STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 02/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 000	INITIAL COMMENTS The survey team entered the facility on 02/17/21 to conduct an unannounced complaint investigation. The survey team was onsite 02/17/21 and 02/18/21. Additional information was obtained offsite on 02/19/21 and 02/22/21. Therefore, the exit date was 02/22/21. 18 of 18 complaint allegations were not substantiated, Event ID# CP9l11.	F 000		
F 761 SS=E	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	F 761		3/3/21

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

Electronically Signed | 03/03/2021

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F 761	Continued From page 1 by: Based on observation and staff interviews the facility failed to keep an unattended medication secured by leaving it on a bedside table in a resident's room for 1 of 1 rooms where intravenous medications were being administered, failed to keep an unattended medication secured by leaving it on top of a medication cart for 1 of 5 medication carts observed, failed to keep an unattended medication secured by leaving it on an overbed table for 1 of 1 residents who was reviewed for medications left at the bedside (Resident #4), and failed to keep unattended medications stored in a locked medication cart for 1 of 5 medication carts observed. Findings included: 1. During an observation on 02/17/21 at 1:38 PM a syringe sealed in a transparent plastic wrapper was seen on the bedside table in room #307. On examination, the labeling of the syringe revealed it contained 500 units in 5 milliliters (ml) of heparin lock flush. Nurse #4 verified that the syringe contained heparin 500 units and placed the syringe in her pocket. In an interview on 02/17/21 at 2:20 PM Nurse #4 stated she should not have left the syringe of heparin on the bedside table in room #307. She indicated that she had just started an intravenous (IV) infusion of medication and had left the syringe on the bedside table to flush the IV line when the infusion was completed. Nurse #4 indicated that medications should not be left in resident rooms because someone could take the medications and harm themselves or even die.	F 761	The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 3/3/2021 Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. On February 17th ,2021 a syringe sealed in transparent plastic wrapper was left on the bedside table identified by state surveyor. Nurse #4 immediately identified the syringe, placed it in her pocket and removed it from the room. Nurse #4 acknowledged that medications should not be left unattended at residents' bedside. On February 17th ,2021 a medication cup was left unattended on top of a nurse's cart with a medication in it identified by state surveyor. Once identified nurse #4 immediately removed medication from the top of the cart. On February 17th ,2021 a medication cart was identified as unlocked and unattended by state surveyor. When identified Medication Aide #1 immediately locked medication cart. Administrator educated Medication Aide #1 on importance of keeping medication cart locked.	

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F 761	Continued From page 2 In a telephone interview on 02/22/21 at 11:16 AM the Director of Nursing (DON) stated that medications should not be left unattended in resident rooms because anyone could take the medication. She indicated that heparin should be administered and then the syringe disposed of and that heparin should not be left in a resident's room to be used later. 2. In a continuous observation on 02/17/21 from 4:21 PM to 4:28 PM a medication cup with half a blue tablet was seen on top of the North hall medication cart. The cart was parked next to the clean linen room in an area marked for medication carts by a sign on the wall. The medication cart was unattended during this time and a resident in a wheelchair was seated next to the cart. Multiple staff members walked past the cart and attended to the resident. At 4:28 PM Nurse #4 walked up to the cart and collected several empty bubble packs and discarded them in the trash. Nurse #4 walked away from the medication cart to the nursing desk leaving the medication cup with the medication inside unattended on the top of the cart. In an interview on 02/17/21 at 4:30 PM Nurse #4 was asked about the medication that was on top of the medication cart. She verified that the medication in the medication cup was half of a clonazepam (a sedative) tablet. Nurse #4 stated that she had a question about the medication, so she left it on top of her cart in the medication cup. She indicated that she should not have left the medication on top of the medication cart unattended because someone could have taken the medication and it could have caused them to become sedated or possibly die.	F 761	On February 22nd, 2021 Phone Interview conducted by state surveyor with Nurse #4 indicated Nurse #4 left medication at bedside of resident per resident request. On February 17th, 2021 Facility Administrator reached out to contract pharmacy to begin Medication Pass audits. On February 17th, 2021 Director of Nursing and Unit Manager In-serviced Nurse #4 on the importance of not leaving medications at bedside or leaving medications unattended anywhere in the facility. On February 18th, 2021 Pharmacy Nurse Consultant conducted Medication Pass Audit with Nurse #4 to determine if any residents were at risk. On February 18th, 2021, the Unit Manager and the Director of Clinical Resources completed a 100% room round to ensure no medications were left at resident bedside. Unit Manager and Director of Clinical Services audited all medication carts for medications left unattended on top of cart. Unit Manager and Director of Clinical Services audited all unattended medication carts to ensure no cart was left unlocked when not in use. No other issues or concerns were identified from these audits. To ensure quality assurance the center has implemented the following steps:	

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F 761	Continued From page 3 In a telephone interview on 02/22/21 at 11:16 AM the Director of Nursing (DON) stated that medications should not be left unattended on top of medication carts. She indicated that a resident could come up and remove the medication from the cart and swallow it. The DON indicated that if a medication was left on top of the medication cart it could be forgotten and not administered to the resident it was prescribed for. 3. Resident #4 was admitted to the facility on 03/17/20 with diagnoses that included, in part: quadriplegia, cardiomyopathy, systolic congestive heart failure and cirrhosis of the liver. Review of an annual Minimum Data Set Assessment (MDS) dated 01/05/21 for Resident #4 revealed she had mildly impaired cognition. She was dependent for all care except for eating for which she required extensive assistance. She had an indwelling urinary catheter and was always incontinent of bowel. She had quadriplegia with impaired mobility of her upper and lower extremities on both sides. She had received both scheduled and as needed pain medication during the assessment look back period. She received a mechanically altered diet and had one Stage 4 pressure ulcer that was present on admission. Review of January and February 2021 Medication Administration Records (MAR) revealed Resident #4 had a physician order for Potassium Chloride 10 meq (Milliequivelants) once a day. Nurse #4 documented on the MAR she had administered Potassium Chloride to Resident #4 on 01/23/21, 02/06/21, 02/17/21 and 02/18/21 between January 1, 2021 and February 19, 2021. In an interview conducted by telephone with the	F 761	All RN, LPN and Medication Aides will be in-serviced on Medication Pass and Keeping Medication Carts locked. Any RN, LPN or Medication Aide not in-serviced by March 3rd ,2021 will not work until they have been in-serviced. For 6 weeks Medication pass audits will be completed weekly by the Pharmacy Nurse Consultant, Director of Nursing or designee. Followed by Medication Pass Audits conducted bi-weekly for the following four weeks. For two weeks, cart lock audits will be conducted by Director of Nursing or Designee three times a day. Followed by daily cart lock audits for two weeks, then weekly cart lock audits for four weeks. For three weeks, daily random room round audits will be conducted by the Director of Nursing or Designee. Followed by weekly random room audits for four weeks. The Director of Nursing or the Administrator will bring the Medication pass audits, cart lock audits and random room round audits to the Quality Assurance Meeting for the next three months.	

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F 761	Continued From page 4	F 761		

Director of Nursing on 02/22/21 at 11:48 AM she stated it was not acceptable to leave medication unattended in a resident's room.

In an interview conducted by telephone with Nurse #4 on 02/22/21 at 1:20 PM she stated she had left the medication Potassium Chloride 10 meq sitting unattended in Resident #4's room. She stated Resident #4 had requested she leave the medication in the resident's room for the next nurse to administer because she wanted to take the pill later and it was the end of Nurse #4's shift. Nurse #4 explained when she returned to work for her next scheduled shift the nurse who had followed her the previous day was rude to her and told her she was not allowed to leave any medication unattended at a resident's bedside. She explained she had never worked in a long term care setting before and was not aware she could not leave medication unattended in a resident's room. She said she went directly to the facility Administrator and "turned herself in" reporting she had made a mistake. She commented she had learned from that experience not to leave medication in a resident's room unattended. She did not remember the date of the incident.

4. On 02/17/21 at 8:45 AM a medication cart in the hallway next to room 333 was observed to be unlocked and unattended continuously for approximately two minutes. In an interview with Medication Aide #1 when she returned to the cart she explained she had left the cart to answer a call bell. She immediately realized she had left the medication cart in the hallway unlocked. She stated she had made a mistake and she knew not to leave a medication cart unlocked and unattended.

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F 761	Continued From page 5 In an interview with the facility Administrator who was accompanying the surveyer on 02/17/21 at 8:45 AM, she stated the medication cart should have been locked when the staff member left it unattended. In an interview with the Director of Nursing on 2/22/21 at 11:48 AM she stated she expected an unattended medication cart to be locked at all times with the computer screen either covered or turned off.	F 761		