and Safety Meeting	2-22-13 2-22-13 3-30-13
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: A. Based on observation on 02/14/2013 the bi-annual inspection on the range hood had not been done in over a year. 42 CFR 483.70 (a)	K 069	A new Ansul System for the Dietary will be installed to ensure that it's up to code. Maintenance will monitor the system after it is in place to ensure inspections are done on a timely basis Maintenance will take all non-compliant issues to the fire and safety meeting.	3-30-13 3-30-13 3-30-13

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	345164	A. BUILDING 02 - BUILDING 02 B. WING _____	02/14/2013

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K 000	INITIAL COMMENTS A. Based on observation on 02/14/2013 there were no LSC deficiencies noted.	K 000		

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

Administrator 2-28-13

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