

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

PRINTED: 05/06/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345260</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ROCKY MOUNT REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 WINSTEAD AVENUE ROCKY MOUNT, NC 27804</b>
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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)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>There were no citations based upon the investigation of Complaints for Intake #NC00099906, #NC00103175, or #NC00103217.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 164		5/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <b>Electronically Signed</b>	TITLE	(X6) DATE <b>04/30/2015</b>
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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 164	<p>Continued From page 1</p> <p>Based on observation, resident and staff interviews, the facility failed to close the door, pull privacy curtain, to provide for resident's privacy needs for a bed bath for 1 of 1 residents' (resident #92).</p> <p>Findings included:</p> <p>Resident #92 was admitted to the facility on 11/23/2012 with diagnoses of aphasia, cerebrovascular disease (CVA), hypertension (HTN), depression, glaucoma, and dementia.</p> <p>The quarterly Minimum Data Set (MDS) dated 02/4/2015 indicated Resident #92 cognition was moderately impaired. The MDS assessed total or extensive assistance was required by staff for bed mobility, transfers, dressing, toilet use, locomotion, and bathing.</p> <p>The care plan updated on 02/10/15 included a problem of Activities for Daily Living (ADL's) self care performance deficit related to recent CVA with mild hemiparesis, and impaired cognition. Interventions included: resident required extensive staff participation for incontinent care, bed mobility, bathing/showering, and personal hygiene.</p> <p>During the initial facility tour (down the 300 hall), observed Nursing Aide (NA) #1 on 04/6/15 at 10:30 AM giving Resident #92 a bed bath with the privacy hall way door and privacy curtain open. Resident #92 was in bed A of a semi-private room and was exposed to anyone passing down the hall. When the nursing aide was questioned why the door was open, she responded by closing Resident #92 's door and pulled the privacy curtain to the hallway.</p>	F 164	<p>This plan of correction is the center's credible allegation of compliance. 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 provisions of federal and state law.</p> <p>F164 □ 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>1. Interventions for affected resident:</p> <p>Resident #92 was assessed for any emotional distress after being exposed during bath and was found not to be in any distress.</p> <p>2. Interventions for residents as having the potential to be affected:</p> <p>Residents have the potential to be affected by this practice. Privacy was immediately provided for Resident #92 by ensuring privacy curtain was drawn between resident #92 and her roommate, and by closing the resident's room door. Director of Nursing and Unit Managers performed daily resident rounding to ensure residents rights, including privacy, were maintained. Staff Development Coordinator (SDC) performed immediate in-servicing/education provided to staff on</p>		

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F 164	Continued From page 2  Interview with Resident #92 on 04/7/15 at 4:41 PM revealed she did notice the hall way door was open on 04/6/15 during her bed bath.  Interview on 04/8/15 at 4:00 PM with NA #1 who confirmed that on 04/6/15 during Resident #92 bed bath she failed to close the resident ' s privacy curtain and hall way door during Resident #92 ' s bed bath, leaving the resident exposed to hallway traffic.  Interview on 04/8/15 at 4:20 PM with the DON revealed it was her expectation that the resident ' s door to be closed, window blinds closed, and privacy curtain fully closed while doing a resident's bed bath.	F 164	resident's rights & dignity.  3. Systemic Change:  On-going staff reinforcement and education for all new hires during their orientation period on providing and maintaining residents' rights by Staff Development Coordinator (SDC). Unit Managers & SDC will conduct weekly audits 5 days a week to perform random rounding of staff providing ADLs and bathing to ensure resident's privacy and rights are being maintained.  4. Monitoring of the change to sustain system compliance on-going:  Director of Nursing will report audits for review during the Quality Assurance & Performance Improvement Committee Meeting for next 3 months. QA committee will review audits to ensure compliance is on-going and to determine the need for further audits beyond 3 months.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		5/5/15	

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F 309	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed: 1) to administer an antibiotic to treat an infection until 7 days after the medication was ordered, and 2) to administer the medication continuously for 14 days as ordered for one of one resident reviewed for multidrug resistant infections. Findings included:</p> <p>Review of the Discharge/Transfer Summary from the local hospital dated 02/25/2015 revealed that Resident #107 had a wound culture in the hospital which indicated the resident had a VRE (Vancomycin Resistant Enterococcal) infection. (A VRE is an infection which is resistant to treatment using the antibiotic Vancomycin and requires the use of a special antibiotic to treat the infection.) The same Discharge/Transfer Summary from the hospital revealed the resident had been started on Zyvox on 02/24/2015 to treat the VRE.</p> <p>A review of the admission orders for Resident # 107 at the facility dated 02/25/2015 revealed an order for the administration of Zyvox, 600 milligrams (mg) by mouth, twice per day for 14 days. (This order indicated the resident would receive a total of 28 doses over 14 consecutive days while in the facility.)</p> <p>A review of the medication administration record (MAR) dated 02/25/2015 through 02/28/2015 revealed the order for Zyvox, 600 milligrams (mg) twice per day was transcribed to the MAR accurately. There were circled initials on the MAR to indicate the Zyvox was not administered for the 8:00 AM or the 8:00 PM doses on 02/25/2015, 02/26/2015, 02/27/2015, or</p>	F 309	<p>This plan of correction is the center's credible allegation of compliance. 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 provisions of federal and state law.</p> <p>F309 □ 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Interventions for affected resident: Physician was notified that Resident #107 did not receive a consecutive 14 day supply of Zyvox as ordered. No new orders were obtained for the resident. Interventions for residents as having the potential to be affected:</p> <p>The Director of Nursing and Unit Managers performed an audit of residents with orders from February 2015 □ April 2015, for Zyvox was performed to ensure medication was provided consecutively for the ordered number of days and that no delay in care was made. After completing an audit, no other residents were found to have been ordered Zyvox and not received a consecutive dose of treatment as ordered. An additional audit was performed for current residents on ABT to ensure residents in community were</p>		

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F 309	<p>Continued From page 4 02/28/2015.</p> <p>A review of the MAR dated 03/01/2015 through 03/31/2015 revealed there were circled initials to indicate the Zyvox antibiotic doses were not administered on 03/01/2015, 03/02/2015, or 03/03/2015. Initials were in place to indicate the Zyvox was administered for both doses (8:00 AM and 8:00 PM) on the following dates: 03/04/2015, 03/05/2015, 03/06/2015, 03/07/2015, 03/08/2015, 03/10/2015, 03/11/2015, 03/12/2015, and 03/13/2015. Initials were missing for the morning dose of Zyvox on 03/09/2015. There were initials in place on the MAR to indicate the morning dose of Zyvox was administered at 8:00 AM on 03/14/2015. There were circled initials on the March 2015 MAR to indicate the Zyvox was not given for 8:00 AM or the 8:00 PM doses on 03/15/2015., 03/16/2015, 03/17/2015.</p> <p>Another section of Resident #107's March 2015 MAR revealed there were initials in place to indicate the Zyvox 600 mg was administered twice daily at 8:00 AM and 8:00 PM on the dates of 03/18/2015, 03/19/2015, 03/20/2015, and the for 8:00 AM dose of Zyvox on 03/21/2015.</p> <p>In summary, the medication administration records for February 2015 and March 2015 revealed Zyvox, 600 mg which was ordered on 02/25/2015 was not administered to Resident #107 until 03/04/2015 at 8:00 PM, and that the administration of the Zyvox continued through 03/14/2015 at 8:00 AM, a total of 10 and ½ days of administration. Resident #107 did not received the prescribed doses for Zyvox for the next 3 and ½ days. The administration of the Zyvox resumed on 03/18/2015 at 8:00 AM and continued through 8:00 AM on 03/21/2015.</p>	F 309	<p>provided medications for the ordered number of days and no delay in care was made.</p> <p>Systemic Change: Licensed staff to be in-serviced/educated by Director of Nursing and Staff Development Coordinator on the proper follow up of new medication antibiotics orders that have been received and faxed to the pharmacy <input type="checkbox"/> If medication not received within 24 hours, facility will perform follow up phone call to be made to the pharmacy to inform &amp; inquire on delivery of new medication.</p> <p>Upon receiving admission transfer orders on new/re-admission residents or residents who return from follow up appointments with orders for high cost medications (i.e. Zyvox) that require prior authorization, a call will be made to the pharmacy by authorized personnel (i.e. DON, ADON, or Supervisor in charge if DON/ADON not available) to inform of approval of medication as soon as the medication order is received. If stated medication is not received within 24 hours, a follow up call will be placed by the facility to inquire on the delay of delivery and receive an estimated to of delivery from the pharmacy.</p> <p>A tracking log will be kept at the nurses' stations when said type medications (high cost requiring facility approval) as well as residents receiving antibiotics; are ordered, to ensure proper follow up. Log will include: Current date; date order for medication received from physician;</p>		

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F 309	Continued From page 5  A review of the Minimum Data Set (MDS) Admission Assessment dated 03/14/2015 revealed Resident #107 was cognitively intact and was re-admitted to the facility from the hospital on 02/25/2015 with diagnoses which included, but were not limited to, hypertension, anemia, and peripheral vascular disease. In addition, the same MDS assessment indicated the resident had received antibiotic therapy during the assessment period.  A review of the nursing care plan for Resident #107 which was initiated on 12/01/2015 and last updated on 04/01/2015 revealed that there were measureable goals and related interventions in place to address the treatment of pressure ulcers. One of the goals of the same nursing care plan was that a pressure ulcer on the buttock would be resolved and free of signs of infection by the day of discharge. An intervention listed for the pressure ulcer was to administer medications as ordered, and to document and monitor the effectiveness of the medication.  In an interview with the Director of Nursing (DON) on 04/09/2015 at 5:30 PM, she stated that the delay in the initiation of the Zyvox therapy was in part because the pharmacy needed prior approval from the facility to fill the prescription due to the high cost of the Zyvox. The DON explained that it was a corporate policy that certain expensive medications must be approved by the administrator before prescriptions could be filled. The DON presented paperwork to indicate that approval for the Zyvox administration was provided to the pharmacy by the facility's administrator on 02/27/2015. The DON also stated that the Zyvox should have been	F 309	Name of medication; Name of ordering physician; date & time call placed to pharmacy for facility approval; Name of staff member authorizing approval (i.e. DON/ADON; Supervisor); Name of pharmacy staff spoken to; Date medication received. An admission checklist is being placed on all new/re-admission charts. This checklist requires initials and signatures of nurse completing tasks of the admission process. The 11p <input type="checkbox"/> 7am nurse will complete a 24 hour chart check and also sign off on the admission checklist. The following morning during clinical rounds, the administrative nursing team will complete a final chart check and sign off on the admission checklist. This process will provide 3 views of the admission orders in less than 24 hours to ensure that the process is completed accurately and timely.  Effective April 1, 2015, Omnicare Pharmacy will be dispensing medications for all facility-responsible claims in 15 day supply quantities.  Director of Nursing and Unit Managers will audit resident's receiving specifically Zyvox; as well as residents on antibiotics three times a week for 3 months to ensure consecutive doses received.  Director of Nursing will report findings in Quality Assurance committee meeting for the next 3 months. QA committee will review audits to ensure compliance is on-going and to determine the need for		

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F 309	Continued From page 6 administered as ordered upon admission, 600 mg twice per day for 14 consecutive days. The DON further explained that the pharmacy only provided a total of 20 Zyvox doses at first, and that she did not understand why the pharmacy did not provide the approved 28 prescribed doses to the facility. The DON stated the facility had to follow up with the pharmacy to obtain the remaining 7 doses of Zyvox, and that this was the reason why the Zyvox was not given on 14 consecutive days from 03/04/2015 through 03/17/2015. The DON also stated she was not sure when the facility called to re-order the remaining doses, and that she would need to research to determine exactly what happened.	F 309	further audits beyond 3 months.		
F 329 SS=D	<b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		5/5/15	

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F 329	<p>Continued From page 7 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to draw an initial baseline Digoxin level for 1 of 2 residents (Resident #118) who had Digoxin initiated during a hospital stay. Findings included:</p> <p>The May 2014 Lexi-Comp: Merck Manual Professional documented, "Digoxin serum concentrations are monitored because Digoxin possesses a narrow therapeutic serum range; the therapeutic endpoint is difficult to quantify and Digoxin toxicity may be life threatening...If a loading dose is not given, Digoxin serum concentration would be obtained after 3 - 5 days of therapy...Amiodarone may increase the serum concentration of cardiac glycosides (such as digoxin)...Signs of Digoxin toxicity are either extracardiac (non-heart related) or cardiac manifestations. Extracardiac manifestations include anorexia, nausea, and fatigue."</p> <p>A 02/18/15 hospital discharge summary documented Resident #118 was admitted to the hospital on 02/03/15, and on 02/18/15 her primary discharge diagnosis was atrial fibrillation. The summary further documented, "She (Resident #118) is being discharged on Digoxin which also will help with her a.fib (atrial fibrillation) rate control....With respect to her atrial fibrillation Amiodarone was started for rate control...."</p>	F 329	<p>This plan of correction is the center's credible allegation of compliance. 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 provisions of federal and state law.</p> <p>1. Interventions for affected resident:</p> <p>An order for a STAT drug level for the Digoxin for Resident #118 was obtained. The specimen was drawn and sent to the lab for processing. Once results were received the physician was notified. Lab results were within normal limits and no new orders were given for this resident.</p> <p>2. Residents with the potential to be affected:</p> <p>Residents have the potential to be affected by this practice. An audit of physician orders from February 2015 □ April 2015 was performed for current facility residents to ensure ordered</p>		



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F 329	<p>Continued From page 8</p> <p>Resident #118 was admitted to the facility on 02/18/15. The resident's documented diagnoses included atrial fibrillation, hypertension, and congestive heart failure.</p> <p>Review of the resident's medication administration record (MAR) revealed she was admitted to the facility on 02/18/15 with orders to receive Digoxin 125 micrograms (mcg) daily (QD) and Amiodarone hydrochloride 200 milligrams (mg) twice daily (BID).</p> <p>The resident's 02/25/15 admission minimum data set (MDS) documented her cognition was severely impaired, she did not resist care, and she required extensive assistance by a staff member for eating.</p> <p>The resident's weight summary documented she weighed 130 pounds on 02/18/15 and 117.5 pounds on 03/25/15.</p> <p>A 03/26/15 interdisciplinary team (IDT) note documented Resident #118 experienced significant weight loss of 5% or greater in the past 30 days, was only eating 0 - 25% of her meals and 0 -25% of her Magic Cup nutrition supplement. "Per nurse (resident) often refused meals/supplements, refer to MD (physician) for consideration of increase in remeron (appetite stimulant)."</p> <p>The resident's weight summary documented she weighed 114.3 pounds on 04/01/15.</p> <p>Review of lab results during the resident's nursing home stay revealed that no Digoxin level had been drawn.</p>	F 329	<p>laboratory tests, including Digoxin levels were ordered and obtained. After completed audit, no other residents were found to not have laboratory testing including digoxin not ordered and/or obtained. The Director of Nursing and Staff Development Coordinator educated Licensed Nurses on the facility 24 hour chart check process. The 24 hours chart check process will include checking each resident's medical record for new physician orders from the admission and previous day to verify transcription of new orders to the Medication Administration Record (MAR), Treatment Administration Record (TAR), and/or the Lab Tracking Log as applicable. Newly hired licensed nurses will be educated by the Staff Development Coordinator during their orientation period on obtaining orders for labs and tracking lab results for proper follow-up, obtaining and processing lab specimens.</p> <p>3. Systemic Change:</p> <p>Director of Nursing &amp; Staff Development coordinator in-serviced/educated all licensed staff on new admission checklist which states medications that require admission lab work to be obtained per facility admission lab protocol. Copy of Admission Lab Protocol will be posted in visible are at the nurses' stations to ensure all new/re-admissions have lab work ordered per facility protocol.</p> <p>An admission checklist is being placed on all new/re-admission charts. This checklist</p>		

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F 329	<p>Continued From page 9</p> <p>At 12:50 PM on 04/09/15 Nurse #3, who cared for Resident #118 on first shift, stated it did not seem that the resident's appetite stimulant was helping improve her meal intake at all, which was still averaging 0 - 25%. She reported it seemed that the resident had lost interest in food and eating.</p> <p>At 2:37 PM on 04/09/15 nursing assistant (NA) #4, who cared for Resident #118 on first shift, stated the resident never ate more than bites of her food, and frequently refused whole meals. She reported it was extremely difficult to get the resident interested in eating anything.</p> <p>At 3:48 PM on 04/09/15 NA #3, who cared for Resident #118 on second shift, stated the resident frequently refused her Magic Cup, and at the most ate about three bites of it in the evenings. She also reported the resident refused her supper meal about three times a week. The NA commented Resident #118's family commented the resident had never been a "big eater", but her appetite had definitely gotten worse since being in the nursing home.</p> <p>At 4:06 PM on 04/09/15 the director of nursing (DON) stated if there was no physician order for a Digoxin level, the facility did not draw one.</p> <p>At 4:39 PM on 04/09/15 Unit Manager #1 stated the hospital reported no record of a Digoxin level being drawn while Resident #118 was hospitalized, and confirmed that the resident was started on Digoxin and Amiodarone while in the hospital.</p> <p>At 6:00 PM on 04/09/15 the facility provided a copy of a stat (at once) lab which documented Resident #118's Digoxin level was 1.2 nanograms</p>	F 329	<p>requires initials and signatures of nurse completing tasks of the admission process. The 11p <input type="checkbox"/> 7am nurse will complete a 24 hour chart check and also sign off on the admission checklist. A 24 hour report form will be utilized during shift change report for communication to on-coming licensed nurses of pending lab orders and required follow up as applicable. The following morning during clinical rounds, the Director of Nursing and the administrative nursing team will complete a final chart check and sign off on the admission checklist. This process will provide 3 views of the admission orders in less than 24 hours to ensure that the process is completed accurately and timely. The lab tracking log will be utilized during clinical rounds by administrative nursing team to monitor for proper follow up on lab orders and specimens obtained. Unit Managers, Supervisors, and Staff Development Coordinators will audit 20 (twenty) residents' medical records weekly for 3 months to verify the 24 hour chart checks are completed and new physician orders are appropriately initiated. Director of Nursing and administrative nursing team will audit the Lab tracking Logs daily, Monday <input type="checkbox"/> Friday in clinical rounds for 3 months to ensure follow up of lab orders and specimens ordered by the physician.</p> <p>4. Monitoring of the change to sustain system compliance on-going:</p> <p>Director of Nursing will present audit reports to the Quality Assurance</p>		

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F 329	Continued From page 10 per milliliter (ng/mL), with the reference range being 0.5 - 2.0 ng/mL.	F 329	Committee for compliance for 3 months. The Quality Assurance Committee will review the audits to determine the need for further auditing beyond 3 months.	5/5/15	
F 367 SS=D	<p>483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN</p> <p>Therapeutic diets must be prescribed by the attending physician.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide fortified foods for 1 of 1 sampled residents (Resident #145) who had fortified foods ordered as part of their diet prescription. Findings included:</p> <p>Resident #145 was admitted to the facility on 04/17/14. His documented diagnoses included Huntington's chorea, hypertenison, and atrial fibrillation.</p> <p>Resident #145's Weight Summary documented he weighed 127 pounds on 04/17/14 and 107.5 pounds on 07/01/14.</p> <p>A 07/21/14 diet order placed Resident #145 on a regular diet with large portions and fortified foods.</p> <p>A 09/24/14 interdisciplinary team (IDT) progress note documented the resident was receiving large portions and fortified foods to help meet the extra nutrition and calories needs generated by the constant movement resulting from Huntington's chorea.</p>	F 367			

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F 367	<p>Continued From page 11</p> <p>Resident #145's Weight Summary documented he weighed 113 pounds on 01/15/15, 117 pounds on 02/25/15, and 120 pounds on 03/11/15.</p> <p>A 03/19/15 Nutrition Risk assessment documented the resident was receiving a regular diet with large portions and fortified foods, was eating 25 - 50% of meals, and he was gradually gaining back some of his weight.</p> <p>A 03/23/15 annual minimum data set (MDS) documented Resident #145's short and long term memory was impaired, his decision making skills were severely impaired, he required extensive assistance with eating by a staff member, and his weight was currently stable.</p> <p>A 03/31/15 care plan documented the resident was at risk for nutritional decline related to the diagnosis of Huntington's disease. Interventions to this problem included the provision of meals per physician diet orders.</p> <p>At 12:35 PM on 04/08/15 Resident #145's tray was prepared at the trayline. The caller verbalized the resident was to receive double portions and fortified foods as documented on the tray slip from which she was calling. However, the cook did not place the fortified food on the resident's plate, and the checker did not catch the mistake before placing the plate in the meal cart. At this time the AM cook stated mashed potatoes and gravy was the fortified food which Resident #145 should have received.</p> <p>At 5:08 PM on 04/08/15 Resident #145's tray was prepared at the trayline. The caller only verbalized the resident was to receive double portions, even though the trayslip documented</p>	F 367	<p>order.</p> <p>3.) Systemic Change</p> <p>The Dietary Manager or Registered Dietician will audit 10 trays of residents receiving fortified foods daily for 4 weeks then weekly for 3 months to ensure these residents are receiving their fortified food per physician order. Registered Dietician conducted an in-service on 4/28/15 with all cooks and dietary aides. The RD reviewed our fortified food policy and following dietary orders per accurate tray cards.</p> <p>4.) Monitoring of the change to sustain system compliance ongoing:</p> <p>The Quality Assurance Committee will discuss and review the results of the Dietary audits monthly for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.</p>		

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F 367	Continued From page 12 the resident had orders for double protions and fortified foods. Therefore, the cook did not place fortified foods on Resident #145's plate, and the checker did not catch the omission prior to placing the resident's tray in the meal cart. At this time the PM cook stated mashed potatoes and gravy was the fortified food which Resident #145 should have received.  At 3:12 PM on 04/09/15 the dietary manager (DM) stated the caller, cook, and checker were supposed to work together to complete one resident plate at a time. The caller was to examine the trayslip and verbalize the whole diet prescription aloud, and remind the cook of any likes, dislikes, and supplements. The cook prepared the plate which was passed on to the checker who was responsible for making sure what was on the plate matched the information on the tray slip.  At 3:32 PM on 04/09/15 the PM cook stated she thought the fortified food was overlooked at Resident #145's supper meal because the information regarding it appeared in the "note" section instead of in the "diet" section. She reported there was a lot of information on the resident's tray slip to process. She commented the checker was supposed to catch any mistakes or omissions, however, before placing the plates in the meal carts.	F 367			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		5/5/15	

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F 371	<p>Continued From page 13</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry tray pans before stacking them in storage, failed to clean the entire microwave and a utensil drawer, and failed to label and date opened food items. Findings included:</p> <p>1. During the initial tour of the kitchen on 04/06/15, beginning at 10:20 AM, 1 of 6 tray pans stacked on top of one another on a storage rack were wet inside. At this time the AM cook stated she thought the PM dietary staff placed these tray pans in storage since she had not yet removed any of her breakfast tray pans from the draining ledge of the three-compartment sink system.</p> <p>During a follow-up tour of the kitchen on 04/09/15, beginning at 3:00 PM, 1 of 6 tray pans stacked on top of one another on a storage rack were wet inside. The PM cook stated she was unsure if these tray pans were stacked in storage after breakfast or after lunch.</p> <p>At 3:12 PM on 04/09/15 the dietary manager (DM) stated her expectation was for staff to make sure any type of kitchenware was clean and dry before stacking it in storage.</p> <p>At 3:32 PM on 04/09/15 the PM cook stated she was trained that kitchenware, including tray pans,</p>	F 371	<p>This plan of correction is the center's credible allegation of compliance. 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 provisions of federal and state law.</p> <p>1.) Interventions for affected resident:</p> <p>All residents have the potential to be affected by this practice.</p> <p>The tray pan was dried and stored properly on 4/9/15. The microwave was cleaned on 4/9/15. The prep drawer and utensils within the prep drawer were cleaned on 4/9/15. The bag of fettuccine noddles, the bag of yellow cake mix, the bag of spice cake mix, the bag of pecan pieces and the bag of brown sugar were all discarded on 4/9/15.</p> <p>2) Interventions for residents identified as</p>	

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F 371	<p>Continued From page 14 was to be air dried before stacking into storage.</p> <p>2. During the initial tour of the kitchen on 04/06/15, beginning at 10:20 AM, the inside top of the microwave was encrusted with dried food particles.</p> <p>During food preparation observation on 04/08/15 at 9:53 AM the inside top of the microwave was encrusted with dried food particles.</p> <p>During food preparation observation on 04/08/15 at 10:10 AM there was food debris and a fine white granular powder inside the drawer and on utensils stored in the drawer beneath a food preparation table.</p> <p>Prior to taking food temperatures at the the trayline on 04/08/15 at 12:05 PM an observation of the microwave revealed the interior top of the microwave was encrusted with dried food particles.</p> <p>During a follow-up tour of the kitchen on 04/09/15, beginning at 3:00 PM, the inside top of the microwave was encrusted with dried food particles. At this time the PM cook stated she used the microwave for warming up foods such as soup.</p> <p>At 3:12 PM on 04/09/15 the dietary manager (DM) stated her expectation was after meals the interior of the microwave was to be wiped out, with the cleaning to include the bottom, sides, and top of the microwave.</p> <p>At 3:32 PM on 04/09/15 the PM cook stated when the microwave was cleaned after meals, the interior top, sides, and bottom were to be wiped</p>	F 371	<p>having potential to be affected:</p> <p>All residents have the potential to be affected by this practice.</p> <p>3.) Systemic Change</p> <p>An audit of the daily and weekly cleaning schedules will be conducted weekly for 12 weeks to ensure compliance and identify area of improvement as needed. The Dietary Manager or Cook on duty will randomly audit for correct storage, labeling and dating in dry storage daily 5 times a week for 4 weeks, then weekly for 4 weeks to ensure compliance and identify area of improvement as needed. The Nursing Home Administrator will make weekly tours with the Dietary Manager of the kitchen to monitor for correct labeling and dating of dry storage and cleanliness through the daily, weekly, and monthly cleaning schedules for 12 weeks to ensure compliance. Registered Dietician conducted an in-service on 4/28/15. The RD reviewed our daily, weekly and monthly cleaning schedules and how to properly date opened dry storage.</p> <p>4.) Monitoring of the change to sustain system compliance ongoing:</p> <p>The Quality Assurance Committee will discuss and review the results of the Dietary audits monthly for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to</p>		

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F 371	Continued From page 15 off. She reported that dried food particles could loosen from the top of the microwave and contaminate foods being heated in it.  3. During the initial tour of the kitchen on 04/06/15, beginning at 10:20 AM, food items in the dry storage room such as a bag of fettuccine noodles, a bag of yellow cake mix, a bag of spice cake mix, a bag of pecan pieces, and a bag of brown sugar were opened but without labels and dates.  At 3:12 PM on 04/09/15 the dietary manager (DM) stated until an assistant or a kitchen manager was hired she was responsible for monitoring storage areas to make sure opened items were labeled and dated. She also reported it was her expectation that the cooks help in monitoring the storage areas.  At 3:32 PM on 04/09/15 the PM cook stated all employees who opened food items were responsible for resealing them and placing labels and dates on them so the facility could use up older food items first.	F 371	ensure compliance is sustained ongoing.		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425		5/5/15	



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F 425	<p>Continued From page 16 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff and pharmacy interviews, the facility's pharmacy failed to provide a prescribed antibiotic to the facility for administration to a resident until 5 days after the medication was ordered, and failed to provide the ordered number of antibiotic doses to the facility to administer for one of five residents reviewed for medication orders, Resident #107. Findings included:</p> <p>Review of the Discharge/Transfer Summary from the local hospital dated 02/25/2015 revealed that Resident #107 had a wound culture in the hospital which indicated the resident had a VRE (Vancomycin Resistant Enterococcal) infection. (A VRE is an infection which is resistant to treatment using the antibiotic Vancomycin and requires the use of a special antibiotic to treat the infection.) The same Discharge/Transfer Summary from the hospital revealed the resident had been started on the antibiotic Zyvox on 02/24/2015 to treat the VRE infection.</p> <p>A review of the admission orders for Resident # 107 at the facility dated 02/25/2015 revealed an</p>	F 425	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated</p> <p>1) Interventions for affected resident : Resident # 107 received their order of Zyvox on</p> <p>2) Interventions for residents identified as having the potential to be affected: An audit was conducted to ensure residents are receiving their medications per physician order. An audit was conducted of current resident's medications to</p>		

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F 425	<p>Continued From page 17</p> <p>order for the administration of Zyvox, 600 milligrams (mg) by mouth, twice per day for 14 days. (This order indicated the resident would receive a total of 28 doses over 14 consecutive days while in the facility.)</p> <p>A review of the medication administration record (MAR) for February 25, 2015 through February 28, 2015 for the resident revealed Resident #107 did not receive the prescribed antibiotic Zyvox, 600 mg from 02/25/2015 through 02/28/2015.</p> <p>A review of the medication administration record for March 1, 2015 through March 31, 2015, revealed the resident did not receive the prescribed twice daily doses of Zyvox until March 4, 2015, and that it was administered for 10 and ½ consecutive days through 8:00 AM on March 14, 2015. Further review of the same medication administration record indicated the resident did not receive the remaining twice daily Zyvox, 600 mg doses until March 18, 2015 at 8:00 AM, continuing through the morning dose on March 21, 2015.</p> <p>A review of the Minimum Data Set (MDS) Admission Assessment dated 03/14/2015 revealed Resident #107 was cognitively intact and was re-admitted to the facility from the hospital on 02/25/2015 with diagnoses which included hypertension, anemia, and peripheral vascular disease. In addition, the same MDS assessment indicated the resident had received antibiotic therapy during the assessment period.</p> <p>In an interview conducted with Pharmacist #1 on 04/09/2015 at 3:17 PM, he stated he was not sure why order for Zyvox, 600 milligrams by mouth for 14 days was not provided to the facility</p>	F 425	<p>ensure medications have been received per physicians orders.</p> <p>3) Systematic Change: Night shift Licensed Nurses will perform a twenty-four (24) hour chart check process which will include checking each resident medical record for new physician orders from the admission and previous day to verify transcription of new orders to the Medication Administration Record (MAR), Treatment Administration Record (TAR) or the Lab Tracking Log as applicable .A twenty-four (24) hour report form will be utilized during shift change report for communication to oncoming Licensed Nurse of pending lab orders and required follow-up as applicable .A lab tracking log will be utilized during clinical rounds by the Director of Nursing ,Unit Manager, Staff Development Coordinator, and Resident Care Specialist to monitor for proper follow-up on lab orders and specimens obtained. Director of Nursing, Unit Manager or Staff Development Coordinator will audit ten(10) resident's medical record weekly for twelve (12) weeks to verify twenty-four (24)hour chart checks are completed and new physician orders are appropriately initiated. Director of Nursing, Unit Manager, Staff Development Coordinator, or Resident Care Specialist will audit the Lab Tracking Log daily (Monday-Friday) in Clinical Rounds for twelve (12) weeks to ensure follow-up of lab orders and specimens ordered by the Physician. Nursing staff on each shift will utilize the Refill Reorder Form daily to order medications from the</p>		

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F 425	<p>Continued From page 18</p> <p>until 5 days after the order was made to the pharmacy or why all 28 doses of the Zyvox were no provided to the facility. Pharmacist #1 provided contact information for another pharmacist on staff who could provide the information.</p> <p>A telephone message was left with Pharmacist #2 on 04/09/2015 at 5:00 PM for a return call for an interview.</p> <p>In an interview with the Director of Nursing (DON) on 04/09/2015 at 5:30 PM, she stated that the delay in the initiation of the Zyvox therapy was in part because the pharmacy needed prior approval from the facility to fill the prescription due to the high cost of the Zyvox. The DON explained that it was a corporate policy that certain expensive medications must be approved by the administrator before prescriptions could be filled. The DON presented paperwork to indicate that approval for the Zyvox administration was provided to the pharmacy by the facility's administrator on 02/27/2015. The DON also stated that the twice daily Zyvox 600 mg should have been provided as ordered for the resident for 14 consecutive days upon admission. The DON further explained that the pharmacy only provided a total of 20 Zyvox doses at first, and that she did not understand why the pharmacy did not provide the approved 28 prescribed doses to the facility. The DON stated the facility had to follow up with the pharmacy to obtain the remaining 7 doses of Zyvox, and that this was the reason why the Zyvox was not given for 14 consecutive days from 03/04/2015 through 03/17/2015. The DON also stated she was not sure when the facility called the pharmacy to follow up on the doses which were not provided,</p>	F 425	<p>pharmacy and the nursing staff on each shift receiving medications from the pharmacy will utilize the dispensing list from pharmacy to ensure medications are received daily. Any medications ordered and not received will be reported to the Director of Nursing using the Medication Not Received Audit Form. The DON will follow-up daily with pharmacy for any medication ordered and not received from pharmacy. Nursing staff was in-serviced on completion of Refill Reorder Form and Medication Not Received Form . Consultant Pharmacist was in-serviced on 4/23/15 on obtaining appropriate lab work per facility's policy. Nursing staff The results will be presented to the Quality Assurance and Performance Committee.</p> <p>4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits for proper obtaining of lab orders and follow up. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing, beyond the three (3) months period.</p>		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345260</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROCKY MOUNT REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 WINSTEAD AVENUE</b> <b>ROCKY MOUNT, NC 27804</b>		
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F 425	Continued From page 19 and that she would need to research to determine exactly what happened.  In a return call from the pharmacy on 04/10/2015 at 1:00 PM, Pharmacist #3 stated that it was the intention of the pharmacy to fill the prescription for Zyvox for Resident #107 on 02/27/2015 after it was approved by the facility's administrator, but that a pharmacist had accidentally canceled the order. Pharmacist #3 stated that the pharmacy did not fill the prescribed Zyvox order until the facility called to follow up on the order. Pharmacist #3 stated he was not sure which date the facility had called the pharmacy to follow up, and that he knew it was important for the Zyvox to be provided as ordered to treat a VRE (Vancomycin Resistant Enterococcal) infection for 14 consecutive days. In addition, Pharmacist #3 stated that he was not sure why all 28 doses were not provided when it was originally delivered to the facility, and that it could have been due to an insurance issue.	F 425			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced	F 428		5/5/15	

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F 428	<p>Continued From page 20</p> <p>by: Based on pharmacist interview, staff interview, and record review the consultant pharmacist failed to alert the facility of the need to draw an initial baseline Digoxin level and of a possible medication interaction between Digoxin and Amiodarone and for 1 of 2 sampled residents (Resident #118) receiving Digoxin as part of their medication regimen. Findings included:</p> <p>The May 2014 Lexi-Comp: Merck Manual Professional documented, "Digoxin serum concentrations are monitored because Digoxin possesses a narrow therapeutic serum range; the therapeutic endpoint is difficult to quantify and Digoxin toxicity may be life threatening...If a loading dose is not given, Digoxin serum concentration would be obtained after 3 - 5 days of therapy....Amiodarone may increase the serum concentration of cardiac glycosides (such as digoxin)."</p> <p>A 02/18/15 hospital discharge summary documented Resident #118 was admitted to the hospital on 02/03/15, and on 02/18/15 her primary discharge diagnosis was atrial fibrillation. The summary further documented, "She (Resident #118) is being discharged on Digoxin which also will help with her a.fib (atrial fibrillation) rate control....With respect to her atrial fibrillation Amiodarone was started for rate control...."</p> <p>Resident #118 was admitted to the facility on 02/18/15. The resident's documented diagnoses included atrial fibrillation, hypertension, and congestive heart failure.</p> <p>Review of the resident's medication administration record (MAR) revealed she was</p>	F 428	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated</p> <p>1) Interventions for affected resident : Resident # 118 an order for a stat Digoxin level was obtained , the specimen was drawn and sent to the lab for processing. Once results were received the physician was notified of results there were no new orders given for resident.</p> <p>2) Interventions for residents identified as having the potential to be affected: An audit of physician orders from February 2015 _April 2015 was performed for current facility residents to ensure ordered laboratory test including Digoxin levels were ordered and obtained After completed audit, no other resident was found to not have laboratory testing including Digoxin not ordered and or obtained .The Director of Nursing performed re-education with Licensed Nurses on reviewing of obtaining orders for lab specimens and tracking of lab</p>		

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F 428	<p>Continued From page 21</p> <p>admitted to the facility on 02/18/15 with orders to receive Digoxin 125 micrograms (mcg) daily (QD) and Amiodarone hydrochloride 200 milligrams (mg) twice daily (BID).</p> <p>In her 03/17/15 Pharmacy Progress Note the consultant pharmacist failed to recommend/address drawing an initial baseline Digoxin level for Resident #118 who was also receiving Amiodarone which had the potential of elevating the serum Digoxin level.</p> <p>Review of lab results during the resident's nursing home stay revealed that no Digoxin level had been drawn.</p> <p>At 3:57 PM on 04/09/15, during a telephone interview with the pharmacy consultant supervisor, he stated the facility's consultant pharmacist was out of the country and unavailable for interview. However, he stated about two months after initiation of Digoxin he would expect the consultant pharmacist to start requesting that a Digoxin level be obtained. He reported there was a potential interaction between Digoxin and Amiodarone, but that would not necessarily affect when an initial Digoxin level would be obtained. He explained monitoring time frames were affected by renal function, pulse rates, age, etc. The supervisor commented the initial dosage of Digoxin was frequently 125 mcg/day, but usage in conjunction with Amiodarone might require lowering that initial dose.</p> <p>At 4:06 PM on 04/09/15 the director of nursing (DON) stated if there was no physician order for a Digoxin level, the facility did not draw one. She stated the facility depended on its consultant</p>	F 428	<p>results for proper follow-up. The Director of Nursing educated Licensed Nurses on the facility twenty-four (24) hour chart check process. The twenty-four (24)hour chart check process will include checking each resident medical record for new physician orders from the admission and previous day to verify transcription of new orders to the Medication Administration Record(MAR), Treatment Administration Record(TAR) or the Lab Tracking Log as applicable. Newly hired Licensed Nurses will be educated during their orientation period on obtaining orders for labs and tracking lab results for proper follow-up, obtaining and processing lab specimens . Consultant Pharmacist will review Digoxin levels during monthly visits.</p> <p>3) Systematic Change: Night shift Licensed Nurses will perform a twenty-four (24) hour chart check process which will include checking each resident medical record for new physician orders from the admission and previous day to verify transcription of new orders to the Medication Administration Record (MAR), Treatment Administration Record (TAR) or the Lab Tracking Log as applicable .A twenty-four (24) hour report form will be utilized during shift change report for communication to oncoming Licensed Nurse of pending lab orders and required follow-up as applicable .A lab tracking log will be utilized during clinical rounds by the Director of Nursing ,Unit Manager, Staff Development Coordinator, and Resident Care Specialist to monitor for proper follow-up on lab orders and specimens</p>		

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F 428	<p>Continued From page 22</p> <p>pharmacist to monitor medication interactions and lab collection since that was their area of expertise.</p> <p>At 4:39 PM on 04/09/15 Unit Manager #1 stated the hospital reported no record of a Digoxin level being drawn while Resident #118 was hospitalized, and confirmed that the resident was started on Digoxin and Amiodarone while in the hospital. She reported the consultant pharmacist was supposed to warn the facility about possible drug interactions and the need for lab monitoring.</p> <p>At 6:00 PM on 04/09/15 the facility provided a copy of a stat (at once) lab which documented Resident #118's Digoxin level was 1.2 nanograms per milliliter (ng/mL), with the reference range being 0.5 - 2.0 ng/mL.</p>	F 428	<p>obtained. Director of Nursing, Unit Manager or Staff Development Coordinator will audit ten(10) resident's medical record weekly for twelve (12) weeks to verify twenty-four (24)hour chart checks are completed and new physician orders are appropriately initiated. Director of Nursing, Unit Manager, Staff Development Coordinator, or Resident Care Specialist will audit the Lab Tracking Log daily (Monday-Friday) in Clinical Rounds for twelve (12) weeks to ensure follow-up of lab orders and specimens ordered by the Physician. Consultant Pharmacist was in-serviced on 4/23/15 on obtaining appropriate lab work per facility's policy. The results will be presented to the Quality Assurance and Performance Committee.</p> <p>4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits for proper obtaining of lab orders and follow up. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing, beyond the three (3) months period.</p>		