STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID # HWV911.	F 000		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review the facility failed to repair the closets for 5 of 40 rooms observed (rooms 417, 415, 409, 408, and 412), failed to repair the walls for 4 of 40 rooms observed (rooms 415, 305, 408, and 227), failed to repair the footboard for 1 of 40 rooms observed (room 409), and failed to repair the headboard for 1 of 40 rooms observed (room 415). Findings included: 1. During observation on 6/5/17 at 4:07 PM and 6/7/17 at 2:17 PM room 417 had two 1 inch by 3 inch sections of veneer on the resident's closet chipped off the left edge and the bottom left corner of the resident's closet. Review of the maintenance orders for April, May, and June 2017 revealed that there were no maintenance slips completed for room 417 regarding the closet. During an interview on 6/5/17 at 4:08 PM Resident #194, the resident in room 417, stated that she would not have a piece of furniture in her home that was in that state.	F 253	1. The closets in need of repair in rooms 417, 415, 409, 408 and 412 will be repaired by the maintenance staff and completed by 7/5/17. The walls that are need of repair in rooms 415, 305, 408 and 227 will be repaired by the maintenance staff and completed by 6/9/17. The footboard in need of repair in room 409 will be repaired by the maintenance staff and completed by 6/9/17. The headboard in need of repair in room 415 will be repaired by the maintenance staff and completed by 6/8/17. 2. 100% observation of all rooms were completed by 6-22-17 by Administrator to ensure that any closets, walls, footboards and headboards were in good repair. Any work orders were completed on 6-23-17 by Administrator for notification to maintenance for any identified areas of concern. The maintenance staff addressed all areas of concern from the	7/5/17

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

Electronically Signed | 06/26/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 1 During an interview on 6/7/17 at 2:42 PM Nurse Aide #1 stated that if she were to notice any furnishings in the residents' rooms or walls in the residents' rooms that were in disrepair, chipped, or splintered she would complete two reports. The first report goes to the maintenance book at the nurse's station and then she would verbally report the concern to the maintenance director. During an interview on 6/7/17 at 2:46 PM Nurse Aide #2 stated that if he saw a resident had a concern with their room or if he noticed the walls were in disrepair or if furniture was in disrepair he put the information in the maintenance log at the nurse's station and then maintenance took care of it. During an interview on 6/7/17 at 3:11 PM Nurse #1 stated that if she noticed that veneer was chipped from the resident's furniture or if there was chipping on a resident's wall they were supposed to fill out a maintenance slip at the nurse's station and the maintenance director checked the book every morning. During an interview on 6/7/17 at 3:21 PM the Maintenance Assistant stated that there was not a current maintenance director in the facility and that he was the only maintenance personnel at that time. He further stated to his knowledge there were no plans to replace or repair the closets, walls, or head and footboards in the resident rooms. He further stated that he did not have any work slips for the closet in room 417. After observing the closet in room 417 he stated that the closet was in disrepair. During an interview on 6/7/17 at 3:50 PM the	F 253	audit by 7-5-17. 3. The maintenance department was in-serviced 100%, to include the maintenance assistant, by the Director of Nursing (DON) on 6-7-17 to check rooms for needed repairs, to include closets, walls, footboards and headboard, daily during the daily room checks and to repair if needed. A monthly schedule was provided to the Administrator on 6-22-17 from maintenance department for room checks for needed repairs to include, closets, walls, footboards and headboards. Licensed nurses and nursing assistants to include, Nurse aide #1 and #2 and Nurse #1, were in-service by the DON and/or Administrator starting on 6/7/17 and completed on 6/26/17 to notify Maintenance of any repairs needed, to include closets, walls, headboards and footboards, when providing care to the residents by completing a work order in the maintenance log. After 6/26/17, Licensed nurses and nursing assistants were not permitted to provide care for patients until they received the aforementioned in-service. All newly hired license nurses and nursing assistants will be in-serviced by the staff facilitator/DON regarding notification of rooms needing repair to include, closets, walls, footboard and headboards, noted during daily care of the residents by completing a work order slip and giving it to Maintenance. All newly hired Maintenance staff will be in-serviced by the Maintenance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 2 Administrator, after observing room 417's closet, stated his expectation was the closet be in good repair and it was not. 2. During observation on 6/6/2017 at 8:22 AM, and 6/7/17 at 2:21 PM room 415 had a 1 inch by 5 inch section of veneer on the resident's closet chipped off the right edge and bottom right corner of the resident's closet. There was a small, inch long gash in the right edge of the closet, about a foot from the floor, with slight splintering. A section of the wall beside the A bed, approximately 5 inches by 6 inches, had the paint scraped off and the plaster scratched. The headboard of the A bed was split vertically and the resulting right and left sides of the headboard remained attached to each other only by the plastic edging. Review of the maintenance orders for April, May, and June 2017 revealed that there were no maintenance slips completed for room 415 regarding the closet, wall, or A bed headboard. During an interview on 6/6/17 at 8:22 AM Resident #50, a resident in room 415 stated that the closet corners had been chipped since she got there and didn't know why but that it could be dangerous. During an interview on 6/7/17 at 2:42 PM Nurse Aide #1 stated that if she were to notice any furnishings in the residents' rooms or walls in the residents' rooms that were in disrepair, chipped, or splintered she would complete two reports. The first report goes to the maintenance book at the nurse's station and then she would verbally report the concern to the maintenance director.	F 253	Director/Administrator to check rooms for needed repairs, to include closets, walls, footboards and headboard, daily during the daily room checks and to repair if needed any closets, walls, footboards and/or headboards found during daily room checks. 3. The administrative staff, to include the Account Receivable Bookkeeper 1, Accounts Receivable Bookkeeper 2, Medical Records Manager, Medical Records Assistant, Payroll Bookkeeper, Admissions Coordinator, Dietary Manager, Activities Coordinator, and Social Worker will monitor 100% of all resident rooms, to include rooms 417, 415, 409, 408, 412, 305, and 227 for rooms in good repair weekly x 8 weeks then monthly x 1 utilizing an Environmental Quality QI tool. The Maintenance department will address immediately any identified areas of concern during the audit. The Administrator will review the Environmental Quality QI Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. 4. The Executive QI committee will meet monthly and review the Environmental Quality QI Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 3 During an interview on 6/7/17 at 2:46 PM Nurse Aide #2 stated that if he saw a resident had a concern with their room or if he noticed the walls were in disrepair or if furniture was in disrepair he put the information in the maintenance log at the nurse's station and then maintenance took care of it. During an interview on 6/7/17 at 3:11 PM Nurse #1 stated that if she noticed that veneer was chipped from the resident's furniture or if there was chipping on a resident's wall they were supposed to fill out a maintenance slip at the nurse's station and the maintenance director checked the book every morning. During an interview on 6/7/17 at 3:21 PM the Maintenance Assistant stated that there was not a current maintenance director in the facility and that he was the only maintenance personnel at that time. He further stated to his knowledge there were no plans to replace or repair the closets, walls, or head and footboards in the resident rooms. He further stated that he did not have any work slips for the closet, walls, and headboard in room 415. After observing the closet, walls, and A bed headboard in room 415 he stated that they were in disrepair. During an interview on 6/7/17 at 3:50 PM the Administrator, after observing room 415's closet, wall, and A bed headboard stated it was his expectation that they were in good repair and they were not. 3. During observation on 6/6/17 at 8:22 AM and 6/7/17 at 2:31 PM room 409 had veneer on the resident's closet chipped off the right edge around the bottom drawer approximately 6 inches	F 253	frequency of monitoring x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 4	F 253		

up the side from the bottom right corner. Two approximately 1.5 foot by 1 inch strips of veneer were missing above both the bottom right and left drawers in the closet, and three approximately 1 inch by 2 inch sections of veneer were missing from the left bottom edge of the closet. The veneer and wood on the A bed footboard's right edge was chipped away which made an approximately 1 inch gap from the plastic edging down the right side of the footboard which was approximately 0.25 inches deep.

Review of the maintenance orders for April, May, and June 2017 revealed that there were no maintenance slips completed for room 409 regarding the closet or A bed footboard.

During an interview on 6/5/17 at 4:20 PM Resident #42, the resident in room 409's A bed, stated that the footboard on her bed had always been in disrepair and that the closet had always been chipped. She further stated that it bothered her because it was possible to cut herself on the chipping. She further stated she had not hurt herself on the furniture yet.

During an interview on 6/7/17 at 2:42 PM Nurse Aide #1 stated that if she were to notice any furnishings in the residents' rooms or walls in the residents' rooms that were in disrepair, chipped, or splintered she would complete two reports. The first report goes to the maintenance book at the nurse's station and then she would verbally report the concern to the maintenance director.

During an interview on 6/7/17 at 2:46 PM Nurse Aide #2 stated that if he saw a resident had a concern with their room or if he noticed the walls were in disrepair or if furniture was in disrepair he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 5	F 253		

put the information in the maintenance log at the nurse's station and then maintenance took care of it.

During an interview on 6/7/17 at 3:11 PM Nurse #1 stated that if she noticed that veneer was chipped from the resident's furniture or if there was chipping on a resident's wall they were supposed to fill out a maintenance slip at the nurse's station and the maintenance director checked the book every morning.

During an interview on 6/7/17 at 3:21 PM the Maintenance Assistant stated that there was not a current maintenance director in the facility and that he was the only maintenance personnel at that time. He further stated to his knowledge there were no plans to replace or repair the closets, walls, or head and footboards in the resident rooms. He further stated that he did not have any work slips for the closet and footboard in room 409. After observing the closet and A bed footboard in room 409 he stated that they were in disrepair.

During an interview on 6/7/17 at 3:50 PM the Administrator, after observing room 409's closet and A bed footboard, stated it was his expectation the closet and footboard be in good repair and they were not.

4. During observation on 6/6/17 at 10:15 AM and 6/7/17 at 3:02 PM room 305's wall beside the head of the A bed was observed to have approximately a 6 inch by 6 inch area where the paint had been scraped off the wall. Behind the head of the bed, the wall had three areas just above the headboard that were approximately 3 inches by 3 inches where the paint was scraped

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 6	F 253		

from the wall and dark marks surrounded the three areas.

Review of the maintenance orders for April, May, and June 2017 revealed that there were no maintenance slips completed for room 305 regarding the wall.

During an interview on 6/7/17 at 2:42 PM Nurse Aide #1 stated that if she were to notice any furnishings in the residents' rooms or walls in the residens' rooms that were in disrepair, chipped, or splintered she would complete two reports. The first report goes to the maintenance book at the nurse's station and then she would verbally report the concern to the maintenance director.

During an interview on 6/7/17 at 2:46 PM Nurse Aide #2 stated that if he saw a resident had a concern with their room or if he noticed the walls were in disrepair or if furniture was in disrepair he put the information in the maintenance log at the nurse's station and then maintenance took care of it.

During an interview on 6/7/17 at 3:11 PM Nurse #1 stated that if she noticed that veneer was chipped from the resident's furniture or if there was chipping on a resident's wall they were supposed to fill out a maintenance slip at the nurse's station and the maintenance director checked the book every morning.

During an interview on 6/7/17 at 3:21 PM the Maintenance Assistant stated that there was not a current maintenance director in the facility and that he was the only maintenance personnel at that time. He further stated to his knowledge there were no plans to replace or repair the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 7	F 253		

closets, walls, or head and footboards in the resident rooms. He further stated that he did not have any work slips for the wall in room 305. After observing the wall around the A bed in room 305 he stated that it was in disrepair.

During an interview on 6/7/17 at 3:50 PM the Administrator, after observing room 305's wall around the A bed, he stated it was his expectation the wall be in good repair and it was not.

5. During observation on 6/6/17 at 8:37 AM and 6/7/17 at 2:25 PM room 408's veneer on the resident's closet was observed to have a 1 inch by an 3 inch section of veneer missing from its left edge. The bottom left corner of the closet was missing a 1 inch by 3 inch section of veneer. The lower right edge of the closet had veneer that had peeled off in four spots, each approximately 1 inch by 2 inches. The wall on the left side of the A bed had an area approximately 6 inches by 2 feet at the A bed side rail where the paint had been scraped off the wall. Beside the head of the A bed the wall's plaster had been scraped from the wall creating a 2 inch by 2 inch indention in the wall.

Review of the maintenance orders for April, May, and June 2017 revealed that there were no maintenance slips completed for room 408 regarding the closet or wall.

During an interview on 6/7/17 at 2:42 PM Nurse Aide #1 stated that if she were to notice any furnishings in the residents' rooms or walls in the residents' rooms that were in disrepair, chipped, or splintered she would complete two reports. The first report goes to the maintenance book at the nurse's station and then she would verbally report the concern to the maintenance director.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 8	F 253		

During an interview on 6/7/17 at 2:46 PM Nurse Aide #2 stated that if he saw a resident had a concern with their room or if he noticed the walls were in disrepair or if furniture was in disrepair he put the information in the maintenance log at the nurse's station and then maintenance took care of it.

During an interview on 6/7/17 at 3:11 PM Nurse #1 stated that if she noticed that veneer was chipped from the resident's furniture or if there was chipping on a resident's wall they were supposed to fill out a maintenance slip at the nurse's station and the maintenance director checked the book every morning.

During an interview on 6/7/17 at 3:21 PM the Maintenance Assistant stated that there was not a current maintenance director in the facility and that he was the only maintenance personnel at that time. He further stated to his knowledge there were no plans to replace or repair the closets, walls, or head and footboards in the resident rooms. He further stated that he did not have any work slips for the closet and wall in room 408. After observing the closet and wall in room 408 he stated that they were in disrepair.

During an interview on 6/7/17 at 3:50 PM the Administrator, after observing room 408 ' s closet and wall, stated that it was his expectation they be in good repair and they were not.

6. During observation on 6/6/17 at 8:48 AM and 6/7/17 at 2:34 PM room 412's closet had a section of veneer, approximately 6 inches by 1 inch, missing off the lower left edge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 9	F 253		

Review of the maintenance orders for April, May, and June 2017 revealed that there were no maintenance slips completed for room 412 regarding the closet.

During an interview on 6/7/17 at 2:42 PM Nurse Aide #1 stated that if she were to notice any furnishings in the residents' rooms or walls in the residents' rooms that were in disrepair, chipped, or splintered she would complete two reports. The first report goes to the maintenance book at the nurse's station and then she would verbally report the concern to the maintenance director.

During an interview on 6/7/17 at 2:46 PM Nurse Aide #2 stated that if he saw a resident had a concern with their room or if he noticed the walls were in disrepair or if furniture was in disrepair he put the information in the maintenance log at the nurse's station and then maintenance took care of it.

During an interview on 6/7/17 at 3:11 PM Nurse #1 stated that if she noticed that veneer was chipped from the resident's furniture or if there was chipping on a resident's wall they were supposed to fill out a maintenance slip at the nurse's station and the maintenance director checked the book every morning.

During an interview on 6/7/17 at 3:21 PM the Maintenance Assistant stated that there was not a current maintenance director in the facility and that he was the only maintenance personnel at that time. He further stated to his knowledge there were no plans to replace or repair the closets, walls, or head and footboards in the resident rooms. He further stated that he did not have any work slips for the closet in room 412.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 10	F 253		

After observing the closet in room 412 he stated that it was in disrepair.

During an interview on 6/7/17 at 3:50 PM the Administrator, after observing room 412's closet, stated it was his expectation the closet be in good repair and it was not.

7. During observation on 6/5/17 at 12:46 PM and 6/7/17 at 2:38 PM room 227's wall behind the headboard was observed to have an area approximately 3.5 feet by 5 inches where the paint had been scraped off and the wood was splintered.

Review of the maintenance orders for April, May, and June 2017 revealed that there were no maintenance slips completed for room 227 regarding the wall.

During an interview on 6/5/17 at 12:48 PM, Resident #2, the resident in room 227, stated that she did know that the wall behind her was splintered and had always assumed that it was the best the facility could do. She further stated she would not want a wall in that state in her own home.

During an interview on 6/7/17 at 2:42 PM Nurse Aide #1 stated that if she were to notice any furnishings in the residents' rooms or walls in the residents' rooms that were in disrepair, chipped, or splintered she would complete two reports. The first report goes to the maintenance book at the nurse's station and then she would verbally report the concern to the maintenance director.

During an interview on 6/7/17 at 2:46 PM Nurse Aide #2 stated that if he saw a resident had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 253	Continued From page 11 concern with their room or if he noticed the walls were in disrepair or if furniture was in disrepair he put the information in the maintenance log at the nurse's station and then maintenance took care of it. During an interview on 6/7/17 at 3:11 PM Nurse #1 stated that if she noticed that veneer was chipped from the resident's furniture or if there was chipping on a resident's wall they were supposed to fill out a maintenance slip at the nurse's station and the maintenance director checked the book every morning. During an interview on 6/7/17 at 3:21 PM the Maintenance Assistant stated that there was not a current maintenance director in the facility and that he was the only maintenance personnel at that time. He further stated to his knowledge there were no plans to replace or repair the closets, walls, or head and footboards in the resident rooms. He further stated that he did not have any work slips for the wall in room 227. After observing the wall in room 227 he stated that it was in disrepair. During an interview on 6/7/17 at 3:50 PM the Administrator, after observing room 227's wall, stated it was his expectation the wall be in good repair and it was not.	F 253		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate	F 278		6/26/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 278	Continued From page 12 each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review the facility failed to accurately code a resident as edentulous on the annual Minimum Data Set (MDS) assessment for 1 of 15 Minimum Data Set assessments reviewed. (Resident #42) Findings included:	F 278	1. The MDS coordinator completed a significant correction to prior comprehensive assessment for Resident # 42 to reflect accurate coding of being edentulous by the MDS nurses. 2.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 278	Continued From page 13 Review of Resident #42's most recent annual MDS assessment dated 3/13/17 revealed the resident was coded as cognitively intact. The resident was also coded as "no" to the question in section L (Oral/Dental Status section) which asked if the resident had no natural teeth or tooth fragment(s) (edentulous). During observation on 6/6/17 at 4:43 PM Resident #42 was observed to have no natural teeth. During an interview on 6/6/17 at 4:44 PM Resident #42 stated that she did not have any teeth and that she had dentures a long time ago at home but threw them away because she never wore them. She further stated she had never had dentures while in the facility. During an interview on 6/7/17 at 1:47 PM MDS Nurse #1 and MDS Nurse #2 stated that they went to the residents' rooms to do head to toe assessments of the residents, spoke to the staff members on all three shifts, and did record review in order to perform their MDS assessments. MDS Nurse #1 further stated that the MDS Nurses completed section L on the MDS assessments. MDS Nurse #2, who did the assessment dated 3/13/17 for Resident #42, stated she had coded the dental status incorrectly. During an interview on 6/7/17 at 1:58 PM the Director of Nursing stated that it was her expectation that MDS assessments were coded accurately. She further stated that it was her expectation that Resident #42's edentulous status be captured on the MDS.	F 278	100% audit of section L for all current resident most current annual MDS assessment will be reviewed, to include resident #42 by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Quality Improvement Nurse (QI Nurse) to ensure all MDS□s completed are coded accurately to include all residents that are edentulous, was completed on 6/26/17 using a MDS Accuracy QI tool. Modifications will be completed by the MDS nurses during the audit for any identified area of concern with the oversite from the DON. 100% in-service of the MDS nurses, to include MDS #1 and #2, regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately to include all residents that are edentulous, are coded correctly on the MDS was completed on 6/20/17 by the DON. 3. 10% of completed MDS□s, to include resident #42, will be reviewed to ensure accurate coding of the MDS to include resident that are edentulous by the ADON, and QI Nurse 3 X□s a week X□s 4 weeks, then weekly X□s 4 weeks and then monthly X□ 1 utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the DON by retraining the MDS nurse and completing necessary modification to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 278	Continued From page 14	F 278	MDS. The DON will review and initial the MDS Accuracy QI tool weekly X 8 weeks and then monthly X 1 to ensure any areas of concerns have been addressed. 4. The Executive QI committee will meet monthly and review audits of MDS Accuracy tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly X 3 months.	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		6/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 431	Continued From page 15 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to discard expired medication on 1 of 5 medication carts observed for medication storage (100 hall medication cart). Findings included: During observation on 6/8/17 at 12:30 PM, 8	F 431	1. The Director of Nursing (DON) discarded Resident #113's expired medication by putting it in a tote and had it sent to pharmacy for disposal on 6/8/17. Nurse #2 was inserviced re: checking dates of medications that are administered and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 431	Continued From page 16 tablets of Metoprolol 50 milligrams Extended Release tablets with an expiration date of 4/28/17 were observed on the 100 hall medication cart. The Metoprolol was labeled for Resident #113 and two tablets had been used. During an interview on 6/8/17 at 12:34 PM Nurse #2 stated that the 8 tablets of Metoprolol 50 mg Extended Release expired on 4/28/17 and should not have been on the medication cart. During an interview on 6/8/17 at 1:20 PM the Director of Nursing stated that the 8 tablets Metoprolol tablets expired 4/28/17. She further stated that it was her expectation that the nurse would check the expiration date on the medication packet and that the nurse should have discarded the outdated medication.	F 431	discarding of expired medications on 6-9-17 by the Director of Nursing (DON). 2. 100% audit was completed on 6-9-17 to ensure all medication carts, to include medication cart on 100 hall utilized by Nurse #2, did not have any medications that were expired that are utilized by the licensed nurse, to include agency nurses, or medication aide by the DON, Assistant Director of Nursing (ADON), and Quality Improvement Nurse (QI Nurse). 100% in-service to all licensed nurses, to include agency nurses, and medication aide on checking medications before administration for expired dates and appropriately discarding expired medications was completed on 6-23-17 by the DON. After 6/23/17, Licensed nurses and nursing assistants were not permitted to provide care for patients until they received the aforementioned in-service. All newly hired licensed nurses, to include agency licensed nurses, and medication aides will be in-serviced on checking medications before administration for expired dates and appropriately discarding expired medications will be completed upon orientation by the Staff Facilitator. 3. Medication Carts will be monitored using a Medication cart/Expired medications QI Tool to ensure all medication carts do not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 431	Continued From page 17	F 431	have expired medications, to include medication cart on 100 hall that was utilized by nurse #2 by the Quality Improvement Nurse, Treatment Nurse 1, Treatment Nurse 2, ADON, Clinical Coordinator 1, and Clinical Coordinator 2, to include nights and weekends, 3 times a week X□s 4 weeks, then weekly X□s 4 weeks then monthly X□s 1 month. The licensed nurse, to include agency nurses, and medication aides will be immediately re-trained by the QI Nurse, Treatment Nurse 1, Treatment Nurse 2, ADON, Clinical Coordinator 1, and Clinical Coordinator 2 for any identified areas of concern. The DON will review and initial the Medication cart/Expired medications QI Tool for completion and to ensure all areas of concerns were addressed weekly X 8 weeks and monthly X 1 month. 4. The Executive QI committee will meet to review the Medication cart/Expired medications QI tool monthly X 3 months to determine issues and trend to include continued monitoring frequency.	