| 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 04/15/2021 |

| 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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 4/11/21 through 4/15/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9UUF11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 4/11/21 through 4/15/21. Event ID# 9UUF11.<br>6 of the 26 complaint allegations were substantiated resulting in deficiencies. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. | F 550 | | 5/14/21 |

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

Electronically Signed | 05/10/2021

| 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 04/15/2021 |

| 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 550 | Continued From page 1<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to maintain a urinary catheter drainage bag in a dignity pouch to promote dignity for 1 of 2 residents reviewed for urinary catheters (Resident #65). The facility failed to promote a resident's dignity by discharging the resident (Resident #227) home in another person's clothing for 1 of 1 resident reviewed.<br><br>The findings included:<br><br>1. Resident #65 was admitted to the facility on 3/1/21 and had a diagnosis of neurogenic bladder with urinary retention.<br><br>The Admission Minimum Data Set (MDS) Assessment dated 3/5/21 noted the resident had severe cognitive impairment and required extensive to total assistance with ADLs (activities | F 550 | F550<br>The Lodge at Rocky Mount Allegation 4/15/2021<br><br>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.<br><br>On April 11th, 2021 State Surveyor identified resident with urinary drainage bag that was not in a dignity pouch.<br><br>On April 11th, 2021: Certified Nursing Assistant returned to room and place | |

| 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 04/15/2021 |

| 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 550 | Continued From page 2<br>of daily living). The MDS noted the resident had an indwelling urinary catheter.<br><br>The resident's Care Plan dated 3/5/21 and updated on 3/26/21 noted the resident required an indwelling urinary catheter related to a diagnosis of neurogenic bladder. The approaches included the following: Store the collection bag inside a protective dignity pouch.<br><br>On 4/11/21 at 1:10 PM, Resident #65 was observed sitting in a wheelchair in her room. There was a urinary drainage bag hanging on the bottom of the bed. The drainage bag was not in a dignity pouch. Two nursing assistants (NAs) were observed to transfer the resident from a wheelchair to a recliner with a mechanical lift and the urinary drainage bag was placed in the chair with the resident for the transfer. The NAs left the room and the drainage bag was not in a dignity pouch.<br><br>On 4/11/21 at 2:17 PM Resident #65 was observed sitting in a recliner in her room. The urinary drainage bag was not in a dignity pouch.<br><br>On 4/11/21 at 2:35 PM an interview was conducted with NA #1. The NA stated the resident was supposed to have a cover over the drainage bag for dignity. The NA was asked who was supposed to put the cover over the drainage bag and the NA stated the nurse was supposed to do this.<br><br>On 4/11/21 at 2:39 PM, NA #1 was observed to return to the room with a dignity pouch and placed the resident's urinary drainage bag in the pouch. | F 550 | dignity pouch over resident's urinary drainage bag. Director of Nursing and Unit Managers conducted full audit of all residents with catheters to ensure dignity pouches were present and identified no other instances of uncovered catheter bags.<br><br>In-services were conducted on the importance of dignity pouches and how to apply. Education included all Registered Nurses, Licensed Practical Nurses, Medication Aides and Certified Nursing Assistants. Any of those not in-serviced by May 14th will not work until they have been in-serviced. Social Service conducted in-service for all staff including nursing, dietary, housekeeping, laundry, maintenance, therapy, activities, social service, business office and administration on Resident Rights and Dignity. Any of those not in-serviced by May 14th will not work until they have been in-serviced.<br><br>To ensure quality assurance audits for appropriate dignity pouches for residents with catheters will be completed five times per week for two weeks, then three times per week for two weeks, then weekly for two months.<br><br>All findings will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. The Quality Assurance Team will determine if additional monitoring is needed based upon the outcomes of the findings. | |

| 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 04/15/2021 |

| 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 550 | Continued From page 3<br>On 4/15/21 at 5:08 PM the Administrator stated in an interview that urinary drainage bags were supposed to be put in a dignity bag. The Administrator further stated the resident had been outside the building on the morning of 4/11/21 to visit with her family.<br>2. Resident #227 was admitted to the facility on 11/16/20 with diagnoses that included hypertension, macular degeneration, and physical debility. Resident #227 was discharged home with Hospice on 12/15/20.<br><br>A review of the admissions Minimum Data Set assessment dated 11/20/20 revealed Resident #227 was cognitively intact and required extensive assistance with her activities of daily living.<br><br>Review of the grievance logs from March 2020 to April 2021 revealed a grievance dated 2/8/21 that detailed on two separate occasions, the resident had another resident's clothing on. The resolution stated an additional person would be assigned to the laundry room.<br><br>During an interview on 4/15/21 at 8:15AM with the Laundry Manager, she revealed she was aware of the grievances related to residents receiving another resident's clothing. She stated she had researched the problem and implemented a new process to reduce this incidence 2 months ago. The Laundry Manager stated an additional staff was added to laundry to address this concern. She further revealed clothing was laundered for residents prior to discharge.<br><br>An interview with the Housekeeping Supervisor on 4/15/21 at 8:20AM revealed the new process started at admission. All clothing was inventoried | F 550 | On February 8th, 2021, Resident grievance detailed on two separate occasions resident had another resident's clothes on. Resident was discharged home in another resident's clothes.<br><br>On February 9th, 2021, a full audit of items in resident's room was conducted by housekeeping manager to ensure all personal items, including clothing, were appropriately distributed. Any issues identified were corrected immediately.<br><br>A new process was put in place to have all clothing items inventoried upon admission. Inventory is initiated upon admission by the receptionist or laundry staff to assure all incoming garments are documented and labeled correctly. Center has implemented a discharge checklist for all residents which includes personal effects to ensure they leave with appropriate belongings.<br><br>To ensure quality assurance housekeeping will complete a weekly random room audit of 10 residents for eight weeks to ensure all clothing in rooms belong to the resident residing in that room. A discharge checklist will be completed on all discharged residents for 3 months.<br><br>All findings will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. The Quality Assurance Team will determine if additional monitoring is needed based | |

| 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 04/15/2021 |

| 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 550 | Continued From page 4<br>by the receptionist who then sent the clothing to laundry to be labeled. Once laundry received the clothing, they labeled the clothing, laundered the clothing, and then delivered the clothing to the resident.<br><br>During an interview with the Business Office Manager (BOM) on 4/15/21 at 8:37AM, she stated she had trained the receptionist staff on the new process. She further revealed the receptionist inventoried all the items the resident brought and placed the inventory sheet in the Electronic Health Record. The BOM stated this process had eliminated confusion related to resident belongings.<br><br>An interview with the Administrator on 4/15/21 at 10:00AM revealed she was aware Resident #227 had been discharged home in another resident's clothing. She further stated she had implemented a checklist that was to be completed for each resident that was discharged. The Administrator stated during the morning meeting, a checklist was given to the Unit Managers for each resident that was discharging on that day. The Administrator further stated once the checklist was completed, it was returned to her. | F 550 | upon the outcomes of the findings. | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced | F 558 | | 5/14/21 |

| 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 04/15/2021 |

| 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 558 | Continued From page 5 | F 558 | | |

by:
Based on observation, record review and staff interview the facility failed to maintain a call bell within reach for 3 of 20 residents observed for call bells (Residents #65, # 231 and #233). The findings included:

1. Resident #65 was admitted to the facility on 3/1/21 and had a diagnosis of non-displaced femur fracture, Anemia, Cognitive Communication Deficit, Neurogenic Bladder with urinary retention, Cerebrovascular Accident (Stroke), Congestive Heart Failure, Hypertension, Diabetes Mellitus and Chronic Kidney Disease.

The Admission Minimum Data Set (MDS) Assessment dated 3/5/21 noted the resident had severe cognitive impairment and required extensive to total assistance with ADLs (activities of daily living).

Review of the resident ' s clinical record revealed Resident #65 was discharged to the hospital on 3/10/21 to have an open reduction, internal fixation (surgery) of a left femur fracture and was re-admitted to the facility on 3/15/21.

The resident ' s Care Plan dated 3/5/21 and updated on 3/26/21 noted the following: "Keep call light within easy reach of resident and answer in a timely manner."

On 4/11/21 at 1:10 PM NA #1 was observed to enter the room of Resident #65 with her meal tray. The resident was sitting in a wheelchair with both feet on the floor. The left knee was observed with an incision that had steri-strips across the incision. The resident appeared to be uncomfortable and told the NA she did not feel

F558
The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 4/15/2021

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 April 11th-15th, 2021, State Surveyors identified 3 instances when call bells were not in reach.

0n April 11th □ 15th, 2021, all call bells were immediately placed within resident□s reach once identified.

On April 15th, 2021, a full facility audit for call bell placement was completed. No additional issues were identified.

In-servicing will be conducted for all staff, including nursing, dietary, housekeeping, laundry, maintenance, therapy, activities, social service, business office and administration. Education will be on appropriate call bell placement to assure call-bells are within reach. Any staff not in-serviced by May 14th, 2021 will not work until they have received the in-service.

To ensure quality assurance audits to

| 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 04/15/2021 |

| 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 558 | Continued From page 6<br>like eating that she was having pain in her leg and had been sitting in this chair ever since they got her up and her knee hurt. The resident stated her knee had been bent for too long. The NA told the resident she got her up at 11:00 AM for a visit with her family. The NA left the room. The resident was observed sitting in a wheelchair on the side of the bed closest to the door to the room. The call bell was observed draped around the bottom of the grab bar on the other side of the bed and the bed was in the high position. The resident was asked if she called for assistance to go back to bed and she stated she could not reach the call bell. NA #1 and NA #2 returned to the room with a mechanical lift and transferred the resident to a recliner. The Resident stated she felt better sitting in the recliner.<br><br>On 4/11/21 at 1:20 PM an interview was conducted with NA #1 and NA #2. The NAs stated they observed the activities coordinator to bring the resident back to her room around 11:30 that morning after visiting with her family. Both NAs stated they had not been in the resident ' s room since she returned at 11:30 AM until NA #1 brought in the resident ' s lunch tray.<br><br>On 4/11/21 at 1:24 PM NA #2 was observed to enter the resident ' s room and placed a blanket over the resident who was sitting in a recliner between the bed and the door to the room. The NA walked around to the other side of the bed and picked up the call bell and placed it on the bed where the resident could reach it.<br><br>On 4/11/21 at 2:27 PM the resident was interviewed and answered questions appropriately. | F 558 | ensure all call bells are within reach for twenty random residents will be completed five times per week for two weeks, then three times per week for two weeks, then weekly for two months.<br><br>All findings will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. The Quality Assurance Team will determine if additional monitoring is needed based upon the outcomes of the findings. | |

| 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 04/15/2021 |

| 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 558 | Continued From page 7<br>On 4/14/21 at 4:51 PM an interview was conducted with the Activity Coordinator who stated they had a housekeeper that worked with activities every other weekend and she was the one that took Resident #65 back to the room after visiting with her family outside in front of the building.<br><br>On 4/14/21 at 5:06 PM an interview was conducted with the housekeeper that worked with activities every other weekend. The Housekeeper stated Resident #65 had a visit with her family at 11:00 AM and she returned the resident to her room at 11:34 AM and positioned her wheelchair beside her recliner and the call bell was where the resident could reach it.<br><br>The Administrator stated in an interview on 4/15/21 at 5:08 PM that every single person working in the facility when working with a resident should ensure the call bell is in place.<br><br>2. Resident #231 was admitted to the facility on 4/7/21.<br><br>The 48 hour base-line care plan revealed Resident #231 required extensive assistance for his activities of daily living. The resident had a diagnosis cardio-vascular disease among others. | F 558 | | |

| 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 04/15/2021 |

| 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 558 | Continued From page 8 | F 558 | | |

During an observation and interview on 4/12/21 at 8:36AM, Resident #231 was lying in bed. The resident stated he wanted to speak to the nurse because he was in pain. The call bell was observed to be lying on the floor on the left side of the bed where the resident was unable to reach.

During an interview on 4/15/21 at 7:20AM, NA #2 stated she was familiar with Resident #231 and had provided care. NA #2 stated Resident #231 was able to use the call bell. NA #2 revealed she had carried a conversation with the resident about how he felt that day.

During an interview with NA #3 on 4/15/21 at 4:00PM, she revealed she had provided care to Resident #231 and stated he was able to use the call bell. NA #3 stated Resident #231 was able to make his needs known.

An interview with the Housekeeping Manager on 4/15/21 at 8:15AM revealed housekeeping staff cleaned resident rooms. She further stated there were times the resident's call bell was observed behind the bed or out of reach of the resident. The Housekeeping Manager stated staff had been instructed to ensure the call bell was within reach of the resident prior to leaving the resident room.

3. Resident #233 was admitted to the facility on 4/9/21 from the hospital following knee surgery. Resident #233 was receiving therapy. Resident #233 was alert an oriented and required extensive assistance with her activities of daily living.

An interview with Resident #233 on 4/11/21 at 11:54AM revealed an NA had provided care the

| 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 04/15/2021 |

| 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 558 | Continued From page 9<br>evening of 4/10/21, after care the NA left the room and closed the door. Resident #233 stated the call bell was on the floor. Resident #233 further stated she was unsure how to get assistance if she had needed it. She revealed staff placed the call bell within reach during the next round which was 2 hours later.<br><br>During an interview with the Administrator on 4/15/21 at 5:08PM, she stated every person working in the facility, when working with a resident, should ensure the call bell is in place. | F 558 | | |
| F 570 SS=C | Surety Bond-Security of Personal Funds<br>CFR(s): 483.10(f)(10)(vi)<br><br>§483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and interviews, the facility failed to provide a surety bond for 40 of 89 residents reviewed, which named the residents of the facility as the Obligee.<br><br>The findings included:<br><br>Review of the facility surety bond, dated 3/15/21, titled "Rider to Change Amount of Suretyship" read in part to be attached to and form part of Patient Trust Fund surety bond number 010102H. The rider cross reference bond number for patient trust bond, dated the 1st day of January, 2019, in the penal sum of $90,000.00 issued by named insurance company as surety on behalf of Rocky Mount Health and Rehabilitation LLC DBA | F 570 | F570<br>The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 4/15/2021<br><br>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.<br><br>On April 15th, 2021 it was identified the Surety Bond had incorrect verbiage | 4/15/21 |

| 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 04/15/2021 |

| 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 570 | Continued From page 10<br>South Village Health and Rehabilitation, as principal in favor of State of North Carolina Division of Medical Assistance Certification Section as Obligee. The State of North Carolina Division of Medical Assistance Certification Section is not accountable for surety bonds.<br><br>During an interview on 4/15/21 at 2:24PM, the Business Officer Manager revealed she would check with corporate to verify the Obligee.<br><br>During an interview with the Administrator on 4/15/21 at 5:15PM, she revealed corporate would update the surety bond. | F 570 | related to the obligee.<br><br>On April 15th, 2021 Surety Bond was corrected to state the obligee as Residents and Aggregate of Rocky Mount Health and Rehabilitation.<br><br>To ensure quality assurance new Surety Bonds will be reviewed by Business Office Manager when it is received to ensure all documentation is filled out correctly. The Regional Reimbursement Specialist will then review all new Surety Bonds to assure compliance.<br><br>Any issues seen in the future will be brought to the Quality Assurance Meeting for review and correction. | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or | F 580 | | 5/14/21 |

| 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 04/15/2021 |

| 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 580 | Continued From page 11<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and family interviews, the facility failed to notify Resident #178's representative of a new pressure ulcer for 1 of 1 resident reviewed for notification.<br><br>The findings included: | F 580 | F580<br>The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 4/15/2021<br><br>Preparation and or execution of this plan does not constitute admission or | |

| 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 04/15/2021 |

| 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 580 | Continued From page 12<br>Resident #178 was admitted to the facility on 9/14/2020 with diagnoses that included nutritional deficiency, osteoporosis, fracture of the upper end of left tibia and others.<br><br>Review of a nursing note dated 9/14/2020 written by Nurse #8 revealed Resident #178 had no alterations in skin.<br><br>Review of the comprehensive Minimum Data Set (MDS) dated 9/21/20 revealed that #178 was always moderately cognitively impaired for daily decision making and required extensive assistance with one person assist for bed mobility and toileting. The MDS further revealed Resident #178 was at risk for developing pressure ulcers, but none were identified during the assessment reference period.<br><br>Review of Resident #178s medical record dated 10/2/2020 revealed no record of any current pressure ulcers.<br><br>Review of a skin assessment dated 10/13/2020 completed by Nurse #7 revealed Resident #178 had a small opened area to her right upper buttocks. A review of Resident #178s medical chart did not reveal any documentation that the resident's RP was notified of an open area.<br><br>An interview was conducted with Unit Manager #1 on 4/14/2021 at 5:32 PM. The manager stated the nurse caring for the resident was responsible for notifying the RP of any newly found pressure ulcers.<br><br>Review of Resident #178s recapitulation of stay revealed the resident was discharged home on 10/16/2020 with home health and referral for | F 580 | 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.<br><br>On October 13th, 2021, Nurse #7 identified an open area to resident's buttocks. There was no documentation that the Responsible Party was notified. Surveyor unable to reach Nurse #7 to verify presence of open area.<br><br>100% audit completed for notification to M.D. and Responsible Party related to change in condition. Following the audit, Unit Managers, Floor Nurses, and Director of Nursing to call M.D. and Responsible Parties for each resident to discuss plan of care and any change in condition over the last 30 days.<br><br>In-service for all Licensed Nurses by Director of Nursing to include notification to M.D. and Responsible Parties, and documentation of notifications in nurse's notes. Anyone not in-serviced by May 14th, 2021 will not work until they are in-serviced.<br><br>To ensure quality assurance nursing notes and M.D. orders will be reviewed by the Administrative Nurse team in morning clinical meeting to ensure notification of change in condition is documented in the nursing notes. This will be audited using the "Change in Condition MD/RP Notification Tool" This tool will be utilized | |

| 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 04/15/2021 |

| 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 580 | Continued From page 13<br>follow up with primary care physician.<br><br>On 4/14/2020 at 8:00 PM, an attempt to contact nurse #7 that completed the skin assessment dated 10/13/2020 was unsuccessful.<br><br>An interview was conducted with Resident #178s RP (Resident Representative) on 4/15/2021 at 8:02 AM. The RP stated that she had not been notified about a pressure ulcer to Resident #178s bottom when the resident was discharged and there was no treatment ordered.<br><br>An interview with the Administrator on 4/15/2020 at 5:40 PM revealed that she expected that staff would notify the RP of new pressure ulcers. | F 580 | for eight weeks.<br><br>All findings will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. The Quality Assurance Team will determine if additional monitoring is needed based upon the outcomes of the findings. | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s).<br>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the | F 657 | | 5/7/21 |

| 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 04/15/2021 |

| 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 657 | Continued From page 14<br>resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to update a resident's Care Plan to include transfers with a mechanical lift for 1 of 37 residents reviewed (Resident #65). The findings included:<br><br>Resident #65 was admitted to the facility on 3/1/21 with a diagnosis of a mechanical fall and a possible nondisplaced femur fracture.<br><br>The Admission Minimum Data Set (MDS) Assessment dated 3/5/21 revealed the resident had severe cognitive impairment. The MDS noted that transfers and ambulation did not occur and the resident required extensive assistance with bed mobility, dressing, toileting, personal hygiene and bathing.<br><br>The resident's Care Plan dated 3/5/21 noted to assist the resident with transfers and ambulation as needed.<br>On 3/10/21 the resident went to an appointment with the orthopedist and was sent to the hospital for surgical repair of a femur fracture and was re-admitted to the facility on 3/15/21.<br><br>The resident's Care Plan was updated on 3/26/21 and read: "Provide assist with ADLs (Activities of Daily Living) mobility and transfers as needed." | F 657 | F657<br>The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 4/15/2021<br><br>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.<br><br>On March 26th, 2021, resident care plan was stated as saying “Provide assist with ADLs mobility and transfers as needed.” State surveyor witnessed resident being transferred to chair by mechanical lift. Transfer by mechanical lift was listed appropriately on patient care guide but not evident on care plan.<br><br>On April 15th resident’s care plan was updated.<br><br>On May 7th, 2021, a full facility audit of care plans for resident mobility and transfers was completed by facility MDS | |

| 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 04/15/2021 |

| 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 657 | Continued From page 15<br><br>A note by the Physician's Assistant (PA) dated 4/7/21 revealed the resident was not walking yet but was working on standing and continued to need assistance for bed mobility and a mechanical lift for transfers to the chair.<br><br>On 4/11/21 at 1:10 PM Resident #65 was observed to be transferred from a wheelchair to a recliner with a mechanical lift by 2 Nursing Assistants (NA) #1 and NA #2.<br><br>An interview was conducted with Physical Therapist #1 on 4/14/21 at 4:15 PM. The Physical Therapist stated he did an evaluation on Resident #65 When she returned from the hospital and determined she needed to be transferred with a mechanical lift. The Physical Therapist stated he would verbally tell the nurse as to how the resident was to be transferred and the nurse would tell the NAs. The Physical Therapist further stated they discuss all residents in the morning meetings and the MDS nurse was present and should add that information to the Care Plan.<br><br>The MDS Nurse stated in an interview on 4/14/21 at 4:32 PM, she put on the Care Plan to provide assist with transfers as needed and the way the resident was to be transferred was on the care guide and she did not put this information on the Care Plan.<br><br>On 4/14/21 at 4:30 PM, the Administrator provided a care guide for Resident #65 that was filled out by hand. The undated form noted under Mobility the resident was to be transferred with 2 person assist with a mechanical lift.<br><br>NA #2 stated in an interview on 4/15/21 at 8:35 | F 657 | nurse and Regional MDS nurse. Any issues identified were immediately corrected. MDS nurse was in-serviced by Regional MDS Nurse on how to individualize care plans to include a resident's specific transfer needs.<br><br>To ensure quality assurance the Regional MDS nurse will audit any new care plans or changes in care plans for appropriate resident mobility and transfer guidance weekly for four weeks, then center MDS Coordinator will audit care plans for appropriate resident mobility and transfer guidance weekly for four weeks.<br><br>All findings will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. The Quality Assurance Team will determine if additional monitoring is needed based upon the outcomes of the findings. | |

| 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 04/15/2021 |

| 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 657 | Continued From page 16<br>AM that therapy evaluated the resident when she returned from the hospital and said to transfer her with a mechanical lift. The NA further stated they have a care guide to refer to or she could ask the nurse or the other NAs if she had a question about a resident's care.<br><br>The Administrator stated in an interview on 4/15/21 at 5:08 PM the NAs were not going to look at the Care Plan but would look at the care guide and look for instructions from the nurses and the other NAs. The Administrator further stated when a resident was discharged from the facility the Care Guide was thrown away. | F 657 | | |
| F 660 SS=D | Discharge Planning Process<br>CFR(s): 483.21(c)(1)(i)-(ix)<br><br>§483.21(c)(1) Discharge Planning Process<br>The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-<br>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.<br>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.<br>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. | F 660 | | 5/14/21 |

| 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 04/15/2021 |

| 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 660 | Continued From page 17 | F 660 | | |

(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to

| 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 04/15/2021 |

| 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 660 | Continued From page 18<br>the resident's goals of care and treatment preferences.<br>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews and agency interviews, the facility discharged the resident home with an intravenous (IV) in her arm to 1 of 1 resident (Resident #227) reviewed.<br><br>Findings included:<br><br>Resident #227 was admitted to the facility on 11/16/20 with diagnoses that included hypertension, macular degeneration and physical debility. Resident #227 was discharged home with Hospice on 12/15/20.<br><br>A review of the admissions Minimum Data Set assessment dated 11/20/20 revealed Resident #227 was cognitively intact and required extensive assistance with her activities of daily living.<br><br>Review of a physician order dated 12/7/20 for Resident #227 indicated to place an IV; start normal saline continuously for re-hydration. The start date of the order was 12/7/20 with an end date of 12/9/20. A subsequent physician order dated 12/9/20 indicated to continue the IV with an | F 660 | F660<br>The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 4/15/2021<br><br>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.<br><br>On December 14, 2021, a resident was discharged home with IV access in arm. Nurse stated IV was not removed because order had not been completed and original placement was difficult.<br><br>On January 1st, 2021, a total skin assessment within 48 hours of discharge was implemented to ensure no resident leaves facility with IV access. | |

| 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 04/15/2021 |

| 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 660 | Continued From page 19<br>end date of 12/10/20.<br><br>Review of the Medication Administration Record for 12/01/20 - 12/31/20 revealed the IV was started on 12/8/20 and administered starting on 2nd shift. The last administration was on 12/10/20 during 3rd shift.<br><br>Review of a nursing progress note dated 12/9/20 revealed the writer had contacted the Nurse Practitioner (NP) related to the stop date of the IV fluids. NP stated IV fluids should go for a total of three days.<br><br>No further documentation of the IV in the progress notes.<br><br>Review of discharge skin assessment completed by Unit Manager #1 on 12/14/20 noted no new skin issues.<br><br>During an interview with the Home Hospice Nurse on 4/14/21, she revealed, during the initial home assessment for Resident #227 on 12/15/20, the resident had an IV located in the right forearm. The Nurse further revealed the IV was covered with clear dressing with a cap on the end of the IV, and no name/date on the dressing. She further stated she had removed the IV and noted there was no swelling at the IV site.<br><br>During an interview with the Unit Manager on 4/14/21 at 4:39PM, she stated she was familiar with Resident #227and had completed the skin assessment for discharge. She further stated she would have seen an IV if one had been present. She further revealed, when the IV was completed, the nurse providing care was responsible to contact the physician and remove | F 660 | A review of all orders for IV use for previous 3 months was conducted to ensure all IV access was removed timely after completion of order. Any current residents with IV□s had orders added to consult with physician regarding removal of IV access upon completion of IV order.<br>By May 14th, 2021 Director of Nursing and Unit Managers to in-service all Licensed Practical Nurses and Registered Nurses on importance of removing IV access once medication orders are completed and in accordance with physician orders for removal. Any one not in-serviced by May 14th, 2021 will not work until in-serviced.<br><br>To ensure quality assurance all IVs and IV orders completion dates will be audited. This audit will be completed five times per week for two weeks, then three times per week for two weeks, then weekly for two months during clinical morning meeting. A discharge assessment to ensure no one is discharged with IV□s will be conducted on all discharges for a minimum sixty days.<br><br>All findings will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. The Quality Assurance Team will determine if additional monitoring is needed based upon the outcomes of the findings. | |

| 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 04/15/2021 |

| 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 660 | Continued From page 20 | F 660 | | |

the IV.

During a subsequent interview with the Unit Manager #1 on 4/15/21 at 2:45PM, she revealed she was not aware Resident #227 was discharged with an IV in her arm. She further revealed she conducted a skin assessment to ensure there were no new wounds and to access current skin issues to ensure the family was aware of the treatment procedures. She further stated the discharge skin assessment reviews skin integrity issues. The Unit Manager #1 stated the nurse that completed the IV solution order was responsible to determine if the IV should remain in place or be removed.

During an interview with Nurse #3 on 4/15/21 at 3:07PM, she revealed the reason the IV was not removed was because the IV hadn't started when it was ordered since the IV was difficult to place. She further stated she hadn't notified anyone because she felt the IV needed to remain.

An interview with the Director of Nursing (DON) on 4/15/21 at 9:45AM revealed she was not aware Resident #227 was discharged with an IV in her arm. She further stated the purpose of the discharge skin assessment was to conduct a thorough assessment and to note any areas of concern. Any areas of concern would be reviewed with the resident or responsible party upon discharge, to ensure they were aware and that appropriate services were in place prior to discharge.

During an interview with the Administrator on 4/15/21 at 10:00AM, she revealed she was aware Resident #227 went home with an IV in her arm. She further stated she had implemented a

| 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 04/15/2021 |

| 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 660 | Continued From page 21<br>process to ensure within 48 hours prior to discharge, a comprehensive skin assessment was conducted. She further stated all residents were to have a skin assessment done prior to discharge. | F 660 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and family interviews, the facility failed to report and initiate treatment to a pressure ulcer when identified for 1 of 3 residents sampled for pressure ulcers (Resident #178).<br><br>The findings included:<br><br>Resident #178 was admitted to the facility on 9/14/2020 with diagnoses that included nutritional deficiency, osteoporosis, fracture of the upper end of left tibia and others.<br><br>Review of a nursing note dated 9/14/2020 and | F 686 | F686<br>The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 4/15/2021<br><br>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. | 5/14/21 |

| 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 04/15/2021 |

| 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 686 | Continued From page 22<br>completed by Nurse #8 revealed Resident #178 had no alterations in skin.<br><br>Review of the comprehensive Minimum Data Set (MDS) dated 9/21/20 revealed that #178 was moderately cognitively impaired for daily decision making and required extensive assistance with one person for bed mobility and toileting. The MDS further revealed Resident #178 was at risk for developing pressure ulcers, but none were identified during the assessment reference period. Resident #178 was incontinent of bowel and bladder.<br><br>Review of the care plan dated 9/21/2020 revealed Resident #178 was at risk for skin breakdown related to impaired mobility due to left tibia fracture and developing pressure ulcers, related to immobility urinary tract infection and other complications related to bowel and bladder incontinence. The goal of the care plan read, Resident #178 will remain free of skin breakdown or complications through next review. The interventions included: daily observation of skin with routine care, skin assessment with proper documentation per facility protocol, assist with turning and repositioning frequently and use pillows for pressure points.<br><br>Review of Resident #178s medical record dated 10/2/2020 revealed no record of any current pressure ulcers.<br><br>Review of a skin assessment dated 10/13/2020 and completed by Nurse #7 revealed Resident #178 had a small opened area to her right upper buttocks.<br><br>Review of the treatment administration record for | F 686 | On October 13th, 2021, Nurse #7 charted in Electronic Medical Record an open area to resident's buttocks. There was no documentation that the MD or Treatment Nurse was notified. No orders were put in place. Unable to reach Nurse #7 to verify existence of open area.<br><br>100% facility skin assessment was completed on May 14th by Director of Nursing and Unit Managers.<br><br>Director of Nursing and Unit Managers in-serviced by Director of Clinical Services on how to review newly identified open areas, notify M.D., obtain orders for treatment, and notify Responsible Party. Director or Unit Manager in-serviced all licensed nurses on how to review newly identified open areas, notify M.D., obtain orders for treatment, and notify Responsible Party. Any one not in-serviced by May 14th 2021 will not be able to work until in-serviced.<br><br>To ensure quality assurance, audits of weekly skin assessments and wound treatment orders will be completed five times per week for two weeks, then three times per week for two weeks, then weekly for two months during morning clinical meeting.<br><br>All findings will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. The Quality Assurance Team will determine if additional monitoring is needed based upon the outcomes of the findings. | |

| 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 04/15/2021 |

| 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 686 | Continued From page 23 | F 686 | | |

10/1/2020 to 10/16/2020 revealed no treatment order for the pressure ulcer.

An interview was conducted with the social worker on 4/14/21 at 5:14 PM. The social worker revealed that she was familiar with Resident #178's discharge. The social worker stated Resident #178 was a managed care resident and the family wanted her discharged due to their not being able to pay out of pocket. The social worker stated that she was never notified of the resident having a pressure ulcer. The social worker stated that Resident 178's RP called to the facility on 10/17/2020 and was upset because she had found a pressure ulcer to residents' buttocks while giving her a bath. resident did not have. The social worker stated Resident #178 discharged home with home health on 10/16/2020 and there were no treatment orders in place because she was not made aware that the resident had a pressure ulcer.

An interview was conducted with Unit Manager #1 on 4/14/2021 at 5:32 PM. The nurse stated she had been the wound/treatment nurse during Resident 178's stay at the facility. The nurse stated she was not made aware of Resident #178 having any skin issues prior to discharge. The UM stated that nurses were to complete a skin integrity report to notify the treatment nurse to follow up.

An attempt on 4/14/2021 to contact the nurse that completed the skin assessment dated 10/13/2020 was unsuccessful.

During an interview with nurse #4 on 4/15/2020 at 4:20 PM. The nurse stated she had cared for Resident #178 and the resident did not have any

| 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 04/15/2021 |

| 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 686 | Continued From page 24<br>skin breakdown.<br><br>An interview was conducted with Resident #178s RP (Resident Representative) on 4/15/2021 at 8:02 AM. The RP stated there was no mention of a pressure ulcer when Resident #178 was discharged on 10/16/2020. The RP stated on 10/17/2020 while bathing Resident #178 an open area the size of a silver dollar was found on her buttocks. The RP stated that she had not been told about a pressure ulcer and there was no treatment.<br><br>An interview with the Administrator on 4/15/2020 at 5:40 PM revealed that she had communicated with the RP and expected that staff would initiate a treatment on all newly found pressure ulcers. | F 686 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§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.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(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;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one | F 690 | | 5/14/21 |

| 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 04/15/2021 |

| 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 690 | Continued From page 25<br>is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to position a urinary drainage bag below the level of the resident ' s bladder for 1 of 3 residents reviewed for urinary catheters (Resident #65). The findings included:<br><br>Resident #65 was admitted to the facility on 3/1/21 and had a diagnosis of neurogenic bladder with urinary retention.<br><br>The Admission Minimum Data Set (MDS) Assessment dated 3/5/21 noted the resident had severe cognitive impairment and required extensive to total assistance with ADLs (activities of daily living). The MDS noted the resident had an indwelling urinary catheter.<br><br>The resident ' s Care Plan dated 3/5/21 and updated on 3/26/21 noted the resident required an indwelling urinary catheter related to a diagnosis of neurogenic bladder. The | F 690 | F690<br>The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 4/15/2021<br><br>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.<br><br>On April 11th, 2021, Surveyor identified resident sitting in recliner with catheter bag placed in chair next to her instead of a position below the bladder.<br><br>On April 11th, 2021, Certified Nursing Assistant entered room and placed | |

| 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 04/15/2021 |

| 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 690 | Continued From page 26<br>interventions included the following: Avoid obstruction in the drainage. Position the bag below the level of the bladder.<br>There was a physician ' s order dated 3/16/21 to maintain the catheter bag below the level of the bladder.<br><br>On 4/11/21 at 1:10 PM Nursing Assistant (NA) #1 and NA #2 were observed to transfer Resident #65 from a wheelchair to a recliner with the use of a mechanical lift. The resident was observed to have a lift pad underneath her and the urinary catheter drainage bag was placed in the wheelchair to the right side of the resident. The NAs were observed to connect the lift to the lift pad and transferred the resident from the wheelchair to a recliner. Once settled in the recliner, the NAs removed the mechanical lift and the NAs left the room with the lift at 1:22 PM. On 4/11/21 at 1:24 PM NA #2 returned with a blanket and placed it over the resident and left the room. The urinary drainage bag remained in the chair beside the resident and above the level of the bladder. Resident #65 stated: "They forgot to put that bag down."<br><br>On 4/11/21 at 2:17 PM the resident was observed sitting in a recliner in her room. The urine drainage bag was observed to be in the chair beside the resident and was above the level of the resident ' s bladder.<br><br>On 4/11/21 at 2:35 PM the resident was observed sitting in a recliner in her room with the urinary drainage bag in the chair beside her above the level of the bladder. NA #1 was asked to check the resident ' s catheter. NA #1 was observed to return to the resident ' s room and hung the urinary catheter bag on the bottom of the bed | F 690 | catheter bag below resident's bladder correcting deficiency. Two Certified Nursing Assistants, who were working with the resident at the time, were in-serviced by Director of Nursing on the importance of keeping catheter bag below bladder to avoid issues with drainage. A full audit of all residents with catheters was completed by Administrator, Director of Nursing and Unit Managers to ensure all catheter bags were stored below the bladder. No new issues identified.<br><br>Director of Nursing and Unit Managers in-serviced all Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants on the importance of placing a catheter bag below bladder level to prevent issues with drainage. Anyone not in-serviced by May 14th will not work until in-serviced.<br><br>To ensure quality assurance the Director of Nursing, Unit Managers or other appointed staff will audit all residents with catheters for appropriate placement. Audits will be completed five times per week for two weeks, then three times per week for two weeks, then weekly for two months.<br><br>All findings will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. The Quality Assurance Team will determine if additional monitoring is needed based upon the outcomes of the findings. | |

| 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 04/15/2021 |

| 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 690 | Continued From page 27<br>frame and stated that the urine should flow down and stated: "That was a careless mistake."<br><br>On 4/15/21 at 8:35 AM NA #2 stated in an interview that the drainage bag should be lower than the bladder and she forgot to reposition the bag prior to leaving the room on 4/11/21.<br>On 4/15/21 at 5:08 PM the Administrator stated in an interview that the catheter drainage bag should be lower than the bladder. | F 690 | | |
| F 759 SS=E | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and staff interviews, the facility failed to administer medications with a 5 percent (%) or less error rate as evidenced by 3 medication administration errors out of 25 opportunities for a medication error rate of 12% for 3 of 8 resident (Residents #6, 243, 60).<br><br>The findings included:<br><br>1. A review of Resident #6's Physician Orders for April 2021 included current medication order for Aspirin 81mg EC (enteric coated) by mouth once daily.<br><br>Review of the manufacturer's instruction included the following instructions: Do not crush or chew enteric coated tablets. Doing so can increase | F 759 | The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 4/15/2021<br><br>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.<br><br>On April 14-15, 2021, Nurse #6 was observed crushing enteric coated aspirin. Resident #6 suffered no adverse side effects from medication error. Facility did not have Diclofenac Sodium Topical Gel | 5/14/21 |

| 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 04/15/2021 |

| 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 759 | Continued From page 28<br>stomach upset. Doing so can release all the medication at once, increasing the risk of side effects.<br><br>On 4/14/2021 at 8:47 AM during the observation of a medication pass, Nurse # 5 was observed as she crushed the medication, placed it in applesauce and administered the medication to Resident #6.<br><br>An interview was conducted with Nurse #6 on 4/14/2021 at 8:55 AM. The Nurse stated she had always crushed the aspirin when administering Resident #6 her medication. The Nurse stated she did not realize the medication could not be crushed.<br><br>An interview was conducted with unit manager #1 on 4/14/21 at 9:01 AM. During the interview the manager stated enteric coated tablets should not be crushed.<br><br>2. On 4/15/2021 at 11:27 AM during the observation of a medication pass, nurse #1 was not able to administer Resident #243's diclofenac sodium topical gel 1% because it was not received from the pharmacy, so medication was omitted. The Nurse did not administer the medication because it was not available from pharmacy and marked medication as not available on the medication administration record.<br><br>An interview was conducted with the Nurse at on 4/14/2021 at 11:33 AM. The Nurse revealed that the medication was not available, and she would have to order medication from the pharmacy.<br><br>An interview was conducted with the DON on 4/15/2021 at 9:00 AM who stated medications | F 759 | 1% available. Two resident missed dose due to medication not being available. Neither resident suffered adverse side effects from missed medications.<br><br>On April 14th, 2021, Medication order was changed by Physician Assistant to chewable aspirin. On April 15th, 2021, Diclofenac Sodium Topical Gel 1% arrived in facility at 3pm and was administered according to consult from in house Physician Assistant.<br><br>Director of Nursing conducted full audit of Enteric Coated Aspirin orders to ensure no resident with crushed medication orders or residents who receive medications via G-Tube had orders in place for enteric coated medication. Consultant Pharmacist reviewed all orders for residents who receive crushed medications or medications via G-Tube for conflicting issues. Director of Nursing and Unit Managers in-serviced all Registered Nurses, Licensed Practical Nurses and Medication Aides on not crushing medications with enteric coating. Any one not in-serviced by May 14th, 2021 will not work until in-serviced. Director of Nursing and Unit Managers in-serviced all Registered Nurses, Licensed Practical Nurses and Medication Aides on the proper process when a medication is not available in house. Any one not in-serviced by May 14th, 2021 will not work until in-serviced.<br><br>To ensure quality assurance Director of nursing, Unit Manager or Pharmacy | |

| 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 04/15/2021 |

| 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 759 | Continued From page 29<br>were to be administered at the time prescribed.<br><br>3. On 4/15/2021 at 5:05 PM during the observation of a medication pass, Nurse #6 was not able to administer Resident #50's diclofenac sodium topical gel 1% because it was not received from the pharmacy, so medication was omitted. The Nurse did not administer the medication because it was not available from pharmacy proceeded to order medication from the pharmacy via the electronic medication administration record.<br><br>An interview was conducted with the Nurse on 4/15/2021 at 5:10 PM. The Nurse revealed that the medication was not available, and she had ordered from the pharmacy.<br><br>An interview was conducted with the DON on 4/15/2021 at 9:00 AM who stated medications were to be administered at the time prescribed. | F 759 | Consultant Nurse will conduct random weekly Med Pass Audits for six weeks.<br><br>All findings will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. The Quality Assurance Team will determine if additional monitoring is needed based upon the outcomes of the findings. | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: | F 880 | | 5/14/21 |

| 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 04/15/2021 |

| 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 880 | Continued From page 30 | F 880 | | |

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents

| 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 04/15/2021 |

| 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 880 | Continued From page 31<br>identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record reviews the facility failed to place Enhanced Droplet Precaution signage on the doors of residents on 14-day quarantine for new admissions, readmissions for 2 of 6 residents reviewed for infection control (Resident #73 & Resident #76) and implement infection control procedures when staff entered resident rooms without wearing appropriate Personal Protective Equipment (PPE) for 2 of 2 residents observed (Resident #16 & Resident #73). The facility failed to follow infection control guidelines to prevent cross contamination when 1 of 2 dietary aides (Dietary Aide #2) touched the outside of their face mask and then handled clean dishes without performing hand hygiene. This failure occurred during a global pandemic.<br>The findings included:<br><br>1. Review of the policy titled "COVID Procedures, Quarantine Guidance" dated March 2021 revealed facilities should quarantine unvaccinated residents that are being admitted into the facility for a 14-day quarantine period.<br><br>Review of Isolation Rooms In-Service dated | F 880 | The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 4/15/2021<br><br>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.<br><br>On April 11-13, 2021, two residents on Enhanced Droplet Precautions were noted to not have proper signage on their doors. Two Housekeeping staff were identified by state surveyor to briefly enter rooms of residents on Enhanced Droplet Precautions, and they did not don gowns. One dietary staff member was identified by state surveyor to touch her face mask and not perform hand hygiene before returning to her duties.<br><br>On April 11-13, 2021, both signs were | |

| 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 04/15/2021 |

| 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 880 | Continued From page 32<br>2/10/21 revealed Isolation rooms are designated by Enhanced Isolation Signs on the door or above the resident name.<br><br>A review of Resident #73's Electronic Health Record (EHR) revealed a physician order dated 3/30/21 that stated Strict Enhanced Droplet Precautions 3/30/21 - 4/13/21. The EHR revealed Resident #73 had not been fully vaccinated for SARS-CoV-2.<br><br>An observation on 4/11/21 at 1:02PM revealed Resident #73 was admitted to the facility from the hospital on 03/30/21, there was no Enhanced Droplet Precautions or transmission based precaution signage on the room door.<br><br>A review of Resident #76's EHR revealed a physician order dated 3/30/21 that stated Strict Enhanced Droplet Precautions 3/31/21 - 4/14/21. The EHR revealed Resident #76 had not been fully vaccinated for SARS-CoV-2.<br><br>An observation on 4/11/21 at 3:40PM revealed Resident #76 was admitted to the facility from the hospital on 3/31/21, there was no Enhanced Droplet Precautions or transmission based precaution signage on the room door.<br><br>During an interview with NA#2 on 4/11/21 at 3:12PM, she stated residents on Enhanced Droplet Precautions had signage on their room. NA#2 further stated that was how she knew when a resident was on EDP.<br><br>During an interview with Nurse #1 on 4/11/21 at 3:16PM, she stated the Admissions Director was responsible for placing EDP signage on resident rooms. | F 880 | immediately rehung appropriately with stronger quality tape to prevent them falling. Dietary Manager immediately asked dietary aide to stop what she was doing and wash hands before returning to duties since she had touched her mask. All Isolation Signs were retaped with new tape and on all four sides to ensure they did not fall.<br><br>Director of Marketing and Admissions was in-serviced on the importance of making sure all signs are hung properly and adequately to prevent them from falling. Director of Housekeeping and Director of Nursing began in-service with all housekeeping staff on the proper PPE to be worn in Enhanced Isolation rooms using video: CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: PPE Lessons https://www.youtube.com/watch?v=YYTATw9yav4 Any Housekeeping Staff not in-serviced by May 7th 2021 will not report to work until in-serviced. Dietary Manager and Director of Nursing began in-service with all Dietary Aides on the importance of hand hygiene using video: Clean Hands - https://youtu.be/xmYMUly7qiE Any Dietary Aide not in-serviced by May 7th 2021 will not be able to report to work until in-serviced.<br><br>To ensure quality assurance the Director of Marketing and Admissions, or other appointed staff member will audit all isolation signs to assure they are securely hung. Audits will be five times per week for two weeks, then three times per week | |

| 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 04/15/2021 |

| 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 880 | Continued From page 33<br><br>During an interview with the Admissions Director on 4/11/21 at 4:08PM revealed she was responsible to ensure the EDP signage was on the resident room for new admissions. She further revealed she followed the Quarantine Guidance for COVID-19, dated March 2021. The admitting nurse would ensure the signage was in place.<br><br>During an interview with the Administrator on 4/15/21 at 5:00PM, she stated EDP signage was to be placed on resident rooms using the Quarantine Guidance for COVID-19, dated March 2021.<br><br>2. Review of the policy titled "COVID Procedures, PPE" dated March 2021 revealed a paragraph titled Residents under investigation (14-day isolation). The policy instructed staff to wear a mask, eyewear, gown and gloves. It further stated the gown and gloves must be changed between residents.<br><br>Review of the Enhanced Droplet Isolation signage revealed before entering this room, follow the instructions below. The instructions stated staff should don a mask, eye protections, gown and gloves prior to entering the resident room.<br><br>a. Resident #16 was readmitted into the facility on 4/11/21 and was placed on Enhanced Droplet Precautions for 14-day quarantine.<br><br>An observation on 4/11/21 at 12:58PM revealed Housekeeping Staff (HK) #1 entered Resident #16's room to empty trash. HK #1 was wearing a mask and no other PPE. | F 880 | for two weeks, then one time per week for four weeks. Director of Housekeeping will perform random audits of housekeeping staff entering isolation rooms to ensure they are donning the proper PPE five times per week for two weeks, then three times per week for two weeks, then one time per week for four weeks. Dietary Manager will perform random audits to ensure proper hand hygiene by dietary staff five times per week for two weeks, then three times per week for two weeks, then one time per week for four weeks.<br><br>All findings will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. The Quality Assurance Team will determine if additional monitoring is needed based upon the outcomes of the findings. | |

| 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 04/15/2021 |

| 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 880 | Continued From page 34 | F 880 | | |

During an interview on 4/11/21 at 1:00PM with HK#1, she stated she was required to wear PPE, to include a gown, gloves, mask and eyewear but she did not. She further stated she was to perform hand hygiene when exiting the resident room. HK #1 indicated she was aware she needed to wear the PPE but was just entering the room quickly to gather trash.

b. Resident #73 was admitted into the facility on 3/30/21 from the hospital and was placed on Enhanced Droplet Precautions for 14-day quarantine.

An observation on 4/11/21 at 1:02PM revealed HK #2 entered Resident #73's room to empty trash. HK #2 was wearing a mask and no other PPE.

During an interview on 4/11/21 at 1:05PM with HK #2, she stated she was required to wear PPE, to include a gown, gloves, mask, and eyewear. HK #2 stated the PPE was to be removed and discarded in the resident room and Alcohol Based Hand Rub (ABHR) was to be applied.

An interview on 4/15/21 at 8:15AM with the Housekeeping Manager revealed housekeeping staff had received training on proper use of PPE and hand hygiene. She further revealed when a resident was on EDP, staff was to don a mask, goggles, gown and gloves prior to entering the room. The Housekeeping Manager stated, after providing services, the staff was to doff the PPE in the resident room, discard the PPE in a biohazard bag and perform hand hygiene. The Housekeeping Manager stated staff were aware if a resident was on EDP through signage placed on the resident door.

| 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 04/15/2021 |

| 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 880 | Continued From page 35 | F 880 | | |

An interview with the Director of Nursing on 4/15/21 at 3:00PM revealed staff had received training on how to don/doff PPE and when to use PPE. She further stated staff were to wear PPE each time they entered the room of a resident on EDP.

During an interview with the Administrator on 4/15/21 at 5:00PM, she stated staff were to wear PPE when entering the room of a resident on EDP.

3. Review of the PPE (Personal Protective Equipment) In-Service dated 3/22/21 document dietary staff attended the training. Review of the training material, example #2, How to Safely Remove Personal Protective Equipment (PPE). Under item 3. Reads as: Mask or Respirator. Front of mask/ respirator is contaminated-Do Not Touch. If your hands get contaminated during mask/ respirator removal, immediately wash your hands, or use alcohol-based hand sanitizer.

The facility Food Service, Dishwashing Machine use, policy revised on March 2010, under Policy Interpretation and Implementation reads as: The following guidelines will be followed when dishwashing: a. Wash hands before and after running dishwashing machine, and frequently during the process.

On 4/13/21 at 2:00 PM dietary staff were observed running the dish machine. Dietary aide #1 was observed, loading the dirty dishware, and running through the dish machine. dietary aide #2 was observed to wash her hands and go to the clean side of the dish machine. Dietary aide #2 pulled the clean dishware out onto the dish shelf

| 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 04/15/2021 |

| 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 880 | Continued From page 36<br>and then placed the items onto the drying rack. The dietary aide #2 member was observed to touch, readjust her face mask with her bare hands, and pull a rack of clean plates out of the dish machine. Then dietary aide #2 began to stack the clean plates without washing her hands.<br><br>In an interview on 4/13/21 Dietary Aide # 2 stated she should have washed her hands after touching her face mask.<br><br>In an interview on 4/13/21 the Certified Dietary Manager stated that staff should make sure to not cross contaminate and wash their hands before touching clean dishware. She indicated face masks slide down, however staff should wash their hands after touching their face mask. | F 880 | | |
| F 881 SS=E | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, record review and staff interview the facility failed to implement an antibiotic stewardship program to monitor antibiotic usage in the facility. The findings included:<br><br>Review of the facility's policy titled Antibiotic | F 881 | F881<br>The Lodge at Rocky Mount Health and Rehabilitation Credible Allegation 4/15/2021<br><br>Preparation and or execution of this plan does not constitute admission or | 5/14/21 |

| 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 04/15/2021 |

| 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 881 | Continued From page 37<br>Stewardship, revised on December 2016 revealed the following: "Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form." The information to be documented on the form included the pathogen identified.<br><br>On 4/15/21 at 9:35 AM the Director of Nursing (DON) was asked who did the training for the nursing staff in the facility and the DON stated: "We all do."<br><br>In an interview with the Administrator on 4/15/21 at 3:44 PM the Administrator provided the facility's infection control logs for March and April 2021 that included the name of the resident and the laboratory culture obtained if any. When asked how she monitored the culture results and if the antibiotic was effective the Administrator stated they received a report from the pharmacy at the end of each month that contained all the antibiotics ordered for that month and the results of any cultures ordered. The culture results were not listed on the facility's infection control log or if an antibiotic was ordered for the infection based on the culture results and showed no evidence of review until the end of the month when compared with the report received from the pharmacy.<br><br>On 4/15/21 at 4:15 PM the Administrator provided the report she received from the pharmacy titled Antibiotic Medications Report: 03/01/21 - 03/31/21. The report listed the resident's name, start and end date of the antibiotic, the physician's order for the antibiotic, the diagnosis and the results of the culture if ordered. This information was not documented on a routine basis on the facility's infection control logs and no outcome was documented. | F 881 | 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.<br><br>On April 15, 2021 it was identified that the center's antibiotic stewardship program did not include a tracking form that included the pathogen identified.<br>Corrective action is for those who have the potential to be affected. Any resident that requires an antibiotic has the potential to be affected by this alleged deficient practice.<br>By May 14th 2021 the Director of Nursing will be educated by the Regional Clinical Manager on proper use of the system for Infection Tracking. By May 14th 2021 the Director of Nursing and Unit Managers will be educated by the Regional Clinical Manager on how to utilize the Matrix system for tracking of all antibiotic usage.<br>The Director of Nursing and/or Unit Managers will enter antibiotic usage into the Infection Event and Tracker of Matrix. The event will be left open until the antibiotic has completed at which time follow up documentation will be completed.<br>To ensure quality assurance the Director of Nursing/Unit Managers, utilizing a QA auditing tool, will review the weekly antibiotic reports generated from Matrix during clinical morning meeting to ensure all antibiotic use is tracked in the system, weekly for the next 2 months, and then monthly for the next two months. | |

| 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 04/15/2021 |

| 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 881 | Continued From page 38<br><br>The Administrator stated she had been SPICE (Statewide Program for Infection Control and Epidemiology) trained and the Director of Nursing was new to the role and was signed up for the SPICE training in September of this year. The Administrator stated that she and the DON were doing the infection control in the facility at this time.<br><br>SPICE is a statewide program in North Carolina for infection control and epidemiology to promote the prevention and control of health care associated infections. | F 881 | The results will be reported by the Director of Nursing, to the monthly QAPI meeting for any further recommendations or root cause analysis. The Director of Nursing will be responsible to follow-up on any recommendation from the committee and additional training is indicated. | |