STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345195	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGECOMBE HEALTH AND REHAB CENTER	1000 WESTERN BOULEVARD TARBORO, NC 27886

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E 000	Initial Comments An unannounced Recertification survey was conducted on 7/8/2019 through 7/11/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # HNUF11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation survey was conducted 7/8/2019 through 7/11/2019. Twelve allegations were unsubstantiated Event ID # HNUF11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) level determination for 1 of 4 residents reviewed for Pre-Admission Screening and Annual Resident Review (PASARR) (Resident #92). The findings included: Resident #92 was admitted to the facility on 7/22/05 with diagnoses that included anxiety disorder and dementia. A review of a social work progress note dated 5/23/19 revealed Resident #92 was assessed as PASARR level II by the state with a severe mental illness.	F 641	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth offact alleged or the 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." Resident # 92 MDS with ARD of 6/25/19 Section A1510 was not coded to reflect the Severe Mental illness. A modification was completed on Resident #92 MDS with ARD of 6/25/19 on Section A1510 by the MDS coordinator on July 10, 2019. The Director of Care management	8/7/19

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

Electronically Signed | 07/30/2019

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F 641	Continued From page 1 A review of Resident #92 ' s MDS assessment dated 5/25/19, which was a significant change assessment, revealed Resident #92 was coded in Section A, question A1510 as not having a severe mental illness. During an interview with MDS Nurse #1 on 7/10/19 at 4:37 PM she stated the assessment was incorrectly coded and Resident #92 was assessed by the state as having a severe mental illness. She stated she would make the correction. An interview was conducted 7/11/19 at 9:46 AM with the Facility Nurse Consultant. She stated the facility had identified coding inaccuracies on MDS assessments as a problem and the inaccuracy should have been caught prior to transmittal of the assessment.	F 641	provided in-servicing to the MDS Coordinators, the Director of Nursing and the Administrator on accurate coding requirements for Section A 1510 on July 15th, 2019. An audit was completed on 7/30/19 by the Director of care management on all Comprehensive assessments completed in the last 30 days to ensure that Section A1510 was coded accurately for residents with Severe Mental illness. Any accuracy issues were immediately corrected. The Director of Care management will utilize a monitoring tool to audit all residents with a Mental illness have accurate coding on Section A1510 weekly x 4 weeks, and then monthly x 2 months. The findings will be reviewed and revised if indicated at QAPI for three months. The Director of Care management is responsible for implementing the plan of correction by August 7th, 2019.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		8/7/19

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F 690	Continued From page 2 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to keep a urinary catheter bag from coming in contact with the floor for 1 of 2 residents reviewed for catheter care. (Resident #31) Findings included: Resident #31 was admitted to the facility on 10/18/16. His active diagnoses included obstructive uropathy. Review of Resident #31's minimum data set	F 690	Resident #31 foley catheter was noted on the floor by the surveyor. When the surveyor alerted the Director of Nursing (DON) on 7/9/19 that the residents catheter bag was in contact with the floor the bag was placed where it would not touch the floor. The Assistant Director of nursing conducted an audit on 7/9/19 and noted there were no other catheter bags touching the floor.	

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F 690	Continued From page 3 assessment dated 4/16/19 revealed he was assessed as moderately cognitively impaired. He had no moods or behaviors and was assessed to have an indwelling catheter. Review of Resident #31's care plan dated 5/9/19 revealed the resident was care planned for having an indwelling catheter. The interventions included to position the catheter bag and tubing below the level of the bladder, anchor the tubing to prevent tension, and provide a privacy bag. During observation on 7/8/19 at 11:09 AM Resident #31 was observed in bed. The catheter bag was observed to be attached to the bed frame and the bottom of the catheter bag was in contact with the floor. During observation on 7/8/19 at 4:16 PM Resident #31 was observed in bed. His catheter bag was observed to be laying flat on the floor and was not attached to the bed frame. During observation on 7/9/19 at 8:00 AM Resident #31 was observed in bed. His catheter bag was observed to be attached to the bed frame and the bottom fourth of the catheter bag was resting on the floor. During an interview on 7/9/19 at 8:07 AM Certified Medication Aide #1 stated catheter bags were to never touch the floor. Upon observing Resident #31's catheter bag he stated it was touching the floor and it should not be touching floor. During an interview on 7/09/19 at 8:10 AM the Director of Nursing stated catheter bags were never to come in contact with the floor. Upon observing Resident #31's catheter bag she stated	F 690	Current Licensed nurses and Nursing assistants were in-serviced by the Director of clinical education on proper positioning of an indwelling catheter bag. This education will be completed by 8/7/19. This education will be part of orientation for newly hired nursing staff. The Unit Managers or the Assistant Director of nursing will audit each resident with an indwelling catheter to validate correct positioning of the Foley catheter bag 3x weekly for a month, and then 2 times monthly for two months. The findings will be reviewed and revised if indicated at QAPI for 3 months. The Director of Nursing is responsible for implementing the plan of correction by 8/7/19.	

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F 690	Continued From page 4 the catheter bag touched the floor and should not. She concluded she would get the issue corrected immediately.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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 observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 3 medication carts observed. (800 Hall Medication Cart)	F 761	When the surveyor alerted the medication nurse of the observation of the unlocked cart on 7/11/19, the medication nurse immediately locked the medication cart. The medication nurse involved was	8/7/19

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F 761	Continued From page 5 Findings included: During observation on 7/11/19 at 10:44 AM the 800 hall medication cart was observed unlocked and unattended approximately three feet from the entrance to a room. The door to the room was open but the curtain was drawn around the resident in the A bed. The middle drawer to the medication cart was observed to be slightly open. The Administrator and a family member were observed at the nurse's station approximately 24 feet away. At 10:46 AM Nurse #1 returned to her medication cart from behind the curtain in the resident's room. During the two minutes of observation the nurse was not in view of the medication cart as she was behind the curtain until she returned to the cart. During an interview on 7/11/19 at 10:46 AM Nurse #1 stated she left the cart unlocked because she left the door open to the room. She further stated she was unable to see the cart while she was in the room for a second behind the curtain, but she left it unlocked because the door was open. During an interview on 7/11/19 at 10:56 AM the Director of Nursing stated if the medication cart was not in view of Nurse #1 she should have locked the cart and pulled it up to the doorway.	F 761	provided 1:1 education on the expectations to supervise an unlocked cart at all times on 7/11/19 by the Director of Nursing. The Assistant Director of Nursing conducted an audit of all the other medication carts on 7/11/19 and no other carts were noted unsupervised. The Director of Clinical education provided in-services to the current licensed nurses on the expectations related to ensuring an unlocked medication cart is supervised at all time. This education will be completed by August 7th, 2019. This will be part of orientation for newly hired licensed nurses. The Unit managers or Assistant Director of nursing will do random audits of medication carts to inspect for supervision of any unlocked medication cart 5 x weekly for one month and then 2 x weekly for two months. The findings will be reviewed and revised if indicated at QAPI for 3 months. The Director of Nursing is responsible for implementing this plan of correction by August 7th, 2019.	