

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

JAN 03 2014


PRINTED: 12/20/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  346336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/12/2013
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NAME OF PROVIDER OR SUPPLIER  ROANOKE RAPIDS HEALTHCARE AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870
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(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)	(X6) COMPLETION DATE
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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to update the care plan to reflect the application of a splint for contracture management for 1 of 3 sampled residents (Resident #7) reviewed for range of motion concerns. Findings included:  Resident # 7 was admitted to the facility on 01/23/13. The resident's documented diagnoses included contracture of hand joint, cerebrovascular accident (CVA) with hemiplegia, and nuclear sclerosis.</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F 280</p> <ol style="list-style-type: none"> <li>1. Resident #7 care plan was updated by ADON to reflect the application of the splint for contracture management on 12/12/13.</li> <li>2. Resident's with the potential to be affected were identified and the medical records were reviewed based on therapy Restorative Nursing referrals and Functional Maintenance Program to verify that care plans included splint applications to prevent further decrease in range of motion. Care plans were updated as needed. This was completed on 12/12/13.</li> <li>3. ADON &amp; Rehab Manager was in-serviced by the DON on care plans to include splint application to prevent further decrease in range of motion on 12/12/13. Nursing &amp; rehab staff in-serviced on contracture management/Restorative Nursing, and process of referrals from 12/12/13-12/27/13.</li> </ol>	12/27/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Nursing Home Administrator (X6) DATE 12/30/13

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 280	<p>Continued From page 1</p> <p>On 01/23/13 "Resident has impaired functional mobility/Resident has contractures" was identified as a problem on Resident #7's care plan. The care plan documented the resident's impairment was due to CVA with left hemiplegia, and evidenced by actual contracture of his left upper and lower extremities. Interventions for this problem included the provision of passive range of motion (PROM) during activities of daily living (ADLs), reporting and documenting any declines in ability, and referral to therapy as necessary.</p> <p>A 08/27/13 Quarterly Minimum Data Set (MDS) documented Resident #7's cognition was severely impaired, and he had bilateral impairment of his range of motion in upper and lower extremities.</p> <p>A 10/17/13 physician order documented, "OT (occupational therapy) clarification: RNS / (restorative nursing services)/nursing staff to don/doff LUE (left upper extremity) resting hand splint daily after morning care routine to be worn 10 hrs (hours) and removed by second shift staff. Skin to be monitored/checked before applying and after removal for any signs of redness, swelling, or discoloration. Perform PROM to LUE hand/digits prior to applying splint."</p> <p>A 11/25/13 Annual MDS documented Resident #7's cognition was severely impaired, and he had bilateral impairment of his range of motion in upper and lower extremities. This assessment also documented Resident #7 was not involved in any restorative nursing program for splint or brace devices.</p> <p>On 12/11/13 review of Resident #7's most recent care plan in his medical record revealed there</p>	F 280	<p>Continued From Page 1</p> <p>4. The ADON will audit Restorative and Functional Maintenance referrals weekly for 12 weeks to validate that care plans are updated as needed. The DON will report to the Quality Assurance Performance Improvement Committee any findings, identified trends or patterns. Any negative findings will be corrected at the time of discovery in accordance to the standard.</p>	
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F 280	<p>Continued From page 2</p> <p>were no updates related to his problem with impaired functional mobility and contractures. No new interventions had been added since the problem was identified on 01/23/13. The preprinted block documenting "Apply devices to affected joints as ordered, observe for redness/irritation" remained unchecked.</p> <p>At 4:23 PM on 12/11/13 the assistant director of nursing (ADON) stated paperwork for Resident #7's transition between OT discharge and splint application by direct care staff was handled by a traveling occupational therapist who accidentally initiated a functional maintenance program rather than a restorative referral. Therefore, she explained Resident #7 was never incorporated into restorative nursing for splint application/removal and PROM.</p> <p>At 9:37 AM on 12/12/13 Nurse #3 and Nurse #4, the facility's MDS nurses, stated care plans were updated at least quarterly, often the updates being made as soon as there was a change in the resident's condition or care. They reported the ADON updated care plans for contractures and range of motion (ROM) when residents were admitted to restorative nursing for services such as splinting and ROM. However, they explained since Resident #7 was accidentally transitioned into a functional maintenance program rather than restorative nursing, the resident's care plan never got updated to reflect the application of a left resting hand/wrist splint.</p> <p>At 11:45 AM on 12/12/13 the director of nursing (DON) stated a resident care plan should be updated when a contracture began to be treated by use of a splinting device.</p>	F 280		
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F 318 F 318 SS=D	Continued From page 3 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review the facility failed to apply a splinting device ordered by the physician for 1 of 3 residents (Resident #7) reviewed for range of motion and contracture concerns. Findings included:  Resident # 7 was admitted to the facility on 01/23/13. The resident's documented diagnoses included contracture of hand joint, cerebrovascular accident (CVA) with hemiplegia, and nuclear sclerosis.  On 01/23/13 "Resident has impaired functional mobility/Resident has contractures" was identified as a problem on Resident #7's care plan. The care plan documented the resident's impairment was due to CVA with left hemiplegia, and evidenced by actual contracture of his left upper and lower extremities.  A 08/27/13 Quarterly Minimum Data Set (MDS) documented Resident #7's cognition was severely impaired, and he had bilateral impairment of his range of motion in upper and	F 318 F 318	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  F 318  1. Resident #7 was screened by Occupational Therapy (OT) and placed on Restorative Nursing Program for splinting and ROM on 12/12/13.  2. An audit was conducted and completed on 12/12/13 of residents on Restorative and Functional Maintenance Programs by the Rehab Manager and the ADON to verify splint application as appropriate per resident.  3. Nursing and rehab staff in-serviced on contracture management and process for restorative referrals by DON, Rehab Manager, and ADON from 12/12/13-12/27/13.	12/27/13

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F 318	<p>Continued From page 4 lower extremities.</p> <p>A 10/17/13 physician order documented, "OT (occupational therapy) clarification: RNS (restorative nursing services)/nursing staff to donn/doff LUE (left upper extremity) resting hand splint daily after morning care routine to be worn 10 hrs (hours) and removed by second shift staff. Skin to be monitored/checked before applying and after removal for any signs of redness, swelling, or discoloration. Perform PROM (passive range of motion) to LUE hand/digits prior to applying splint."</p> <p>A 11/25/13 Annual MDS documented Resident #7's cognition was severely impaired, and he had bilateral impairment of his range of motion in upper and lower extremities. This assessment also documented Resident #7 was not involved in any restorative nursing program for splint or brace devices.</p> <p>On 12/09/13 at 11:17 AM Nurse #1 stated Resident #7's left hand was contracted, but he did not wear a splint.</p> <p>On 12/09/13 at 11:46 AM Resident #7 was resting in bed, but no resting splint had been applied to his left hand.</p> <p>On 12/10/13 at 10:35 AM and 4:40 PM Resident #7 was resting in bed, but no resting splint had been applied to his left hand.</p> <p>On 12/11/13 at 11:15 AM Resident #7 was resting in bed, but no resting splint had been applied to his left hand.</p> <p>At 4:05 PM on 12/11/13 nursing assistant (NA) #1</p>	F 318	<p>Continued From Page 4</p> <p>4. Referrals for Restorative Nursing &amp; Functional Maintenance Programs will be reviewed by the rehab manager and ADON for appropriate interventions and program weekly for 12 weeks. DON/designee will conduct audits weekly of splint application for 12 weeks. The DON will report to the Quality Assurance Performance Improvement Committee any findings, identified trends or patterns. Any negative findings will be corrected at the time of discovery in accordance to the standard.</p>	

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F 318	<p>Continued From page 5</p> <p>pulled back Resident #7's covers, and there was no resting splint on his left hand. This NA stated she was not aware that the resident was supposed to be wearing a splint, and she was never trained about how and when to apply a splint to his left hand. She reported Resident #7 could open his right hand completely, but the resident could only partially open his left hand. Upon observation the resident had the thumb of his left hand inside his clenched palm/hand. The resident was unable to completely open his left hand, but the hand was clean and without dead skin or odor. NA #1 commented she had to take extra time to wash Resident #7's hand so that odor would not develop since he kept it clenched all the time. This NA checked the resident's room, but was unable to find a splint.</p> <p>At 4:12 PM on 12/11/13 the therapy manager/occupational therapist stated Resident #7 was on OT caseload from 09/25/13 through 10/17/13. She explained OT was working with the resident on orthotics/fitting of a splinting device/contracture management. Upon discharge from OT, the therapy manager reported the resident was supposed to be referred to restorative nursing for application and removal of a left resting hand/wrist splint to reduce the resident's abnormal tone. She commented the restorative aides were also supposed to provide PROM in conjunction with the splinting. According to the therapy manager, training was conducted with the restorative aides and caregiver on how to apply and remove Resident #7's splint.</p> <p>At 4:23 PM on 12/11/13 the assistant director of nursing (ADON) stated paperwork for Resident #7's transition between OT discharge and splint</p>	F 318		
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F 318	<p>Continued From page 6</p> <p>application by direct care staff was handled by a traveling occupational therapist who accidentally initiated a functional maintenance program rather than a restorative referral. She reported a therapist searched Resident #7's room, and was unable to find a splint. However, she commented this therapist found a splint in laundry, and applied to Resident #7's left hand. According to the ADON, her expectation would be for the splint to be applied after the resident's morning bath and to be removed after 10 hours or before going to bed in the evening.</p> <p>At 5:03 PM on 12/11/13 Resident #7 was observed with his left resting hand/wrist splint in place. The resident stated the device was comfortable, and he did not have any concerns about wearing it.</p> <p>At 5:07 PM on 12/11/13 Nurse #2, who cared for Resident #7 on second shift, stated he could not open or use his left hand due to a stroke. However, she reported his right hand was functional and without contracture. She commented she had never seen a splint placed on the resident's left hand.</p> <p>At 9:06 AM on 12/12/13 Resident #7 was resting in bed. His left resting hand splint was not in place, but it was in his dresser drawer. The resident's name was not on the splint although there was a tag on which his name could be written.</p> <p>At 9:12 AM on 12/12/13 NA #2, who cared for Resident #7 on first shift, stated Resident #7 was unable to completely open his left hand, and she had to take extra care with a cloth and soap to keep the resident's hand clean and without odor.</p>	F 318		
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F 318	<p>Continued From page 7</p> <p>She reported the first time she saw a splint in the resident's room was this morning, and she had never seen the resident before with a splint on his left hand.</p> <p>At 9:25 AM on 12/12/13 the therapy manager/occupational therapist stated the traveling occupational therapist was in so many buildings where they each had their own way of doing things that she did not realize that she was supposed to transition Resident #7 into splinting by direct care staff by initiating a restorative nursing referral. According to the therapy manager, restorative aides were supposed to apply and remove all splints, and they were responsible for taking dirty splints to the laundry in the morning and picking them up later the same afternoon. She reported running all splinting through the restorative department allowed the restorative aides to provide thorough PROM before splint application. However, she explained because the traveling occupational therapist instead transitioned Resident #7 into a functional maintenance program none of this splinting procedure occurred.</p> <p>At 10:53 AM on 12/12/13 the director of nursing (DON) stated because Resident #7's left hand was contracted without splint application there was a chance the resident's hand hygiene could have declined, leading to possible skin breakdown, and his contracture could have worsened.</p>	F 318		
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NAME OF PROVIDER OR SUPPLIER  ROANOKE RAPIDS HEALTHCARE AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	
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K 000	INITIAL COMMENTS  This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V protected construction,Onestory, with a complete automatic sprinkler system.	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	JAN 24 2014
K 029 SS=D	The deficiencies determined during the survey are as follows: 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	K 029	K 029  1. The doors to the soiled and the clean linen sides of the laundry room have had the closures on them adjusted so that they are now closing and latching completely while both dryers and all equipment is in operation. Those adjustments were completed on 1-10-14.  2. The Plant Operations Manager will continue to monitor those doors once daily for one week, then once per week for two months and then monthly. Those monitoring checks will be logged and kept in the preventative maintenance log book.	1/24/14
K 056 SS=D	This STANDARD is not met as evidenced by: A. based on observation on 01/09/2014 the door to the soiled and the clean linen of the laundry failed to close and latch.. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to	K 056	3. The Plant Operations Manager will report to the Quality Assurance Performance Improvement Committee monthly and review the preventative maintenance log regarding closure of those doors. Any further issues with the doors will be corrected at the time of discovery in accordance to the standard.	

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

*MMA, NHA*

TITLE

*NHA*

(X6) DATE

*1-24-14*

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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NAME OF PROVIDER OR SUPPLIER  ROANOKE RAPIDS HEALTHCARE AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	
(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
K 056	Continued From page 1 provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: A. Based on observation on 01/09/2014 there was no heat in the riser room. 42 CFR 483.70 (a)	K 056	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  K 056  1. An electric wall mounted heater was installed in the riser room on 1-24-14. The installation of that heater was completed by a licensed electrician.  2. The Plant Operations Manager will continue to monitor the operation of that heater once weekly during the months of November, December, January, February and March, then monthly the remaining months of the year. Those monitoring checks will be logged and kept in the preventative maintenance log book.  3. The Plant Operations Manager will report to the Quality Assurance Performance Improvement Committee monthly and review the preventative maintenance log regarding the heater in the riser room. Any issues with the heater will be corrected at the time of discovery in accordance to the standard.	1/24/14

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

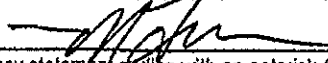
PRINTED: 01/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BLDG 02 OF 02  B. WING _____	(X3) DATE SURVEY COMPLETED  01/09/2014
NAME OF PROVIDER OR SUPPLIER  ROANOKE RAPIDS HEALTHCARE AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	
(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
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: A. Based on observation on 01/09/2014 the exit door at Med. Records was very hard to open. 42 CFR 483.70 (a)	K 038	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  K 038  1. The push bar on the exit door at medical records was adjusted on 1-10-14 and the door now opens easily, as designed.  2. The Plant Operations Manager will continue to monitor the operation of that door at medical records, once daily for one week, then once weekly for two months, then monthly thereafter. Those monitoring checks will be logged and kept in the preventative maintenance log book.  3. The Plant Operations Manager will report to the Quality Assurance Performance Improvement Committee monthly and review the preventative maintenance log regarding the operation of that door at medical records. Any further issues with that door will be corrected at the time of discovery in accordance to the standard.	1/24/14

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

TITLE

(X6) DATE



NHA

1-24-14

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.

CP