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

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 ______	C 11/07/2019

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

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E 000	Initial Comments An unannounced Recertification Survey was conducted on 11/4/19 through 11/7/19. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID TRU911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted on 11/4/19 through 11/7/19. Event ID: TRU911. 0 of the 18 complaint allegations were substanitated. The Statement of Deficiencies was amended on 11/27/19 at tag F842.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow physician ' s orders to repeat a laboratory test for 1 of 5 residents reviewed for unnecessary medications (Resident #4). The findings included: Resident #4 was admitted to the facility on 8/8/11 and had diagnoses that included peptic ulcer and gastro-intestinal bleeding. Review of the physician ' s orders revealed an order dated 10/24/19 for Nu-Iron 150 milligrams daily for anemia. Repeat CBC (complete blood	F 658	Chowan River Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that this Summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Chowan River Nursing & Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the	11/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/24/2019

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 658 Continued From page 1
count) in one week.

Review of a nursing progress note for Resident #4 revealed an entry dated 10/24/19 that noted the physician was notified of a hemoglobin of 7.3 (low) and new orders were received to start Nu-Iron and repeat a complete blood count (CBC) in one week. Review of the clinical record failed to reveal the results for the repeat CBC.

An interview was conducted with the Director of Nursing (DON) on 11/6/19 at 11:05 AM. The DON stated the repeat CBC ordered on 10/24/19 had been written in the lab book to be drawn on 10/31/19 but had not been done and would draw the lab test right away. The DON further stated the nurse on the night shift was supposed to look at the lab book to see what labs needed to be drawn prior to the end of the shift and if unable to draw the blood the nurse would tell the nurse on the day shift and that nurse would draw the blood. The DON continued and stated sometimes the night shift nurse would just draw the labs that required the resident to be fasting on night shift and the nurse on the day shift would draw the other labs. The DON stated that Nurse #1 worked the 11 PM to 7 AM shift on 10/30-31/19.

An interview was conducted with Nurse #1 on 11/6/19 at 4:50 PM. Nurse #1 stated she did not specifically recall what she did on the morning of October 31, 2019 but usually would draw the fasting labs and would tell the on-coming nurse what labs had been drawn.

The DON stated in an interview on 11/6/19 at 4:58 PM that prior to 10/31/19 the unit manager had quit suddenly and on the morning of 10/31/19 the day shift nurse called to say she would be late

F 658

Statements of Deficiencies nor does it constitute an admission that nay deficiency is accurate. Further, Chowan River Nursing & Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F658

Resident # 4□s lab was obtained on 11/6/19 by the Hall Nurse.

On 11/7/19 a 100% audit of all Physician orders to include Discharge Summaries for labs and medication orders within past 30 days to include Resident #4 was initiated by Director of Nursing (DON), Assistant Director of Nursing/Quality Improvement Nurse and Staff Facilitator utilizing a Resident Census. Audit was completed on 11/22/19.The DON immediately addressed any areas of concern during the audit to include re-education.

On 11/7/19 a 100% in-service was initiated by Director of Nursing for all Nurses regarding following Physician orders, Chart Checks, Stat Orders and Admissions orders. In-service will be completed by Director of Nursing by 11/24/19. All newly hired Licensed Nurses will be in-services regarding following Physician orders Chart Checks and

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F 658	Continued From page 2 and then did not come in at all so a medication aide passed medications and the treatment nurse was the resource person for the medication aide and the treatment nurse did not draw labs and the repeat CBC was missed. On 11/7/19 at 1:18 PM an interview was conducted with the Director of Nursing and the Administrator. The DON stated it was her expectation for labs to be drawn per physician ' s order. The Administrator stated she had already started a performance improvement plan for the missed lab.	F 658	Admission orders during orientation by the Director of Nursing. 10 % of all physician orders to include resident # 4 will be audited by the hall Nurses on 11-7 to ensure all physician orders are followed to include labs utilizing the Physician Order Audit Tool weekly for 8 weeks and monthly for 1 month. The Director of Nursing will review and initial the Physician Order Audit Tool to ensure completion and that all areas of concerns were addressed weekly x 8 weeks then monthly x 1 month. The Administrator will present the findings of the Physician Order Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Physician Order Audit Tool to determine the need for any trends or further frequency of monitoring.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		11/26/19

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F 812	Continued From page 3 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean the steam table under shelf for one of one steam tables observed. The findings included: A review of the Dietary Policy Manual (Version Date 8-2013) under weekly Cleaning Assignments the second line reads as: "Clean and polish steam table." Review of the posted weekly Cleaning Schedule reads as: "the following equipment/area will be cleaned weekly by the assigned employee. Once you complete the assigned cleaning have it checked off by manager." The second page reads as: "Delime steamtable inside. Clean the entire steamtable." The steamtable Weekly Cleaning Schedule was last initialed as completed on October 20, 2019. During an observation on 11/6/19 at 11:57 PM the 6 well steam table was observed. The 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles. A second observation on 11/7/19 at 10:11 AM the 5 ½ foot underside of the steam table shelf was	F 812	F812 The dietary steam table and underneath the steam table was cleaned on 11/7/19 by Dietary Assistant. On 11/7/19 a 100% audit was initiated by the dietary assistant of all kitchen equipment to include steam table and underneath the steam table using a Cleaning Audit Tool. Audit will be completed by 11/24/19. The Dietary Manager Assistant will immediately clean any kitchen equipment with any areas of concern during the audit and Dietary Manager will address any areas of concern to include re-education. On 11/7/19 a 100% In-service was initiated by the Dietary Manager for Dietary Manager, all Dietary Aides, Cooks, and Dietary Manager Assistant regarding ensuring kitchen equipment is cleaned and kept in a sanitary condition and the policy, procedure and cleaning schedule for checking and cleaning kitchen equipment. In-service will be completed by 11/24/19. All newly hired dietary employees to include Dietary Managers,	

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F 812	Continued From page 4 observed to be covered with dark dried food particles. In an interview on 11/7/19 at 10:44 AM the Certified Dietary Manager stated the steam table was cleaned on a weekly basis. She stated the steam table would be cleaned immediately and the cleaning schedule updated to include the undershelf. In an interview on 11/7/19 at 1:02 PM the Administrator stated she would expect the kitchen staff to follow the cleaning schedule and it would be cleaned right away.	F 812	Dietary Assistants, Dietary aides and Dietary cooks will be in-serviced regarding ensuring kitchen equipment is cleaned and kept in a sanitary condition and the policy, procedure and cleaning schedule for checking and cleaning kitchen equipment during orientation by the Dietary Manager. The Dietary Cook will check the steam table and underneath the steam table for cleanliness utilizing a Steam Table Dietary Audit Tool weekly for 8 weeks then monthly for 1 month. The Dietary Manager will review and initial the Steam Table Dietary Audit Tool to ensure completion and that all areas of concerns were addressed weekly for 8 weeks and monthly for 1 month. The Administrator will present the findings of the Steam Table Dietary Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet monthly for 3 months and review the Steam Table Dietary Audit Tool determine the need for any trends or further frequency of monitoring.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		11/26/19

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F 842	Continued From page 5 agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained	F 842		

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F 842	Continued From page 6 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately document a medication for 1 of 5 residents reviewed for unnecessary medications (Resident #4). The findings included: Resident #4 was admitted to the facility on 8/8/11 and had a diagnosis of type 2 diabetes mellitus. Review of the physician ' s orders for Resident #4 revealed an order dated 5/8/17 for Glucotrol 5 milligrams (mg) 1 tablet by mouth every morning. Hold for finger stick blood sugar less than or equal to 145. Review of the Medication Administration Record (MAR) for October 2019 revealed documentation the Glucotrol 5mg was to be administered daily at 8:00 AM. The MAR contained initials that the 8:00	F 842	F842 F842 On 11/6/19 resident # 4 received Glucotrol per physician's orders to include parameters by the hall nurse. On 11/7/19 a 100% audit of Medication Administration Records (MARS) for the past 30 days to include Resident #4 was completed by Director of Nursing (DON), Assistant Director of Nursing/Quality Improvement Nurse, Treatment Nurse and Staff Facilitator utilizing Resident Census to ensure that all medications were given per physician orders to include parameters. The Director of Nursing will immediately address any areas of	

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F 842 Continued From page 7

AM dose of Glucotrol was administered on 10/25/19, 10/28/19 and 10/29/19. The fingerstick blood sugar was documented on 10/25/19 as being 138, 10/28/19 as 144, and 10/29/19 as 125 and contained the same initials for the three doses. Review of the MAR for November 2019 revealed documentation the Glucotrol 5mg was to be administered daily at 8:00 AM. The MAR contained initials that the 8:00 AM dose of Glucotrol was administered on 11/1/19, 11/4/19, 11/6/19. The fingerstick blood sugar was documented on 11/1/19 as being 143, 11/4/19 as 128 and on 11/6/19 as 138 and all the entries contained the same initials as the entries listed above on the October MAR. The Director of Nursing identified the initials as those of Nurse #2.

On 11/6/19 at 11:02 AM an interview was conducted with Nurse #2. The Nurse stated she did not give the Glucotrol this AM due to the parameters listed by the physician and forgot to circle her initials. The Nurse was observed to review the MARs and stated due to the parameters ordered by the physician she would not have given the Glucotrol for the other days the blood sugar was less than or equal to 145. The Nurse was observed to circle her initials for the Glucotrol for 11/6/19.

The MAR for November 2019 revealed the 8:00 AM dose of Glucotrol was initialed as given on 11/5/19 and the fingerstick blood sugar was documented as 142. The Director of Nursing identified the initials as those of Nurse #3.
On 11/6/19 at 4:50 PM an interview was conducted with Nurse #3 who verified that she passed medications for Resident #4 on 11/5/19 on the day shift. The Nurse was asked if she

F 842

concern during the audit.

On 11/7/19 a 100% in-service was initiated by Director of Nursing for all nurses regarding following Physician orders to include documentation and Parameters. In-service will be completed by 11/24/19. All newly hired Licensed Nurses will be in-services regarding following Physician orders to include documentation and Parameters by the Director of Nursing or Staff Facilitator.

10 % of all MARS to include Resident # 4 will be audited by the Assistant Director of Nursing utilizing the Quality Assurance (QA) Audit Tool for Following Physician's orders weekly for 8 weeks and monthly for 1 month. The DON will review and initial the QA Audit Tool for Following Physician's orders to ensure completion and that all areas of concerns are addressed weekly x 8 weeks then monthly x 1 month.

The Administrator will present the findings of the QA Audit Tool for Following Physician's orders to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the QA Audit Tool for Following Physician's orders to determine the need for any trends or further frequency of monitoring.

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F 842	Continued From page 8 gave Resident #4 the Glucotrol yesterday morning and Nurse #3 stated she did. When asked about the blood sugar being 142 and the parameters ordered by the physician, Nurse #2 further stated she would not have given the medication if his blood sugar was 145 or less but could not remember specifically what she did. The Nurse further stated she should have circled her initials and written on the back of the MAR why the medication was not given. On 11/7/19 at 1:18 PM an interview was conducted with the Administrator and the DON. The DON stated it was her expectation for the nurses to follow the doctor ' s orders as written. The DON further stated if a medication was not given the nurse was supposed to circle her initials and document on the back of the MAR why the medication was not given. The Administrator stated they had already started a performance improvement plan related to the documentation of the Glucotrol.	F 842		