STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to correctly code	F 278	F278 483.20(G)-(j) ASSESSMENT	3/3/17

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

Electronically Signed | 02/14/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 the Minimum Data Set (MDS) for 3 of 7 residents (Residents #2, 44 and 112) reviewed for level II Preadmission Screening and Resident Review (PASRR), for 1 of 2 residents (Resident #67) reviewed for vision and for 1 of 1 resident (Resident #4) reviewed for falls. The findings included: 1) Resident #2 was readmitted to the facility on 8/21/15 with diagnoses which included major depressive disorder, psychosis and delusional disorder. A review of the North Carolina Division of Medical Assistance Form dated 12/17/15 revealed Resident #2 had a PASRR number which ended with the letter B. There was no expiration date. A review section A of the annual Minimum Data Set (MDS) dated 7/8/16 indicated he did not have a level II PASRR. A review of the Care Plan dated 11/18/16 revealed the resident had a "problematic manner in which he acts characterized by ineffective coping; paranoid/delusional/hallucinations and suspicious behavior related to psychiatric illness and delusional disorder". The interventions included to reassure resident he was safe and staff were always present. On 1/26/17 at 8:40 AM Admissions Coordinator #1 stated she obtained the PASRR information and gave the information to medical records to scan into the electronic medical record. On 1/26/17 at 8:54 AM Medical Records Staff #1 stated she obtained the admission paperwork including the PASRR form and scanned it into the electronic medical record. She stated the PASRR continued to be the same unless there was a change in the resident's level of care. On 1/26/17 at 9:30 AM MDS Nurse #2 stated she was responsible for the MDS coding information including section A. She stated she looked at the	F 278	ACCURACY/COORDINATION/CERTIFIED Resident #2, #44 and #112 MDS was modified on 1/27/17 to reflect accurate coding of level II Preadmission screening and Resident review (PASRR) by the MDS nurses. Resident #67 MDS was modified on 2/8/17 to reflect accurate coding of vision by the MDS nurses. Resident #4 MDS was modified on 2/2/17 to reflect accurate coding of falls by the MDS nurse. 100% audit of all current resident most current MDS will be reviewed, to include residents #2, #44, #112, #67 and #4 by the ADON, DON, QI Nurse, and Nurse Consultant to ensure all MDS's completed are coded accurately to include all PASRR level II, vision and falls was completed on 2/14/17 using a resident census. Modifications will be completed by the MDS nurses during the audit for any identified area of concern with the oversite from the DON. 100% in-service of the MDS nurses regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately to include all PASRR level II, Vision and Falls are coded correctly on the MDS was completed on 2/13/17 by the DON. 10% of completed MDS's, to include resident's #2, #44, #112 and #4, will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 Admission form to obtain the PASRR number. She added if the PASRR number ended with the letter B it meant it was a PASRR level II. She reported the information for PASRR must be answered on the admission and annual MDS and she should have looked at it closer as she was responsible to make sure it was accurate. She stated the PASRR information for Resident #2 was inaccurate. On 1/26/17 at 12:24 the Administrator stated she expected the MDS to be coded accurately. 2) Resident #44 was admitted to the facility on 2/10/2009 with diagnoses which included cerebral palsy, bipolar disorder, psychosis and intellectual disabilities. A review of the NC Division of Medical Assistance Form revealed a PASRR# dated 2/13/09 and that Resident #44's PASRR number ended with the letter B. A review section A of the annual Minimum Data Set (MDS) dated 11/9/16 revealed she did not have a level II PASRR. On 1/26/17 at 8:40 AM Admissions Coordinator #1 stated she obtained the PASRR information and gave the information to medical records to scan into the electronic medical record. On 1/26/17 at 8:4 AM Medical Records Staff #1 stated she obtained the admission paperwork including the PASRR form and scanned it into the electronic medical record. She stated the PASRR continued to be the same unless there was a change in the resident's level of care. On 1/26/17 at 9:30 AM MDS nurse #2 stated she was responsible for the MDS coding information including section A. She stated she looked at the Admission form to obtain the PASRR number. She added if the PASRR number ended with the letter B it meant it was a PASRR level II. She reported the information for PASRR must be	F 278	reviewed to ensure accurate coding of the MDS to include PASRR level II, Vision and Falls by the ADON 3 X's a week X's 4 weeks, then weekly X's 4 weeks and then monthly X's 1 utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the DON by retraining the MDS nurse and completing necessary modification to the MDS. The DON will review and initial the MDS Accuracy QI tool weekly X's 8 weeks and then monthly X's 1 to ensure any areas of concerns have been addressed. The Executive QI committee will meet monthly and review audits of MDS Accuracy tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 3	F 278		

answered on the admission and annual MDS and she should have looked at it closer as she was responsible to make sure it was accurate. She stated the PASRR information for Resident #44 was inaccurate.
On 1/26/17 at 12:24 the Administrator stated she expected the MDS to be coded accurately.
3) Resident # 112 was readmitted to the facility on 11/30/16 with diagnoses which included adult failure to thrive, anxiety disorder, bipolar disorder, major depressive disorder, post-traumatic stress disorder and dementia.
A review of the NC Division of Medical Assistance Form dated 2/9/16 revealed Resident #112's PASRR number ended with the letter B.
A review of section A of the admission Minimum Data Set (MDS) dated 12/7/16 revealed she did not have a level II PASRR.
On 1/26/17 at 8:40 AM Admissions Coordinator #1 stated she obtained the PASRR information and gave the information to medical records to scan into the electronic medical record.
On 1/26/17 at 8:4 AM Medical Records Staff #1 stated she obtained the admission paperwork including the PASRR form and scanned it into the electronic medical record. She stated the PASRR continued to be the same unless there was a change in the resident's level of care.
On 1/26/17 at 9:30 AM MDS Nurse #2 stated she was responsible for the MDS coding information including section A. She stated she looked at the Admission form to obtain the PASRR number. She added if the PASRR number ended with the letter B it meant it was a PASRR level II. She reported the information for PASRR must be answered on the admission and annual MDS and she should have looked at it closer as she was responsible to make sure it was accurate. She stated the PASRR information for Resident #112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 4	F 278		

was inaccurate.
On 1/26/17 at 12:24 the Administrator stated she expected the MDS to be coded accurately.

4) Resident #67 was admitted to the facility on 8/8/11 with diagnoses which included hypertension, diabetes mellitus, hyperlipidemia, anxiety disorder, and depression.
Review of an in house eye exam consult dated 3/14/16 revealed the resident was seen by an eye doctor. The resident was documented as having stated his eyes did not bother him and he used his glasses when he needed them.
Review of Resident #67's most recent Minimum Data Set (MDS) dated 11/8/16, coded as a quarterly assessment, revealed the resident was assessed as cognitively intact. Resident #67's vision was assessed to be impaired and corrective lenses were not used for the vision assessment.
During an interview on 1/25/17 at 10:10 AM Resident #67 stated he had glasses and used them for reading the newspaper. Resident #67 stated he was happy with his glasses and had no problems with his vision.
During an interview on 1/25/17 at 4:12 PM Nurse #1 stated Resident #67 read the newspaper when he wanted to and used his glasses in order to read the newspaper.
During an observation on 1/25/17 at 4:31 PM Resident #67 was observed playing cards in the dining room without glasses.
During an interview on 1/25/17 at 4:33 PM Resident #67 stated he could see the cards without his glasses. He further stated he only needed glasses for reading.
During observation on 1/26/17 at 8:30 AM Resident #67 read standard newspaper print while wearing his glasses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5	F 278		

During an interview on 1/26/17 at 8:35 AM MDS Nurse #1 and MDS Nurse #2 stated they took a piece of paper with large and small print and used it to assess residents' vision. They further stated that when a resident had corrective lenses, the resident used the corrective lenses during the vision assessment. MDS Nurse #1 stated she did not have Resident #67 wear his glasses when she performed the assessment for the MDS 11/8/16. She stated she did not remember the reason she did not have Resident #67 use corrective lenses during the assessment on 11/8/16.
During an interview on 1/26/17 at 8:47 AM the Director of Nursing stated she believed the MDS assessments for vision were performed with glasses if the resident had glasses. She stated that to her knowledge, Resident #67 did not have any issues with vision and was able to see well when wearing glasses. She further stated that Resident #67 had glasses for a long time and it should have been reflected in the MDS assessment on 11/8/17.

5. Resident #4 was admitted to the facility on 5/9/16 with diagnoses that included acute and chronic respiratory failure, chronic obstructive pulmonary disease, diabetes, hypertension and congestive heart failure.

Quality Improvement for falls notes written on 7/11/16 at 4:46 PM by the Director of Nursing (DON), indicated on 7/1/16 at 10:48 AM, Resident #4 had been involved in an assisted fall.

The 8/15/16 quarterly Minimum Data Set (MDS) indicated the resident was cognitively intact with no behaviors. Resident #4 required extensive assistance for bed mobility and transfer. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 resident was not identified as having a fall since the previous assessment. The MDS Coordinator was interviewed on 1/26/17 at 9:46 AM. She stated falls were defined as any change in height and included an assisted fall. The MDS Coordinator added any assisted fall would be captured on the MDS. She added that when completing the fall section of the MDS she would review incident reports, quality improvement notes and nurse' s noted to see if any fall had occurred from the end of one assessment through the assessment period for the next MDS. The MDS nurse then read the 7/11/16 quality improvement note and reviewed the 8/15/16 MDS and acknowledged Resident #4' s fall had not been captured and therefore, the MDS was not accurate. Resident #4 had been discharged from the facility and was not available for interview.	F 278		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309		3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and Resident #1's physician and record review, the facility failed to stop a treatment and assess exhibited signs and symptoms of pain for 1 of 3 sampled residents (Resident #1) whose wound treatment was observed. Findings included: Resident #1 was most recently readmitted to the facility on 6/8/11 with diagnoses that included hypertension, protein calorie malnutrition, contractures, dementia and diabetes. Review of a Wound Ulcer Flow-Sheet dated 11/14/16 indicated a suspected deep tissue injury measuring 1.5 centimeters (cms) by 1 cm was found on the resident's sacrum. The pressure ulcer was assessed and a treatment started. On 11/21/17, the nurse documented on the Wound Ulcer Flow-Sheet, that Resident #1 had experienced pain during the dressing change to the pressure ulcer. Tylenol was given and the nurse added the Tylenol had been effective in relieving the resident's pain.	F 309	F309 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHESTWELL BEING Resident #1 was assessed for pain to include the time period during wound care treatments by the Treatment Nurse on 1/25/2017. The physician was notified of resident #1'□s complaint of pain during treatment on 1/25/2017 by the Treatment Nurse. A new order for pain medication was received on 1/25/2017 to administer pain medication every morning. 100% of all residents, to include Resident #1, were assessed for pain to include residents that received wound care treatments by the Assistant Director of Nursing, Hall Nurse on 02/13/2017. 100% of all residents, to include resident #1, progress notes and flow sheets for all resident receiving dressing changes starting 1/26/2017 to 2/10/2017 were reviewed by corporate nurse consultants for documentation of signs and symptoms	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 The 12/5/16 Wound Ulcer Flow-Sheet, completed by a nurse, indicated the pressure ulcer was tender with dressing changes. The 1/9/17 Annual Minimum Data Set (MDS) indicated Resident #1 had short and long term memory impairment with severely impaired cognitive skills for daily decision making. His speech was assessed as unclear and rarely understood. Resident #1 was identified as requiring extensive to total assistance with all activities of daily living. His sacral pressure ulcer was coded as a Stage III. The MDS indicated the Resident #1 received both scheduled and as needed pain medication during the assessment period. The MDS included a staff assessment of Resident #1's pain which indicated the resident's pain was identified through non-verbal sounds such as crying, whining, gasping, moaning or groaning and facial expressions such as grimaces and winches. There was no identification of protective body movements or postures suggestive of hitting. Review of the care plan, initiated on 1/5/17 and most recently reviewed on 1/17/17 indicated the resident had pain due to his sacral pressure ulcer. Resident #1's goal was to be pain free through the next review date using the following interventions: acknowledge the presence of pain and discomfort, administer pain medication as needed and ordered, anticipate the resident's need for pain relief and respond appropriately and document and report complaints and non-verbal signs of pain. A pain assessment, completed on 1/9/17, by a facility nurse indicated the resident was unable to report pain due to being non-verbal. The resident	F 309	of pain completed on 2/10/2017. All residents identified with having signs and symptoms of pain, Medication Administration Records (MARs) were reviewed to ensure prescribed pain medications were being administered per physician□s order by corporate nurse consultant on 2/10/17. No areas of concern were identified. The Treatment nurse was inserviced on 1/26/2017 by the DON regarding pain assessments and pain management to include when residents are having signs and symptoms of pain prior to and during dressing changes, immediately stopping the dressing change if the resident appears to be in pain, providing pain meds as ordered and notifying the MD with new or ineffective pain management. An in-service was initiated on 1/26/2017 by the Staff Facilitator, with all licensed nursing staff, to include the treatment nurse regarding pain assessments and pain management to include when residents are having signs and symptoms of pain such as grimacing, verbalization, flinching and other bodily movements that would indicate pain to include during dressing changes. This education will include assessing the resident for pain prior to and during dressing changes, immediately stopping the dressing change if the resident appears to be in pain, providing pain meds as ordered and notifying the MD with new or ineffective pain management by the hall nurse. The in-services will be completed by 01/26/2017. All newly hired licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9 was described as having occasional moan and groan, low level speech with a negative or disapproving quality, sad, frightened, and frowning facial expression, tense, fidgeting body language, but since the resident was non-verbal there was no need to console. A pressure ulcer treatment was observed on 1/25/17 at 9:40 AM. The resident was lying quietly in bed. Nursing Assistant (NA) #1 removed the wedges from underneath the resident and positioned him on his right side. Resident #1 had no moans, groans or other indications of pain during the removal of the wedges and the positioning on his right side. When the treatment nurse removed the outer dressing, Resident #1 yelled and continued to moan and groan until the removal had been completed. When the dressing removal had been completed, Resident #1 was observed to lie quietly without signs and symptoms of pain. When the treatment nurse starting cleaning the pressure ulcer, Resident #1 again began to moan and groan and yell. The surveyor intervened and asked if the resident had been pre-medicated prior to the treatment. The treatment nurse answered, "No" and continued the treatment. After cleaning the wound had been completed, the resident lay quietly until the treatment nurse started packing the wound. Again, the resident moaned, groaned and yelled out. When the nurse completed the treatment, Resident #1 again lay quietly without signs and symptoms of pain. Review of the January Medication Administration Record (MAR) after the completion of the treatment, revealed Resident #1 had received his scheduled dose of Tylenol 650 milligrams on	F 309	nurses will be inserviced regarding pain assessments and pain management to include when residents are having signs and symptoms of pain such as grimacing, verbalization, flinching and other bodily movements that would indicate pain to include during dressing changes during orientation by the Staff Facilitator. This education will include assessing the resident for pain prior to and during dressing changes, immediately stopping the dressing change if the resident appears to be in pain, providing pain meds as ordered and notifying the MD with new or ineffective pain management by the hall nurse. All residents, to include resident #1, will be assessed for pain on admission and with any changes by the hall nurse and quarterly, by the Minimum Date Set (MDS) nurses utilizing the pain assessment and/or MDS assessment form. The physician will be notified of all residents identified with having new or ineffective pain management by the hall nurse. All residents receiving dressing changes will be assessed for pain by the treatment nurses prior to the dressing changes. If any resident is identified as having signs and symptoms of pain prior to the dressing change the treatment nurse will notify the hall nurse and the hall will administer prescribed pain medication. If no pain medication is prescribed the hall nurse will notify the MD. If a resident has pain during a dressing change the treatment nurse will immediately stop the dressing change,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 1/25/17 during the 8:00 AM medication pass. At 9:55 AM on 1/25/17, the treatment nurse documented in progress notes that during wound care, a noted area of white at the center of the wound appeared to be a bone sheath. She noted the resident had received Tylenol per schedule at 8:00 AM. The treatment nurse also documented that during wound care, Resident #1 yelled when the wet saline gauze touched his skin and when the moist packing was inserted into the wound bed. She added there had been no signs of discomfort when the wound care was completed. The nurse documented she notified the physician about the change in the wound's appearance (observation of bone), requested a change in treatment and requested a change in pain medication. NA #1 was interviewed on 1/25/17 at 12:06 PM. She stated at times, when she assisted with wound care, the resident yelled out during treatment; adding during the treatment this morning, Resident #1 seemed to be in pain as he yelled, moaned and groaned when the dressing was removed, when the wound was cleaned and packed, but had not yelled or struck out at her when she turned and positioned the resident. The NA also stated the resident's moans and groans had ended when the treatment ended. On 1/25/17 at 3:50 PM, the treatment nurse (TN) was interviewed. She stated the resident received regularly scheduled Tylenol each morning during the 8:00 AM medication pass. She stated she had been taught to stop treatments if a resident was uncomfortable. The treatment nurse stated when Resident #1 was in pain, he became aggressive. Since he had not	F 309	assess the residents pain, and notify the hall nurse. The hall nurse will administer prescribed pain medication. If no pain medication is prescribed, the hall nurse will notify the MD. 10% of all resident□s pain assessments for newly admitted residents and current residents Quarterly MDS assessments, Medication administration records, and electronic pain logs will be reviewed by the Assistant Director of Nursing, 3X□s per week x 4 weeks, weekly x 4 weeks the monthly x 1 months for completion of the assessment and to ensure that all residents identified with signs and symptoms of pain has been assessed, prescribed pain medications have been administered per MD order, and physician have been notified of new or ineffective pain management utilizing a Pain Management QI tool. The ADON and/or Staff Facilitator will observe dressing changes on 10% of residents with dressing changes 3 x□s a week X 4 weeks then weekly for 4 weeks then monthly X 1 month to ensure If any resident are identified as having signs and symptoms of pain prior to the dressing change the hall nurse will administer prescribed pain medication utilizing the Treatment Pain Management QI tool. If any resident is identified as having signs and symptoms of pain prior to the dressing change the treatment nurse will notify the hall and the hall nurse will administer prescribed pain medication. If no pain medication is prescribed the hall nurse will notify the MD. If a resident has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 hit at her this morning, she had not thought he was in pain. The treatment nurse acknowledged the resident only yelled when she touched him, but thought that was due to the products used to clean the wound being cold. She stated she had not asked the resident if he was in pain or requested pre-medication prior to the dressing change. The Director of Nursing (DON) was interviewed on 1/26/17 at 11:20 AM. The DON stated she expected nurses to stop treatments and try to figure out what was causing residents to yell during treatment. She acknowledged he had received Tylenol during the 8:00 AM medication pass, but since he yelled each time the treatment nurse touched the pressure ulcer, she had not considered the Tylenol effective for Resident #1's pain. The DON added she would have expected the nurse to assess the root cause of the resident's pain. If a symptom of pain for Resident #1 was hitting, she would have expected to find that on the care plan. The DON stated pain assessments were completed on admission and quarterly, but were not routinely completed for residents on pain medication. A telephone interview with Resident #1's primary care physician (PCP) was held on 1/26/17 at 2:00 PM. The PCP stated he would have expected the nurse to stop the treatment for any signs and symptoms of pain, assess the reason for the pain and call so he could change the pain medication schedule so Resident #1 received pain medication prior to dressing changes. The PCP stated Resident #1's wound had improved since the dead tissue had been removed about a month ago, which probably made the resident more sensitive to pain, resulting in the need for better	F 309	pain during a dressing change the treatment nurse will immediately stop the dressing change, assess the residents pain and notify the hall nurse. The hall nurse will administer prescribed pain medication. If no pain medication is prescribed the hall nurse will notify the MD. The DON will review and initial the Pain Management QI tool and the Treatment Pain Management QI tool weekly X□s 8 week and then monthly X□s 1 month for completion and to ensure any areas of concern have been addressed. The Executive QI committee will meet monthly and review audits of Pain Management QI tool and Treatment Pain Management QI tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 pain control.	F 309		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to keep the medication cart locked for 2 of 4 medication carts (A hall medication cart and C hall medication cart) observed to be unlocked with no staff within visual observation of the carts. The facility's undated policy titled, "Medication Storage" listed under Paragraph D that the medication cart shall be locked at all times when not under the direct physical supervision of a licensed nurse. On 1/25/17 at 11:40 AM the medication cart for the A hall was observed to be unlocked and unattended. There were no staff members observed near the cart. The cart was sitting on the left side of room 103. The door to room 103 was closed. On 1/25/17 at 11:43 AM Nurse #3 was observed to exit room 103 and go to the cart. She stated she had left the medication cart unlocked. During an interview on 1/25/17 at 2:16 PM with	F 431	F431 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS Nurse #2 and #3 were inserviced re: locking medication cart at all times when left unattended on 01/27/2017 by the Staff Facilitator. 100% audit was completed on 2/9/17 to ensure all medication carts were locked when left unattended by the licensed nurse by the DON. No areas of concern were noted at that time. 100% inservice to all licensed nurses to include nurse #2 and #3 on locking the medication cart when unattended completed on 01/27/2017 by Staff Facilitator. All newly hired licensed nurses will be in-serviced on locking the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 Nurse #3 she stated she left the medication cart unlocked and unattended. She stated she was aware she should not leave the medication cart unlocked. On 1/26/17 at 12:25 PM the Director of Nursing (DON) stated it was facility policy to keep the medication carts locked when the nurse was not with them or with in the nurses visual field. She added the danger was the unlocked carts would give visitors and residents access to the medications in the cart. 2. The facility's undated policy, titled, "Medication Storage" ,listed under Paragraph D that the medication cart shall be locked at all times when not under the direct physical supervision of a licensed nurse. On 1/23/17 at 6:20 PM, during the initial tour of the facility, the medication cart for the C hall was seen with the lock mechanism in an out position indicating medications had not been secured within the cart. The nurse was in a room close by, but not was not within view of the cart and was unable to visualize the medication cart from her position. At 6:30 PM, Nurse #2 returned to the medication cart and was interviewed. She confirmed she had left the medication cart unlocked and out of her view while she was in a resident's room. Nurse #2 added she had meant to stay in the hall where she could see the medication cart, but had gone in the room where she could not see the cart. The Director of Nursing (DON) was interviewed on 1/26/17 at 12:25 PM. The DON stated facility policy required that medication carts should be locked when the nurse was unable to keep the	F 431	Medication Cart while unattended will be completed upon orientation by the Staff Facilitator. Medication Carts will be monitored using a Medication Cart Security QI Tool to ensure all medication carts are locked when left unattended, to include cart utilized by nurse #2 and #3 by the Administrator, Administrative Nurses to include nights and week-ends, 3 times a week X's 4 weeks, then weekly X's 4 weeks then monthly X's 1 month. The licensed nurse will be immediately re-trained by the Staff Facilitator for any identified areas of concern. The DON will review and initial the Medication Cart Security tool for completion and to ensure all areas of concerns were addressed weekly X's 8 weeks and monthly X's 1 month. The Executive QI committee will meet to review the Medication Cart Security tool monthly X's 3 months to determine issues and trend to include continued monitoring frequency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 medication cart within her visual field. She added there was explanation or excuse for the medication cart not to be locked. The DON added an unlocked medication cart gave both residents, staff and visitors access to the medications stored in the cart.	F 431		