

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/24/2016
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNT REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 160 WINSTEAD AVENUE ROCKY MOUNT, NC 27804	
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F 252 SS=D	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide a clean interior for 1 of 5 bathrooms (shared bathroom for rooms 310 and 312) observed for cleanliness. Findings included: Review of the Nursing Notes revealed Resident #12 died in the facility on 06/04/16. On 08/23/16 at 6:28 AM the shared bathroom for rooms 310 and 312 was observed. There was a urinal with Resident #3's name and room number and a urinal with Resident #12's name and room number on the lid of the toilet tank. The urinal for Resident #12 contained used gauze. The lid to the toilet tank also held a meal card from the previous Friday dinner (08/19/16) for resident #3. There was one urinal on the floor next to the toilet with resident #12's name and room number which contained used gauze. There was a graduate (a container used to measure fluid output) stained cloudy on the floor next to the toilet with Resident #12's name and room number. In an interview on 08/23/16 at 6:32 AM Nursing Assistant (NA) #6 stated it was the responsibility of the NA not the housekeeper to remove used urinals and graduates from the bathroom when a resident was discharged or died. On 08/23/16 at 2:56 PM the condition of the shared bathroom for rooms 310 and 312</p>	F 252	<p>F-252</p> <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>Resident #3's bathroom was deep cleaned on 8/25/16 and any personal resident items were removed.</p> <p>2) Interventions for residents identified as having potential to be affected:</p> <p>All resident bathrooms were reviewed Housekeeping Department for cleanliness on 8/25/16. Any issues noted were addressed by housekeeping staff.</p>	9/14/16

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

TITLE

(X6) DATE

Electronically Signed

09/08/2016

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 252	Continued From page 1 remained unchanged. In an interview on 08/23/16 at 3:28 PM Nurse #9 stated the housekeepers were responsible for cleaning the bathrooms and disposing of any trash or used equipment that was no longer in use. On 08/24/16 at 9:16 AM the condition of the shared bathroom for rooms 310 and 312 remained unchanged. In an interview on 08/24/16 at 9:37 AM Housekeeper #1, who had worked on the 300 hall, stated if urinals or graduates were left in the bathroom of a resident who was no longer there the housekeeper would throw them away. In an interview on 08/24/16 at 10:10 AM the Housekeeping Manager stated that usually the nurses would empty out the bathroom of used equipment when a resident was discharged from the facility. He indicated if the nurses did not, then the housekeepers would dispose of any trash or equipment that was left. He indicated after a resident was discharged or died there should be no disposable equipment left in the bathroom that had been used by the resident. In an observation and continued interview on 08/24/16 at 10:20 AM the Housekeeping Manager was shown the connecting bathroom between rooms 310 and 312. He indicated he saw it as a problem that the dirty used equipment had not been discarded when Resident #12 died and that the meal tray card was still on top of the toilet lid. The Housekeeping Manager stated it was his expectation that the urinals and graduate for Resident #12 should have been thrown away when the resident died and the meal card also should have been thrown away. In an interview on 08/24/16 at 12:20 PM the Director of Nursing (DON) stated it was ultimately the responsibility of the Nursing Assistant to	F 252	3.) Systemic Change Housekeeping and nursing staff will be in-serviced by 9/14/16 on properly cleaning a room after a resident is discharged. Guardian Angels, which consist of our Department Leaders, will review resident bathrooms daily for one week then weekly for the next 3 months for compliance. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the Guardian Angel 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.		

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F 252	Continued From page 2 dispose of used urinal and graduates when a resident was discharged or died, however everyone should be checking. In an interview on 08/24/16 at 12:40 PM the Administrator stated not discarding used disposable equipment from the bathroom of a deceased resident was unacceptable.	F 252			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to thoroughly rinse the soap from residents' bodies after bathing for 2 of 2 sampled residents (Resident #6 and Resident #2). Findings included: 1. Resident #6's Quarterly Minimum Data Set (MDS) dated 08/08/16 revealed he was admitted to the facility on 03/22/16 with diagnoses of heart failure, hypertension and depression. Resident #6 was cognitively aware and was totally dependent on one person for bathing. In an observation of bathing on 08/23/16 at 10:40 AM Nursing Assistant (NA) #7 provided privacy for Resident #6. A basin of water was brought to the bedside. A washcloth was dipped in the clear water of the basin and provided to Resident #6 for facial cleansing. Soap was then added to the washcloth and Resident #6's upper body was	F 312	F-312 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. 1.) Interventions for affected resident: Resident #2 and Resident #6 were given bed baths on 8/25/16.	9/14/16	

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F 312	Continued From page 3 washed. The soapy washcloth was dipped several times into the basin and then the same washcloth was used to "rinse" the soap from Resident #6's upper body. NA #7 then patted Resident #6 upper body dry. A fresh basin of water was brought to the bedside. A liberal amount of soap was put on a fresh washcloth and placed in the basin. NA #7 proceeded to wash Resident #6's perineal area. The washcloth was then placed back into the visibly soapy water and dipped up and down several times. The perineal area was then "rinsed" with the soapy washcloth. The area was patted dry. Fresh water was brought to the bedside. Soap was applied to a fresh washcloth and placed into the basin of water. Resident #6 was rolled to the side and the back was washed. The washcloth was dipped up and down in the soapy water and used to "rinse" the soap from the back. Visible soap was still on the back when NA #7 patted the area dry with a towel. Fresh water was obtained and Resident #6's buttocks were washed with a clean washcloth after a liberal amount of soap was added. The washcloth was put into the basin of water with visible soap and dipped up and down several times. The washcloth was used to "rinse" the buttocks. Resident #6's buttocks were patted dry. Fresh water was put in the basin. Soap was applied to a clean washcloth and dipped in the basin. Resident #6 was assisted to his back and NA #7 washed his legs and feet. NA #7 proceeded to pat the legs and feet dry without attempting to rinse the soap from them. Immediately following the bath the directions on the shampoo and body wash provided for Resident #6's bath was reviewed. The directions revealed: "Apply to damp cloth or add small amount to basin of warm water. Cleanse patients face. Continue down the body. Rinse thoroughly.	F 312	2) Interventions for residents identified as having potential to be affected: This has the potential to affect all residents. 3.) Systemic Change No rinse soap will be used as part of our bathing process beginning 9/14/16. CNAs will be in-serviced by 9/14/16 on proper bed bath technique. Unit Managers will audit 10 bed baths a week for one week then 10 bed baths a month for 3 months for compliance. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the bed bath 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.		

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F 312	Continued From page 4 Pat dry." In an interview on 08/23/16 at 1:10 PM Resident #6 stated that his skin did get "itchy." He stated staff members used a special cream to help with the itching. In an interview on 08/23/16 at 2:46 PM NA #7 stated when a resident was bathed the soap should be rinsed off the body. She indicated she had become nervous and after the bath she realized she had not rinsed the soap from Resident #6's body. She indicated not rinsing the soap off the body could cause the skin to become dry or "itchy." She indicated Resident #6 had cream that she put on his skin which helped the itching. In an interview on 08/24/16 at 11:59 AM the Treatment Nurse stated not rinsing soap from a resident's skin could cause dry skin, itching, or irritation. In an interview on 08/24/16 at 12:20 PM the Director of Nursing (DON) stated it was her expectation that soap be thoroughly rinsed off the residents during their baths unless no-rinse soap was used. 2. Resident #2's Quarterly MDS dated 06/23/16 revealed he was admitted to the facility on 08/25/15 with diagnoses of anemia, asthma and chronic kidney disease. Resident #2 was moderately cognitively impaired and was totally dependent on one person for bathing. In an observation of bathing on 08/23/16 at 11:37 AM NA #8 provided privacy for Resident #2. A basin of warm water was brought to the bedside. A washcloth was dipped in the clear water and was used to cleanse Resident #2's face. Body wash was applied to the washcloth and the cloth was placed into the basin of water. Resident #2's upper body was washed. The washcloth was returned to the visibly soapy water and dipped up	F 312			

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F 312	Continued From page 5 and down several times. The washcloth was used to "rinse" the soap off the upper body. The upper body was patted dry. Resident #2 was rolled to the side and fresh water was obtained. Body wash was applied to a fresh washcloth and the cloth was dipped in the basin creating visibly soapy water. Resident #2's perineal area was cleansed. The washcloth was placed back into the soapy water and dipped several times and then used to "rinse" the perineal area. The area was patted dry. Fresh water was brought to the bedside. Body wash was applied to a fresh washcloth and placed into the basin of water. Resident #2's back was washed. The washcloth was then dipped into the visibly soapy water several times and used to "rinse" the back. The area was patted dry. Resident #2's buttocks were cleansed and "rinsed" with the soapy water. The buttocks were patted dry. Fresh water was brought to the bedside and body wash was applied to a clean washcloth. The washcloth was placed into the basin creating soapy water. Resident #2's legs and feet were washed and then patted dry. No attempt to rinse the legs and feet was noted. Immediately following the bath the directions on the bottle of body wash used to bathe Resident #2 were reviewed. The directions revealed: There were 3 pictures on the container depicting the use of the body wash. Picture #1 was of the body wash being squeezed out of the bottle. Picture #2 showed a shower head with what appeared to be water coming out onto a figure using the body wash to bathe. Picture #3 was of a bent arm with a ship on the bicep. There were no written directions although there was a toll-free telephone number provided for any questions regarding the product or its use. In an interview on 08/23/16 at 1:22 PM NA #8	F 312			

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

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F 312	Continued From page 6 stated Resident #2's family provided the body wash that was used during the bath. She indicated when a resident was bathed the aide should rinse with clear water and not re-use the soapy water that was in the basin. She stated there should be no suds in rinse water. NA #8 indicated she had used soapy water and not clear water to rinse Resident #2. In an interview on 08/24/16 at 11:59 AM the Treatment Nurse stated not rinsing soap from a resident's skin could cause dry skin, itching, or irritation. In an interview on 08/24/16 at 12:20 PM the DON stated it was her expectation that soap be thoroughly rinsed off the residents during their baths unless no-rinse soap was used. She indicated if there were picture directions and not written directions, and there were questions about the use, she expected the aide to ask the nurse or to call the provided toll-free number.	F 312			