STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345311	A. BUILDING _____ B. WING _____	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROXBORO HEALTHCARE & REHAB CENTER	901 RIDGE ROAD ROXBORO, NC 27573

(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 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide privacy cover for the urinary catheter drainage bag for 1 of 1 sampled resident with an indwelling catheter (Resident #151). The findings included: Resident #151 was admitted on 6/20/16. The diagnoses included, urinary retention, pressure ulcer and neuromuscular dysfunction of bladder. The quarterly Minimum Data Set assessment, dated 3/3/17, indicated Resident #151 had severe cognitive impairments and required total assistance with activities of daily living. During an observation on 5/2/17 at 3:25 PM, Resident #151 was lying in bed with an uncovered drainage bag on the floor that could be seen from the hall. The bed was at the lowest position on the floor and the drainage bag and tubing were lying beside the resident on the floor at the same level as the urinary bladder. During an interview on 5/2/17 at 3:34 PM, Nurse #2 confirmed Resident 151 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor without privacy cover. Nurse #2 stated the urinary drainage bag should be	F 241	F241 STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #151 was given a privacy cover for their urinary catheter drainage. For those residents having the potential to be affected by the same alleged deficient practice(s), the facility has in-serviced all nursing staff on the enhancement of quality of life and how to protect and promote the residents rights with dignity. Similarly, licensed nurses were instructed by the Assistant Director of Nursing on the facility□s expectation specific to the provision of Catheter care protocol. To ensure compliance the direct care workers will complete a daily rounding worksheets for those residents with indwelling Foley catheter systems for a	5/26/17

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

Electronically Signed | 05/26/2017

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F 241	Continued From page 1 covered. During an interview on 5/2/17 at 3:34 PM, the Nurse Aide (NA #3) confirmed Resident #151 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor next to the resident without privacy cover. NA #3 emptied the urinary drainage bag while the bed remained on the floor. NA #3 stated he was unaware of who lowered the bed and left the drainage bag uncovered or on the floor. During an interview on 5/3/17 at 2:53 PM, the Assistant Director of Nursing (ADON) stated the expectation was for the staff to provide a privacy bag over the drainage bag. During an interview on 5/4/17 at 9:15 AM, the Administrator stated the expectation was for staff to provide a privacy cover over the drainage bag.	F 241	privacy cover over the drainage bag. Daily during shift the charge nurse(s) shall make direct observations and monitor the completion of the daily rounding worksheet each shift. The Director of Nursing or designee shall conduct weekly audits for one month and then quarterly audits thereafter. The Director of Nursing shall present any identified findings/observed discrepancies, to the Assurance Committee monthly for one month and quarterly thereafter.	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (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. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		5/26/17

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F 315	Continued From page 2 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interviews and record review, the facility failed to keep the drainage bag off the floor and below the bladder for 1 of 1 sampled resident with an indwelling catheter (Resident #151). The findings included: Resident #151 was admitted on 6/20/16. The diagnoses included, urinary retention, pressure ulcer and neuromuscular dysfunction of bladder. The quarterly Minimum Data Set assessment, dated 3/3/17, indicated Resident #151 had severe cognitive impairments and required total assistance with activities of daily living. Review of the care plan, updated on 3/3/17,	F 315	F315 STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #151□s catheter was replaced and reposition for proper placement below the bladder. For those residents having the potential to be affected by the same alleged deficient	

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F 315	Continued From page 3 identified the history of recurrent urinary tract infection and catheter present due to stage IV pressure ulcer on coccyx. The goal included the resident would have reduced symptoms of urinary tract infection, reduced adverse effects from antibiotics and would be clean, dry, free of odors. The interventions included encourage fluids, provide catheter care as indicated, report signs and symptoms of dehydration to physician and notify family of changes. During an observation on 5/2/17 at 3:25 PM, Resident #151 was lying in bed with urinary drainage bag on the floor. The bed was at the lowest position on the floor and the drainage bag and tubing was lying beside the resident on the floor at the same level as the urinary bladder. During an interview on 5/2/17 at 3:25 PM, the family member stated Resident 151 ' s bed had been lowered to the floor by the aide, but was unsure which aide had lowered the bed. The drainage bag had been lying beside the resident since the bed was lowered. During an interview on 5/2/17 at 3:34 PM, Nurse #2 confirmed Resident 151 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor and the urinary drainage bag was on the same level as the urinary bladder. Nurse #2 stated the urinary drainage bag should kept below the urinary bladder and off the floor. During an interview on 5/2/17 at 3:34 PM, the Nurse Aide (NA#3) confirmed Resident #151 ' s bed was positioned on the floor and the urinary drainage bag was lying on the floor next to the resident without privacy cover. NA#3 emptied the urinary drainage bag while the bed remained on	F 315	practice(s), all licensed nursing staff and direct care staff have been in-serviced by the Assistant Director of Nursing, specific to the correct Foley catheter care and management, proper placement, prevention of infection and proper protocol. To ensure compliance, direct care workers will complete a daily rounding worksheets for those residents with indwelling Foley catheter systems for proper placement of the drainage bag. Daily during shift the charge nurse(s) shall make direct observations being sure to observe the proper placement of the drainage bag and monitor the completion of the daily rounding worksheet The Director of Nursing or designee shall conduct weekly audits for one month and then quarterly audits thereafter. The Director of Nursing shall present any identified findings/observed discrepancies, to the Quality Assurance Committee monthly for one month and quarterly thereafter.	

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F 315	Continued From page 4 the floor. NA#3 stated he was unaware of who lowered the bed and left the drainage bag uncovered or on the floor. During an interview on 5/3/17 at 2:53 PM, the Assistant Director of Nursing (ADON) stated the expectation was for the staff to ensure the catheter drainage bag was below the bladder. ADON stated the resident's bed should have been at proper position. The ADON stated the catheter bag should be both off the floor and below the level of the bladder. During an interview on 5/4/17 at 9:15 AM, the Administrator stated the expectation was for staff to ensure the urinary drainage bag was below the urinary bladder and off the floor.	F 315		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy	F 328		5/26/17

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F 328	Continued From page 5 services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff	F 328	F328	

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F 328	Continued From page 6 interviews the facility failed to administer oxygen as ordered for 1 of 1 resident reviewed for oxygen therapy (Resident #28). Findings included: Resident #28 was admitted on 1/6/17. Review of the quarterly Minimum Data Set assessment, dated 3/24/17, revealed that the resident was moderately cognitively impaired. His diagnoses included chronic obstructive pulmonary disease (COPD) and anemia. The resident received oxygen therapy. Review of Resident 28 ' s physician ' s order dated 3/18/17 revealed the order for oxygen therapy via nasal cannula four liters per minute continuously, as well as order to check the oxygen saturation (oxygen blood level) every shift. Review of Resident 28 ' s plan of care, dated 3/29/17, revealed an alteration in oxygenation. The goal was to keep the resident with adequate oxygenation. The approaches were to administer oxygen as ordered, monitor for respiratory distress and vital signs. Review of Resident 28 ' s Medication Administration Record from 5/1/17 to 5/4/17 revealed that the oxygen therapy via nasal cannula four liters per minute continuously was provided during first and second shifts. Review of Resident 28 ' s vital signs records for May 2017 revealed the abnormal oxygen saturation as 94% on 5/1/17 at 3:48 PM and 92% on 5/2/17 at 8:37 PM (normal range is between 95 and 100%).	F 328	STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #28□s oxygen was reapplied as ordered. A respiratory assessment was completed by a licensed nurse and the physician notified of the assessment findings. Oxygen currently is currently being administered per physician orders. For those residents having the potential to be affected by the same alleged deficient practice(s), all residents with physician orders for oxygen were assessed for oxygen administration delivery according to physician□s orders and all were compliant. All licensed nursing staff and direct care staff have been in-serviced by the Assistant Director of Nursing, specific to oxygen administration, following physician orders related to oxygen and monitoring the resident receiving oxygen. To ensure compliance, during each shift the direct care workers will complete an Oxygen Round Report monitoring the residents receiving oxygen administration and the licensed nurse will monitor the completion of the daily rounding report. The Director of Nursing or designee shall conduct weekly audits for one month and	

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F 328	Continued From page 7 Record review of Resident 28 ' s nurses ' notes, dated 5/1/17 at 1:05 PM and 5/2/17 at 3:10 PM, revealed that the resident received oxygen therapy continuously via nasal cannula four liters per minute with no noted respiratory distress. During the observations on 5/1/17 at 10:10 AM, 10:50 AM and 11:50 AM, Resident #28 was sitting in the wheelchair in his room: the oxygen tubing and nasal cannula were on the floor, connected to the working oxygen concentrator. The resident did not show symptoms of respiratory distress. During the observations on 5/2/17 at 11:50 AM, 1:20 PM, 2:30 PM, 3:40 PM and 4:30 PM, Resident #28 was sitting in the wheelchair in his room. The nasal cannula was on resident ' s face, connected to the oxygen cylinder, attached to the wheelchair. The oxygen flow meter was set up for four liters per minute with the oxygen regulator gauge indicated "0" level of oxygen. The resident did not show symptoms of respiratory distress. On 5/2/17 at 11:10 AM, during an interview, Nurse #1 indicated that Resident #28 had diagnosis of COPD and received oxygen therapy via nasal cannula four liters per minute continuously. All the staff was responsible for providing the oxygen therapy equipment and supply for Resident #28 during all three shifts. She stated the nurse aides checked the status of oxygen therapy with every round and reported to the nurse when the oxygen cylinder needed to be changed. All the nurses had access to the locked oxygen supply room. On 5/3/17 at 10:10 AM, during an interview, Restorative Aide #1, who was assigned to work	F 328	then quarterly audits thereafter. The Director of Nursing shall present any identified findings/observed discrepancies, to the Quality Assurance Committee monthly for one month and quarterly thereafter.	

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F 328	Continued From page 8 with Resident #28, indicated that the resident received oxygen therapy via nasal cannula four liters per minute. She stated the aides checked the status of oxygen therapy with every round and reported to the nurse when the oxygen cylinder needed to be changed. She indicated she did not observe Resident #28 with the oxygen tubing and nasal cannula lying on the floor or empty oxygen cylinder. On 5/3/17 at 12:10 PM, during an interview, the Physician indicated that if the continuous oxygen therapy was ordered, she expected the resident to have the oxygen therapy at all times.	F 328		