	-	ND HUMAN SERVICES				FOR	M APPROVED
							O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY IPLETED
			A. BUILDING				
		345260	B. WING				C
		545200	D. 11110		STREET ADDRESS, CITY, STATE, ZIP CODE	10)/13/2017
NAME OF PI	ROVIDER OR SUPPLIER						
ROCKY M	OUNT REHABILITATION	I CENTER			160 S WINSTEAD AVENUE		
					ROCKY MOUNT, NC 27804		1
(X4) ID		ATEMENT OF DEFICIENCIES	ID PREFI	IV.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG	, , , , , , , , , , , , , , , , , , ,	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
F 000	INITIAL COMMENTS	6	F	000)		
	A complaint investig	ation survey was conducted					
		h 10/13/17. Immediate					
	Jeopardy was identifi						
	CFR 483.10 at tag F	157 at a scope and severity					
	(J)						
	-	309 at a scope and severity					
	(J)						
	The tag E300 constitu	uted Substandard Quality of					
	Care.	died Substandard Quality of					
	Immediate Jeopardy	began on 09/04/17 for					
		removed on 10/13/17. An					
	extended survey was	conducted.					
F 157			F	157			11/6/17
SS=J							
	CFR(s): 483.10(g)(14	4)					
	(g)(14) Notification of	Changes					
		Changes.					
	(i) A facility must imm	nediately inform the resident;					
		lent's physician; and notify,					
		her authority, the resident					
	representative(s) whe	en there is-					
		ving the resident which					
		has the potential for requiring					
	physician intervention	Ι,					
	(B) A significant char	ige in the resident's physical,					
	mental, or psychosod						
		n, mental, or psychosocial					
		reatening conditions or					
	clinical complications	-					
							(X6) DATE
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		
Electroni	cally Signed						11/03/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 11/21/2017 DRM APPROVED NO. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		LE CONSTRUCTION		ATE SURVEY OMPLETED		
		345260	B. WING			C 10/13/2017		
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCKY M	OUNT REHABILITATION	CENTER			160 S WINSTEAD AVENUE			
					ROCKY MOUNT, NC 27804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 157	Continued From page	• 1	Í F	157	7			
		atment significantly (that is,		101	1			
	a need to discontinue							
		erse consequences, or to						
	(D) A decision to tran	sfer or discharge the						
	resident from the faci §483.15(c)(1)(ii).	0						
	 i) When making notification under paragraph (g) 14)(i) of this section, the facility must ensure that II pertinent information specified in §483.15(c)(2) s available and provided upon request to the hysician. 							
	physician.							
	. ,	also promptly notify the lent representative, if any,						
	(A) A change in room as specified in §483.7	or roommate assignment 0(e)(6); or						
	· · ·	ent rights under Federal or ns as specified in paragraph						
	update the address (r phone number of the This REQUIREMENT	ecord and periodically nailing and email) and resident representative(s). is not met as evidenced						
	and record review, th physician of a change	ician and family interviews e facility failed to notify the e in condition for one of three			The statements included in this a of compliance are not an admissi do not constitute an agreement w	on and		
	when Resident #3 ha	Resident #3) for notification, d recurring low blood sugars burs; and the facility failed to			alleged deficiencies herein. The allegation of compliance is compliance of state and federal			
		sponsible Party (Resident nt was sent to the hospital,			regulations as outlined. To rema compliance with all federal and s			

Facility ID: 953217

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STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COM	D. 0938-039 E SURVEY PLETED
		345260	B. WING			C / 13/2017
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZI		
ROCKYN	OUNT REHABILITATION	CENTER		160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 157	for one of three reside notification. The Immediate Jeopa AM when Nurse #2 cl sugar and documente Immediate Jeopardy at 7:15 PM when the allegation of immedia facility will remain out scope and severity le the potential for more not immediate jeopar education to ensure r place that are effectiv Example #2 for Resid with potential for more not immediate jeopar (D). Findings included: 1.A review of the med Resident #3 was adm on 9/1/2017 with diag vertebrae, low back p pulmonary disease (C Mellitus. A review of the signed Resident #3 dated 9/ medications were: Le 15 units subcutaneou Glyburide (oral medic control) 3 milligrams (daily and Metformin (ents reviewed for ardy began 9/4/2017 at 1:06 hecked Resident #3's blood ad the reading as 39. The was removed on 10/13/2017 facility provided a credible te jeopardy removal. The c of compliance at a lower vel of D (no actual harm with than minimal harm that is dy) to complete employee nonitoring systems are in re. lent #6 is no actual harm that is dy and the scope is isolated dical record revealed nitted from the local hospital noses of fractured ain, chronic obstructive COPD) and Type II Diabetes d physician orders for 1/2017 revealed the diabetic vemir (long acting insulin) isly (under the skin) daily, cation for Type II diabetes (mg) by mouth (po) twice oral medication for Type II mg po twice daily. Also	F 15	 regulations, the center hat take the actions set forth allegation of compliance. F157 Resident # 3 no longer refacility. Resident #6's restwas updated on #6's cut 10/30/17. Residents that reside in forthe potential to be affected notify physician of signified In-servicing of licensed number following Physician order notification of change wat 10-13-2017 by the staff of coordinator and the Direct The Unit managers will renotes daily to capture sig and ensure there is MD/I 12 weeks. The Director audit progress notes twict twelve weeks to validate documentation of assess Findings from the audits in the monthly quality ass committee and quality mmodified based on the firm 	in the following esides in the sponsible party irrent condition on the facility have ed by failure to cant change. urses regarding rs, and s completed on development ctor of Nursing. eview progress gnificant changes RP notification for of Nursing will ce weekly for notification and sments. will be reviewed surance onitoring will be	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/21/2017 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345260	B. WING				C 13/2017
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
				160 S WINSTEAD AVENU	E		
ROCKYM	OUNT REHABILITATION	CENTER		ROCKY MOUNT, NC 2	7804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	sugar check and order sugar 0-199 = 0 units 60 call MD, 200 - 300 = 10 units insulin; 401 - 500 = 20 units insuli A review of progress of 9/4/2017 at 1:06 AM of complained of weakney was checked and door per deciliter (mg/dl). If Resident #3 was give pudding and the blood rechecked. This note A review of a Medicat written by Nurse #1 of 240 cubic centimeters sugar was given and the 8:30 AM blood su mg/dl. A review of Medicatio 9/4/2017 at 9:10 AM if was not administered 59. Documentation of Resident #1 noted the blood su mg/dl and was rechect and orange juice with also documented Resi of 81 mg/dl at 11:30 A 1:00 PM noted the blood	dose depending on a blood pred by a sliding scale (blood insulin and blood sugar < = 5 units insulin; 301 - 400 1 - 450 = 15 units insulin, 451 n; > 500 Call MD. notes revealed a note on which stated Resident #3 ess. Resident's blood sugar cumented at 39 milligrams Documentation indicated n 2 cups apple juice and d sugar would be was written by Nurse #2. ion Administration Note n 9/4/2017 at 8:05 AM noted s (cc) orange juice with documented in the note was gar was rechecked to be 59 n Administration Note dated ndicated long acting insulin due to blood sugars of 39 - as by Nurse #1. silled Note written by Nurse	F 15	7			

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DEPARTMENT OF HEALTH					FOR	D: 11/21/2017 MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345260	B. WING			10	C / 13/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCKY MOUNT REHABILITATIO	ON CENTER			160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
 and Nurse #1 indic and oriented. A review of a Media dated 9/4/2017 at 5 #3 revealed docum mg had been held mg/dl and it was in orange juice and su A Health Status no 9/4/2017 at 5:32 Pl indicated Resident at 4:30 PM. The no alert, verbal with th note also indicated the phone with a fa Physician was notified of the was notified of the An additional Healt written by Nurse #3 The note stated Re 50 mg/dl at 8:00 Pl time Intra Muscular Resident #3's blood note also document and verbal and hav touch. The note ind physician with infor having low blood su A Health Status no AM by Nurse #6 wa documentation that 	gar noted to be up to 64 mg/dl ated Resident #3 was alert cation Administration Note c00 PM and written by Nurse entation the Metformin 500 due to a low blood sugar of 60 dicated Resident #3 was given ugar. The was reviewed, dated M by Nurse #3. The note #3's blood sugar was 60 mg/dl te described the resident as e complaint of feeling bad. The Resident #3 was talking on mily member. The on-call ied and an order was obtained ugon for blood sugar less than further indicated Resident #3 order. The Status note was reviewed, 6, on 9/4/2017 at 11:44 PM. sident #3's blood sugar was M. Glucagon was given one (IM) and at 10:00 PM d sugar was 60 mg/dl. This ted Resident #3 as being alert ing skin warm and dry to licated a fax was sent to the mation about Resident #3	F	157				

Facility ID: 953217

If continuation sheet Page 5 of 31

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		345260	B. WING				C 13/2017	
NAME OF P	ROVIDER OR SUPPLIER		ł	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCKY M	OUNT REHABILITATION	CENTER			160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	N SHOULD BE COMPLETI E APPROPRIATE DATE		
F 157	checked at 12:35 AM noted was the Nurse another nurse admini AM and Resident #3's documented at 54 mg documented at 54 mg documented a nurse was notified and a co indicated in the note B (EMS) arrived and as approximately 12:50 J indicated the EMS not 12:53 AM. The Admission Minim 9/5/2017 was partially Resident #3 was not needed extensive to to of Daily Living. Reside independently after the The care plan dated S risk of hypo / hypergly interventions was:" O milk etc. to counteract notify MD." On 10/11/2017 at 8:50 interview, Resident #3 Resident #3 had lived she was the care give family member stated completely alert and o and could tell you how family member also s	dicated the blood sugar was and was 36 mg/dl. Also called for assistance and stered Glucagon at 12:37 s blood sugar was g/dl. Nurse #6 also called 911, the physician de was initiated. It was Emergency Medical Services sumed care at AM. Documentation ted the time of death at um Data Set (MDS) dated v completed and noted assessed for cognition and total assistance for Activities ent #3 could eat he tray was set up. 9/5/2017 noted a focus of v/cemia. One of the range juice / honey / sugar / t hypoglycemic reaction & 0 AM in a telephone 3's family member stated a with her for ten years and er for Resident #3. The I Resident #3 was priented, could feed herself w she was feeling. The tated Resident #3 could wn care before she fell and	F	157				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,			(X3) DATE SURVEY COMPLETED		
		345260	B. WING				C 13/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
BOCKV M	OUNT REHABILITATION	CENTED		1	60 S WINSTEAD AVENUE		
RUCKIW	CONT REHABILITATION	GENTER		R	ROCKY MOUNT, NC 27804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	IOULD BE COMF	
F 157	from the 11 PM to 7 A #1 stated when she g reading on Resident # Supervisor if she show was told the blood sug gone up and down sin Resident #3 orange ju raise the blood sugar. In a telephone intervise on 10/12/2017 at 2:15 she did not remember about low blood sugar if she had been told a mg/dl, she would have immediately. On 10/12/2017 at 3:20 #3 stated when she c sugar at 4:30 PM on 9 called the on-call phy Glucagon for blood su Nurse #3 stated she c because the blood su sugar was checked at 50 mg/dl, Nurse #3 st given one time and th again at 10:00 PM an stated she faxed infor low blood sugars to th would know Resident sugar readings. On 10/12/2017 at 5:0 interview, Nurse #2 st of the low blood sugar 9/4/2017 at 1:06 AM.	tated she did not get report M nurse on 9/4/2017. Nurse of the low blood sugar #3 she asked the RN uld call the physician, and gar for Resident #3 had nee admission and to give uice with sugar to try and ew with the RN Supervisor 5 PM, the Supervisor stated r Resident #3 or anything r. The RN Supervisor stated ibout a blood sugar of 39 e said to call the physician 0 PM in an interview, Nurse hecked Resident #3's blood 9/4/2017, and it was 60, she sician and got an order for ugar less than 60 mg/dl. did not give the Glucagon gar was 60. When the blood t 8:00 PM and noted to be rated the Glucagon was the blood sugar was checked d was 60 mg/dl. Nurse #3 mation about Resident #3's he physician, so that he #3 was having low blood	F	157			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/21/2017 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345260	B. WING			_		C 13/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ROCKY M	OUNT REHABILITATION	CENTER			60 S WINSTEAD AVENUE ROCKY MOUNT, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 157	Continued From page or two hours, but faile In an interview by tele 2:05 PM, the physicia records there in front #3 as having some fra of pain, COPD and po Diabetes. The physici to be called if Resider 39 mg/dl and he expe done. The physician s of being called at any low blood sugar. The should be called when physician or not. The Administrator was Jeopardy on 10/13/20 The facility provided a immediate jeopardy re 6:43 PM. The Credibl jeopardy removal indi The procedure for imp plan of correction for An Ad Hoc Quality As Improvement (QAPI) 10/11/17 and included of Nursing, Staff Deve Manager and Physicia incident occurring on re-education regardin	e 7 d to record it. ephone on 10/13/2017 at n stated he did not have any of him but recalled Resident actured vertebrae with a lot ossible pneumonia and an stated he would expect at #3 had a blood sugar of octed a recheck would be stated he had no recollection time about Resident #3's physician stated someone ther it was the on-call s notified of the Immediate 117 at 1:25 PM. a credible allegation of emoval on 10/13/2017 at e Allegation of immediate cated: blementing the acceptable the specific deficiency cited;		157			ATE	
	An Ad Hoc QAPI mee	d on 10/13/2017. ting was conducted on						

Facility ID: 953217

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345260	B. WING			- C - 10/13/2017			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
ROCKY M	OUNT REHABILITATION	CENTER			60 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE		
F 157	Director of Nursing, S Coordinator for Notific Following MD orders. reviewed F157 IJ and On 10-13-2017 progra any changes and con and RP were necessa In-servicing of 100% regarding the facility p Orders was complete education consisted of information necessary following physician or who was not in-service removed from the sch is completed with the assistance were educ notification of change the licensed nurse thi will continue until all s These in-services will orientation of all licen forward. The monitoring proce of correction is effecti deficiency cited rema compliance with the r To remain in compliar of the Administrator, the The unit managers wire as written by checking	ded the Administrator, Staff Development cation of Change and The Ad hoc committee I allegation of compliance. The fundamental of all licensed nurses bolicy on following Physician d on 10-13-2017. The of the fundamental y for transcribing and ders. Any licensed nurse cated will not work and will be nedule until this in-servicing m. The certified nursing cated on reporting and s/s of hypoglycemia to s started on 10/13/17 and staff educated by the DON. I be added to the general sed nurses from this point dure to ensure that the plan ve and that specific ins corrected and/or in egulatory requirements; the and under the direction beginning 10-13-17; ill review physician order that orders were followed	F	157					

Facility ID: 953217

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	ΓIPLI	E CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG _		COMPLETED	
		345260	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCKY M	IOUNT REHABILITATION	CENTER			160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 157	audit physician order weeks to validate ord written by checking the record. Director of Nursing, L Development and We validate the staff's ret presented by conduct audits randomly throu- including weekends. opportunities will be in The Administrator and Coordinator will review weeks. The title of the persor implementing the acc Administrator. The Credible Allegation The survey team revier documentation condu- and the Director of Net were interviewed and information on notifica- procedure for response been provided and de- of the in-service inform The survey team revier in-service to all Nursing symptoms of hypogly symptoms listed and Nursing Assistants in	report twice weekly for 12 ers are being followed as he medication administration Init Managers, Staff bekend Supervisor will ention of the education ting education validation ughout all three shifts Those noted with mmediately re-educated. d/or Staff Development w these audits weekly for 12 in responsible for eptable plan of correction: on was validated by: ewed the in-service toted by the RN Consultant ursing. Licensed Nurses confirmed the in-service ation of change and se to hypoglycemia had emonstrated their knowledge mation. ewed the documentation of ng Assistants on signs and	F	157			

Facility ID: 953217

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/21/2017 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345260	B. WING				C 13/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCKY M	IOUNT REHABILITATION	CENTER			60 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 157	Continued From page	- 10	_	157			
1 107	1 0	cemia had been provided		157			
	and they could demor						
	information.						
		ealed Resident #6 was					
	admitted to the facility	uded Hypertension, Diabetes					
	and muscle weakness	• •					
	The Administry Minim	www.Data Catidated					
	The Admission Minim 5/19/2017 indicated th	he resident was moderately					
		and required extensive					
	-	rson for all activities of daily					
	living (ADLs).						
	Record review of the	Physicians orders for					
		an order dated 9/27/2017 to					
		he Emergency Department					
	(ED) for evaluation.						
	Record review of the	nursing notes included an					
		9/27/2017 at 4:38 PM. The					
	note revealed Reside	ent #6 was sent to the ician orders for evaluation.					
		ducted with Resident #6's					
		P) on 10/13/2017 at 10:20 d the resident was sent to					
		vening of 9/27/2017. The RP					
	-	otified of the resident being					
	-	ntil the following morning.					
		e was very involved in the d almost daily and was					
		as not notified when the					
	- ·	t of the facility. The RP					
		staff were very aware of the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED A. BUILDING			ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/21/2017 APPROVED). 0938-0391
345260 B. WING 10/13/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 S WINSTEAD AVENUE 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) COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 157 Continued From page 11 interest she had in the resident's care and knew she was to be notified when the resident was sent to the hospital. F 157 F 157 An interview was conducted with Nurse #5 on 10/13/2017 at 11:00 AM. Nurse #5 reported she was Resident #6's primary nurse the evening of 9/27/2017. Nurse #5 indicated shortly after she arrived for her shift on the evening of 9/27/2017, F 157	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE COMP	SURVEY LETED
160 S WINSTEAD AVENUE 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) COMPLE COMPLE DATE DEFICIENCY F 157 Continued From page 11 interest she had in the resident's care and knew she was to be notified when the resident was sent to the hospital. F 157 An interview was conducted with Nurse #5 on 10/13/2017 at 11:00 AM. Nurse #5 reported she was Resident #6's primary nurse the evening of 9/27/2017. Nurse #5 indicated shortly after she arrived for her shift on the evening of 9/27/2017, F 157			345260	B. WING		_		
ROCKY MOUNT REHABILITATION CENTER 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE COMPLE DATE F 157 Continued From page 11 interest she had in the resident's care and knew she was to be notified when the resident was sent to the hospital. F 157 F 157 An interview was conducted with Nurse #5 on 10/13/2017 at 11:00 AM. Nurse #5 reported she was Resident #6's primary nurse the evening of 9/27/2017. Nurse #5 indicated shortly after she arrived for her shift on the evening of 9/27/2017, F 157	NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
OPREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE DATE F 157 Continued From page 11 interest she had in the resident's care and knew she was to be notified when the resident was sent to the hospital. F 157 F 157 An interview was conducted with Nurse #5 on 10/13/2017 at 11:00 AM. Nurse #5 reported she was Resident #6's primary nurse the evening of 9/27/2017. Nurse #5 indicated shortly after she arrived for her shift on the evening of 9/27/2017, F 157	ROCKY M	OUNT REHABILITATION	CENTER					
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resident to the ED for evaluation due to some abnormal laboratory results which were sent to his office earlier in the day. Nurse #6 indicated it was an extremely busy evening and she did not remember to call and notify the resident's RP when the resident was sent to the hospital. Nurse #5 stated she knew part of the process for sending any resident to the hospital included notifying the RP. Nurse #5 indicated she worked a double shift on 9/27/2017 and remembered in the early morning hours of 9/28/2017 that the RP was not notified when Resident #6 was sent to the hospital. Nurse #5 indicated she worked to the hospital the resident was sent to the hospital at 4:30 PM the day before and no one notified her. An interview was conducted with the Director of Nursing (DON) on 10/13/2017 at 2:45 PM. The DON indicated she was unaware of any residents being sent to the ED and the RP not to be notified at the time a resident is sent out for evaluation. The DON stated the expectation was for the responsible party to be notified at the time a resident was sent out of the facility.	F 157	interest she had in the she was to be notified to the hospital. An interview was com 10/13/2017 at 11:00 A was Resident #6's pri 9/27/2017. Nurse #5 i arrived for her shift or the physician called a resident to the ED for abnormal laboratory r his office earlier in the was an extremely bus remember to call and when the resident wa #5 stated she knew p sending any resident notifying the RP. Nurs a double shift on 9/27 the early morning hou was not notified when the hospital. Nurse #5 7:00 AM to call the RF was very upset that th hospital at 4:30 PM th notified her. An interview was com Nursing (DON) on 100 DON indicated she was being sent to the ED a the next day. The DO not an acceptable fac to be notified at the tin evaluation. The DON for the responsible pa	e resident's care and knew a when the resident was sent ducted with Nurse #5 on AM. Nurse #5 reported she mary nurse the evening of indicated shortly after she in the evening of 9/27/2017, and ordered to send the evaluation due to some esults which were sent to e day. Nurse #6 indicated it sy evening and she did not notify the resident's RP is sent to the hospital. Nurse art of the process for to the hospital included se #5 indicated she worked /2017 and remembered in urs of 9/28/2017 that the RP is Resident #6 was sent to b indicated she waited until P. Nurse #5 stated the RP he resident was sent to the he day before and no one ducted with the Director of /13/2017 at 2:45 PM. The as unaware of any residents and the RP not notified until N further indicated it was ility practice for the RP not me a resident is sent out for stated the expectation was irty to be notified at the time	F 157				

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345260	B. WING			C I 0/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I	0/15/2017	
				160 S WINSTEAD AVENUE			
ROCKY M	OUNT REHABILITATION	CENTER		ROCKY MOUNT, NC 27804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 241	Continued From page	e 12	F 24	1			
F 241 SS=D	DIGNITY AND RESP CFR(s): 483.10(a)(1)	ECT OF INDIVIDUALITY	F 24	1		11/6/17	
	resident in a manner promotes maintenand her quality of life reco individuality. The faci promote the rights of This REQUIREMENT by: Based on resident, fa and record review, th the dignity of resident disrespectfully to two for dignity (Resident a Findings included: 1. A review of medica #11 was admitted on 9/7/2017 with diagno seizure disorder, anx The Significant Chan (MDS) dated 9/28/20 cognitively intact and things and felt down, nearly every day. The #11 needed supervise	the resident. is not met as evidenced amily and staff interviews e facility failed to maintain ts when staff spoke of three residents reviewed #4 and Resident #11). al records revealed Resident 5/14/2015 and readmitted ses of Parkinson 's disease, iety and depression. ge Minimum Data Set 17 noted Resident #11 was had little interest in doing depressed and hopeless e MDS indicated Resident ion to extensive assistance ily Living with the physical		 F241 1. Nurse 7 is no longer employed Rocky Mount Rehabilitation. Res and # 11 are being treated with or respect. 2. Residents that reside in the fat the potential to be affected. Res were interviewed between 10/20 10/26/2017 by Department Head ensure residents were being treated dignity and respect. All residents interviewed voiced being treated dignity and respect by staff. 3. Facility staff will be educated or resident abuse and customer se guidelines by the Director Of Nursing/designee by 11/6/2017. residents will be interviewed 5x 	sident #4 dignity and idents //2017 and ds to ated with ated with with on rvice Random		
	A review of grievances revealed Resident #11 had filed a grievance against Nurse #7, for being mean to him. The resolution to the grievance was Nurse #7 would be terminated when a replacement was hired. The grievance was signed by the Administrator.			 4 weeks to ensure all are treated dignity and respect by the Socia Worker/designee then 3x weekly weeks. 4. Findings from these interviews 	l / for 4		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/21/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345260	B. WING				C / 13/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ROCKY M	OUNT REHABILITATION	I CENTER			60 S WINSTEAD AVENUE OCKY MOUNT, NC 27804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	Continued From page 13 On 10/11/2017 at 2:55 PM, in an interview, NA #2		F	241	Committee for further review and		
					Committee for further review and recommendations monthly for a minir	num	
	 stated she had heard Nurse #7 talk bad to residents and residents had told her that Nurse #7 talked bad to them. On 10/11/2017 at 4:15 PM, in an interview, the facility Administrator was asked what the resolution to the grievance meant. The Administrator stated "Well, her nursing skills are fine, it is her customer service that needs improvement." The Administrator stated Nurse #7 had been reeducated more than one time, but now the grievance had gone through the corporate office. On 10/12/2017 at 2:55 PM, Resident #11 stated he had filed a grievance against Nurse #7 because she was "mean" to him. Resident #11 stated when Nurse #7 was mean to him he felt "bad, I felt real bad." 2. A review of medical records revealed Resident #4 was admitted on 7/24/2017 with diagnoses of 				of 3 months and quality monitoring wi modified based on the findings.		
	joint pain, anxiety and The Admission Minim 7/31/2017 noted Res intact and needed ex Activities of Daily Livi assistance of one to A review of the medic	num Data Set (MDS) dated ident #4 to be cognitively tensive assistance for all ing with the physical two persons. cal record revealed Resident					
	Resident #4 stated N	5 PM, in an interview, urse #7 had been very urse #7 was hateful to					

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		ID HUMAN SERVICES MEDICAID SERVICES		FORM	APPROVED 0. 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345260	B. WING				C 13/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
ROCKY M	OUNT REHABILITATION	CENTER			60 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 241	had a catheter and he should be careful, if the should have to have needed someone to a bathroom. Resident # into the bathroom and cord when she was fill come back to assist he Resident #4 stated she and pulled the call be in and said" We don't like that." Resident #4 felt like she should have like she was doing wr On 10/11/2017 at 2:30 interview, the family ne stated Nurse #7 was The family member stated tell the 3PM - 11PM no leaking and Resident family member noted member that NA #1 d into the room and said The family member stated tell the 3PM - 11PM no leaking and Resident family member noted member that NA #1 d into the room and said The family member stated the family member state	also. Resident #4 stated she er physician told her she he catheter was pulled out ve surgery, therefore, she assist her to and from the 44 indicated NA #1 took her d told her to pull the call bell hished and NA #1 would her out of the bathroom Il cord and Nurse #7 came have time to wait on you 4 stated she was upset and twe done more for herself, rong. 0 PM, in a telephone nember of Resident #4 not nice to the residents. tated Resident #4's catheter Resident told NA #1. The I NA #1 said that she would hurse, but the catheter was #4 was getting wet. The resident #4 told the family id tell Nurse #7 who came d "what did you do now?" tated she had seen Nurse mething Resident #4 said, disrespect Resident #4 in mber. 5 PM, in an interview, NA #2 Nurse #7 talk bad to ts had told her that Nurse	F	241				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 11/21/201 APPROVE . 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE S COMPL	ETED	
		345260	B. WING		C 10/13/2017		
NAME OF PI	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	• •		
ROCKY M	OUNT REHABILITATION	CENTER		S WINSTEAD AVENUE CKY MOUNT, NC 27804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 241 F 309 SS=J	investigation revealed #7 had been mean to occasion. The resolut "Employee will be ter is hired." On 10/11/2017 at 4:1 facility Administrator v resolution meant. The her nursing skills are service that needs im Administrator stated I reeducated more that grievance had gone t When the Administrat #4's statement, the A suspending Nurse #7 Administrator stated I residents with dignity PROVIDE CARE/SEI WELL BEING CFR(s): 483.24, 483. 483.24 Quality of life Quality of life is a fun applies to all care and residents. Each resid facility must provide t services to attain or m practicable physical, well-being, consisten comprehensive asses 483.25 Quality of care Quality of care is a fun applies to all treatment	A review of the grievance d the resident stated Nurse o him on more than one tion to the grievance stated: minated when replacement 5 PM, in an interview, the was asked what the e Administrator stated "well, fine, it is her customer oprovement." The Nurse #7 had been n one time, but now the hrough the corporate office. tor was informed of Resident dministrator stated he was ' immediately. The he expected staff to treat RVICES FOR HIGHEST 25(k)(I) damental principle that d services provided to facility dent must receive and the he necessary care and naintain the highest mental, and psychosocial t with the resident's ssment and plan of care.	F 241			11/6/17	

Event ID: M14E11

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/21/201 FORM APPROVED OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345260	B. WING _		C 10/13/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE
ROCKY M	IOUNT REHABILITATION	CENTER		160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE CIENCY)
F 309	that residents receive accordance with profe practice, the compret care plan, and the re- but not limited to the (k) Pain Managemen The facility must ensu- provided to residents consistent with profes the comprehensive p and the residents' go. (I) Dialysis. The facili residents who require services, consistent v of practice, the comp care plan, and the re- preferences. This REQUIREMENT by: Based on family, sta and record review, the interventions to mana- one residents review #3) when the Resider sugars over a 24-hou expired in the facility. Immediate Jeopardy Nurse #2 noted Resider weakness. Nurse #2 blood sugar and docu- per deciliter (mg/dl) a Resident #3's blood s as rechecked. Resider on 9/5/2017. Immedia	dent, the facility must ensure a treatment and care in essional standards of nensive person-centered sidents' choices, including following: t. ure that pain management is who require such services, ssional standards of practice, erson-centered care plan, als and preferences. ity must ensure that a dialysis receive such with professional standards rehensive person-centered sidents' goals and t is not met as evidenced ff and physician interview e facility failed to provide age diabetic care for one of ed with Diabetes (Resident in thad recurring low blood in period. The Resident	F 3	F309 F309 Resident #3 no longer facility. Residents that reside i the potential to be affe manage diabetes. On 10-12-2017 residents in facility were assessed orders for diabetic mar place as it relates to ou and MD orders by the In-servicing of licensed diabetic management, orders, and notificatior completed on 10-13-20	n the facility have cted by failure to 10-11-2017 and residing in the to ensure adequate nagement were in utlined parameters Director of Nursing. d nurses regarding following Physician n of change was

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			0.00			B NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	. ,	DATE SURVEY COMPLETED
			A BOILDING			С
		345260	B. WING			10/13/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
ROCKY M	OUNT REHABILITATION	I CENTER		160 S WINSTEAD AVENUE		
				ROCKY MOUNT, NC 27804	4	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page	e 17	F 30	19		
	Credible Allegation of			development coordina	ator and the Director	
		will remain out of compliance		of Nursing. The Unit r		
		severity level of D (no actual		progress notes daily t		
		al for more than minimal		changes and ensure i		
		ediate jeopardy) to complete and to ensure monitoring		notification. The Direct audit progress notes	-	
	systems are in place	-		weeks to validate not	2	
				documentation. The I	Director of Nursing	
	Findings included:			will pull the report for		
				glucose readings dail		
		cal record revealed Resident ne facility from a local		ensure that any levels therapeutic have MD		
		with diagnoses of fractured		interventions in place		
		pain, chronic obstructive				
	pulmonary disease (0	COPD), Type II Diabetes		Findings from the auc		
	Mellitus.			in the monthly quality		
	The bosnital dischar	ge summary dated 9/1/2017		committee and quality modified based on the		
		vealed Resident #3 was			e mangs.	
	noted to have docum	ented hypoglycemia and				
		insulin) on hold. Included in				
	-	ary was information stating				
	control) was discontir	cation for Type II diabetes nued.				
	The admission asses	ssment dated 9/1/2017 noted				
		ands and is understood.				
		sident needed set up help				
		e was no interim care plan				
	noted.					
	A review of the signe	d physician orders for				
		1/2017 revealed the diabetic				
		evemir (long acting insulin)				
		usly (under the skin) daily, cation for Type II diabetes				
		(mg) by mouth (po) twice				
		(oral medication for Type II				
	diabetes control) 500					

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	· · ·	IPLETED	
					С		
		345260	B. WING		1	10/13/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 160 S WINSTEAD AVENUE			
ROCKYN	IOUNT REHABILITATION	CENTER		ROCKY MOUNT, NC 27804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 309	acting insulin) to be in before meals with the sugar check and orde sugar 0-199 = 0 units below 60 call physicia insulin; 301 - 400 = 10 units insulin, 451 - 50 500 Call MD. Progress notes were and revealed a Medic dated 9/2/2017 which was on order. A review of the Medic (MAR) revealed blood Resident #3 before m Documentation in the Resident #3 had bloo mg/dl, 139 mg/dl, 165 given. The MAR note were recorded as 10° 87 mg/dl and no insul On the MAR dated 9/ documentation of bloo mg/dl, 60 mg/dl, 50 m noted as given. The MAR further indid the Levemir insulin or indicated the Levemir was held on 9/4/2017 Resident #3 received 9/3/2017 and once or indicated in the MAR on 9/2/2017, the PM of	order for Novolog (rapid njected three times daily e dose depending on a blood ered by a sliding scale (blood is insulin and blood sugar an (MD), 200 - 300 = 5 units 0 units insulin; 401 - 450 =15 00 = 20 units insulin; above reviewed for Resident #3 cation Administration Note in indicated Glyburide 3 mg cation Administration Record d sugars were checked for neals and at bedtime. MAR indicated on 9/2/2017 of sugars of 84 mg/dl, 100 5 mg/dl and no insulin was id on 9/3/2017 blood sugars 1 mg/dl, 90 mg/dl, 84 mg/dl, lin was recorded as given. 4/2017 Resident #3 had od sugars of 52 mg/dl, 81 ng/dl and no insulin was cated Resident #3 refused	F 30				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345260	B. WING _				C 13/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
				16	60 S WINSTEAD AVENUE		
ROCKYM	OUNT REHABILITATION	CENTER		R	OCKY MOUNT, NC 27804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 309	A review of progress i 9/4/2017 at 1:06 AM v complained of weaking was checked and door per deciliter (mg/dl). I Resident #3 was give pudding and the blood rechecked. This note On 10/12/2017 at 5:0 interview, Nurse #2 st of the low blood suga 9/4/2017 at 1:06 AM. sure that he rechecked or two hours, but faile stated the blood suga when he rechecked it physician. A review of a Medicat written by Nurse #1 o 240 cubic centimeters sugar was given and the 8:30 AM blood su mg/dl. On 10/12/2017 at 12:: interview, Nurse #1 st from the 11 PM to 7 A #1 stated when she g reading on Resident # to be 52 mg/dl at 8:30 asked the RN Superv physician, and was to Resident #3 had gone admission and to give with sugar to try and r #1 stated she did not	notes revealed a note on which stated Resident #3 ess. Resident's blood sugar sumented at 39 milligrams Documentation indicated n 2 cups apple juice and d sugar would be was written by Nurse #2. 1 PM, in a telephone tated he had no recollection r for Resident #3 on Nurse #2 stated he was to the blood sugar after one d to record it. Nurse #2 r must have been normal or he would have called the ion Administration Note n 9/4/2017 at 8:05 AM noted s (cc) orange juice with documented in the note was gar was rechecked to be 59 20 PM in a telephone tated she did not get report M nurse on 9/4/2017. Nurse ot the low blood sugar #3, which was documented D AM on 9/4/2017, she isor if she should call the ld the blood sugar for	F	309			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED	
		345260	B. WING				C / 13/2017	
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
ROCKY M	OUNT REHABILITATION	CENTER			60 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 309	mg/dl on 9/4/2017 at A review of a Medicat dated 9/4/2017 at 9:1 insulin was not admir of 39 - 59. Document A review of a Daily SF #1, on 9/4/2017 at 4:0 documentation of Res checks 4 times and n #1 noted the blood su mg/dl and was recher and orange juice with also documented Res of 81 mg/dl at 11:30 A 1:00 PM noted the blo orange juice with sug given and the blood s 64 mg/dl and Nurse # alert and oriented. A review of a Medicat dated 9/4/2017 at 5:0 revealed documentat had been held due to mg/dl. and indicated orange juice and suga A Health Status note 9/4/2017 at 5:32 PM indicated Resident #3 at 4:30 PM. The note alert, verbal with the o note also indicated R the phone with a fami Physician was notifier to administer Glucago	8:30 AM. tion Administration Note 0 AM indicated long acting histered due to blood sugars ation was by Nurse #1. killed Note written by Nurse 00 PM revealed sident #3 had blood sugar o insulin coverage. Nurse ugar at 8:30 AM was 82 cked to register 59 mg/dl sugar was given. The note sident #3 had a blood sugar AM and another check at bod sugar was 53 mg/dl and ar was documented as sugar was noted to be up to the indicated Resident #3 was ction Administration Note 0 PM written by Nurse #3 ion the Metformin 500 mg a low blood sugar of 60 Resident #3 was given ar.	F	309				

Facility ID: 953217

If continuation sheet Page 21 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE		
		345260	B. WING				C 13/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
BOCKYM	OUNT REHABILITATION	CENTED			160 S WINSTEAD AVENUE			
RUCKTW	OUNT REHABILITATION	CENTER			ROCKY MOUNT, NC 27804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TION SHOULD BE COMPL THE APPROPRIATE DA		
	Continued From page was notified of the ord An additional Health S written by Nurse #3, o The note stated Resid 50 mg/dl at 8:00 PM. time Intra Muscular (I Resident #3's blood s note also documented and verbal and having touch. The note indica physician with informa having low blood suga A Health Status note 9/5/2017 at 2:07 AM documentation that a #3's room and called respond. The note indica checked at 12:35 AM noted was the Nurse another nurse admini AM and Resident #3's documented at 54 mg documented an urse was notified and a co indicated in the note F (EMS) arrived and as approximately 12:50 A	e 21 der. Status note was reviewed, on 9/4/2017 at 11:44 PM. dent #3's blood sugar was Glucagon was given one M) and at 10:00 PM ugar was 60 mg/dl. This d Resident #3 as being alert g skin warm and dry to ated a fax was sent to the ation about Resident #3 ars. written by Nurse #4 on was reviewed and revealed nurse entered Resident to Resident #3 who did not dicated the blood sugar was and was 36 mg/dl. Also called for assistance and stered Glucagon at 12:37 s blood sugar was g/dl. Nurse #4 also called 911, the physician de was initiated. It was Emergency Medical Services sumed care at		309	DEFICIENCY)	ΔΤΕ	DATE	
	report dated 9/5/2017 pulseless and had no respiratio EMS documented lea #3's chest to record h was present and extra	gency Medical Services revealed Resident #3 was ns when they arrived. The ids were applied to Resident eartbeat, but no heartbeat emities were cold. The t #3 was not transported to						

Facility ID: 953217

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/21/2017 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345260	B. WING				C 13/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCKY M	OUNT REHABILITATION	CENTER			60 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 309	allow EMS to pronour report indicated the fa funeral home to trans On 10/11/2017 at 8:50 interview, Resident #3 Resident #3 had lived she was the care give family member stated completely alert and c and could tell you how family member also s perform a lot of her ow fractured her back. Th Resident #3 was inter things and was not lik age. The family memb would refuse her diab because it had been c at home. Resident #3 when Resident #3 hav would sometimes, hav or may act as though having a conversation On 10/12/2017 at 2:19 was conducted with th worked on 9/4/2017 d PM shift. The RN Sup remember Resident # blood sugar. The RN been told about a bloo have said to call the p	hysician was notified to nee Resident #3 dead. The icility would contact the port the body. O AM in a telephone B's family member stated with her for ten years and er for Resident #3. The Resident #3 was priented, could feed herself v she was feeling. The tated Resident #3 could wn care before she fell and he family member stated rested in lots of different e most people of the same per stated Resident #3 etic medication in the facility discontinued when she was 's family member stated d low blood sugar, she ve cold sweat on her skin, she was sleepy while h. 5 PM a telephone interview he RN Supervisor who uring the 7:00 AM to 3:00 iervisor stated she did not 3 or anything about low Supervisor stated if she had pod sugar of 39, she would ihysician immediately.	F	309	DEFICIENCY)		
	sugar at 4:30 PM on 9	hecked Resident #3's blood 9/4/2017, and it was 60 on-call physician and got an					

Facility ID: 953217

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		D HUMAN SERVICES				FORM	APPROVED	
						OMB NO. 0938-0391		
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COMF	SURVEY	
			A. BOILD				С	
		345260	B. WING				13/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
КОСКУ М	OUNT REHABILITATION	CENTER			160 S WINSTEAD AVENUE			
					ROCKY MOUNT, NC 27804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE	
F 309	mg/dl. Nurse #3 state Glucagon because th When the blood suga and noted to be 50 m Glucagon was given of sugar was checked and 60 mg/dl. Nurse #3 st about Resident #3's lo physician, so that he was having low blood stated she did not kno received from the MD In an interview by tele 2:05 PM, the physicial records there in front #3 as having some fra of pain, COPD and po Diabetes. The physicial to be called if Residen 39 mg/dl and he expet done. The physician so of being called at any low blood sugar. The should be called whet	r blood sugar less than 60 d she did not give the e blood sugar was 60. r was checked at 8:00 PM g/dl, Nurse #3 stated the one time and the blood gain at 10:00 PM and was ated she faxed information ow blood sugars to the would know Resident #3 sugar readings. Nurse #3 ow if a response was ephone on 10/13/2017 at n stated he did not have any of him but recalled Resident actured vertebrae with a lot ossible pneumonia and an stated he would expect nt #3 had a blood sugar of octed a recheck would be stated he had no recollection time about Resident #3's physician stated someone ther it was the on-call ne expected to be called if a	F	309				
	The Administrator was Jeopardy on 10/13/20	s notified of the Immediate 117 at 1:25 PM.						
	immediate jeopardy re	a credible allegation of emoval on 10/13/2017 at e allegation of immediate cated:						

Facility ID: 953217

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						APPROVED
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE	
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
	345260	B. WING				13/2017
OVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
OUNT REHABILITATION	CENTER					
SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORRECTION		(X5)
						COMPLETION DATE
Continued From page	24	F3	309			
Improvement (QAPI) 10/11/17 and included of Nursing, Staff Deve Manager and Physicia incident occurring on re-education regardin began on 10/11/2017 the nurses were educ An Ad Hoc QAPI mee 10/13/2017 and includ Director of Nursing, S Coordinator for Notific Following MD orders.	meeting was conducted on d the Administrator, Director elopment Coordinator, Unit an's Assistant, to analyze 9-4-2017. Licensed nurse g Diabetic Management and continued until 100% of ated on 10/13/2017. ting was conducted on ded the Administrator, taff Development cation of Change and The Ad hoc committee					
On 10-11-2017 and 10 in the facility were ass orders for diabetic ma outlined parameters a completed by DON ar Residents with diabet ensure that orders we to be initiated if and w was found to be in no In-servicing of 100% of regarding the facility p Orders, Notification of	0/12/2017 residents residing sessed to ensure adequate inagement as it relates to and MD notification nd nursing management. es were also reviewed to ere in place for interventions when their blood sugar level n-therapeutic range.					
	F DEFICIENCIES CORRECTION OVIDER OR SUPPLIER DUNT REHABILITATION SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L Continued From page The procedure for imp plan of correction for f An Ad Hoc Quality As Improvement (QAPI) 10/11/17 and included of Nursing, Staff Deve Manager and Physicia incident occurring on re-education regardin began on 10/11/2017 the nurses were educ An Ad Hoc QAPI mee 10/13/2017 and included Director of Nursing, S Coordinator for Notific Following MD orders. reviewed F309 IJ and On 10-11-2017 and 11 in the facility were asso orders for diabetic ma outlined parameters a completed by DON ar Residents with diabet ensure that orders were to be initiated if and w was found to be in no In-servicing of 100% of regarding the facility p Orders, Notification of Hypoglycemia was co	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: (X2) MUL A BUILDI 345260 B. WING OVIDER OR SUPPLIER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 24 F : The procedure for implementing the acceptable plan of correction for the specific deficiency cited; An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 10/11/17 and included the Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager and Physician's Assistant, to analyze incident occurring on 9-4-2017. Licensed nurse re-education regarding Diabetic Management began on 10/11/2017 and continued until 100% of the nurses were educated on 10/13/2017. An Ad Hoc QAPI meeting was conducted on 10/13/2017 and included the Administrator, Director of Nursing, Staff Development Coordinator for Notification of Change and Following MD orders. The Ad hoc committee reviewed F309 IJ and allegation of compliance. On 10-11-2017 and 10/12/2017 residents residing in the facility were assessed to ensure adequate orders for diabetic management as it relates to outlined parameters and MD notification completed by DON and nursing management. Residents with diabetes were also reviewed to ensure that orders were in place for interventions to be initiated if and when their blood sugar level was found to be in non-therapeutic range. In-servicing of 100% of all licensed nurses regarding the facility policy on following Physician Orders, Notification of Change, and Hypopglycemia was completed on10-13-17, by the S	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A BUILDING, 345260 B. WING	FEETICENCIES (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER (X2) MULTIFIC CONSTRUCTION 345260 B. WING CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 100 SWINSTEAD AVENUE RECORDECTORY UNST EMENT OF DEFICIENCIES (EACH DEPICIENCY USE PLAN OF CORRECTING REDULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, 2IP CODE 100 SWINSTEAD AVENUE RECORDECTORY UNST EMERTIC OF DEFICIENCIES (EACH DEPICIENCY USE THE PRICE DEB DE YPUL) RECULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTIVE RECORDECTORY USE THE PRICE DEB DE YPUL RECORDECTORY USE THE PRICE DEB DE YPUL RECORDECTORY USE THE PRICE DEB DE YPUL RECORDECTORY ON LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTIVE RECORDECTORY ON LSC IDENTIFYING INFORMATION) Continued From page 24 F 309 PROVIDER'S PLAN OF CORRECTIVE RECORDECTORY USE THE APPROPRIE DEFIDENCY Continued From page 24 F 309 F 309 Continued From page 24 F 309 Continued From page 24 F 309 Continued From page 24 F 309 Continued GOPPIDIES F 309 Continued From page 24 F 309 An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 10/11/12 and continued until 100% of the nurses were educated on 10/13/2017. An Ad Hoc QAPI meeting was conducted on 10/13/2017 and included the Administrator, Director Of Nursing, Staff Development Coordinator fon	F GEFICIENCIES CORRECTION (X1) PROVIDERSUPLEXCUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) CONDER OR SUPPLER (X3) DIVERT REHABILITATION CENTER (X3) STREET ADDRESS, CITY, STRE, 21P CODE test SWINSTEAD AVENUE ROCKY MOUNT, NC 27804 SUMMARY STREELEN OF DEFIDENCIES (EACH DEFIDENCY WIST SE PRECEDED BY FULL PEOLING TO USST DENTIFYING WIST SE PRECEDED BY FULL PEOLING OF USST DENTIFYING WIST SE PRECEDED BY FULL PEOLING TO THE SPECIFIC DESTIFYING WIST SE PRECEDED BY FULL PEOLING TO USST DENTIFYING WIST SE PRECEDED TO THE APPROPRIATE DEFICIENCY) Continued From page 24 F 309 The procedure for implementing the acceptable plan of correction for the specific deficiency cited; An Ad Hoc QAPI meeting was conducted on 101/11/27 and conducted the Administrator, Director of Nursing, Staff Development Coordinator for Notification of Change and Following MD Orders. The Ad hoc committee reviewed F309 IJ and allegation of compliance. (CAPI meeting was conducted to 101/3/2017 and included the Administrator, Director of Nursing, Staff Development Coordinator for Notification of Change and Following MD Orders. The Ad hoc committee reviewed F309 IJ and allegation of compliance. (CAPI meeting was conducted to 101/2017 minued the Adminued the Adminued the Adminued the DEFICENCY On 10-11-2017 and 10/12/2017 residents residing

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345260	B. WING				C 13/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ROCKY MOUNT REHABILITATION CENTER					160 S WINSTEAD AVENUE		
	SUMMARY ST		ID	r	ROCKY MOUNT, NC 27804 PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG				X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 309	Continued From page definition of significan	e 25 it change: Significant	F	309			
	change is defined as	a decline in the resident's ude decline in cognition,					
	condition causing furt licensed nurses were	her impairment. The also in-serviced regarding					
	-	cribing physician orders to I record. Any licensed nurse					
	who was not in-servic	ed will not work and will be					
		nedule until this in-servicing m. The certified nursing					
	assistance were educ	cated on reporting					
		and s/s of hypoglycemia to started on 10/13/17 and					
	will continue until all s	staff educated by the DON.					
		l be added to the general sed nurses from this point					
	forward.						
	The monitoring proce of correction is effecti	dure to ensure that the plan ve and that specific					
	deficiency cited remain	ins corrected and/or in					
	compliance with the r	egulatory requirements;					
	To remain in compliar of the Administrator, t	nce and under the direction beginning 10-13-17;					
	daily to capture any s	ill review progress notes ignificant changes and					
		P notification. DON will audit weekly for 12 weeks to					
	validate notification a	nd documentation of					
		will pull report of all diabetic daily to ensure that any					
	levels that are not the						
	notification and interv	entions in place. The ad disciplinary action in					
	place of 10/13/2017.						

Facility ID: 953217

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	-	ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY	
-	CORRECTION	IDENTIFICATION NUMBER:	· /				LETED	
						С		
		345260	B. WING			10/	13/2017	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE			
ROCKY M	OUNT REHABILITATION	CENTER			160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION				COMPLETION DATE	
F 309	Continued From page	e 26	F	309	9			
	Director of Nursing, U	Init Managers, Staff						
		ekend Supervisor will						
		ention of the education ting education validation						
	audits randomly throu							
	including weekends.							
		mmediately re-educated. d/or Staff Development						
		w these audits weekly for 12						
	weeks.							
	The title of the person responsible for							
		eptable plan of correction:						
	Administrator.							
	The credible allegatio	n was validated by:						
	The survey team revi	ewed the documentation for						
	in-service for licensed							
	10/13/2017 and is on	going. The in-service				I		
	included: Signs and symptoms	of hypoglycemia (this was						
		Nursing Assistants and						
		vs by the survey team.)						
		ined for testing blood sugar, e need for glucose and						
	notification of the phy	-				I		
	The survey team revi	ewed the in-service						
		icted by the RN Consultant ursing. Licensed Nurses				I		
		confirmed the in-service				I		
	information on diabet					I		
		dentification of hypoglycemia				I		
	by interviews with lice demonstrate knowled	ensed nurses who could						
	provided by the in-sei	-				I		

Facility ID: 953217

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/21/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345260	B. WING			C 10/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROCKY M	OUNT REHABILITATION	CENTER		10	60 S WINSTEAD AVENUE		
		OLIVIER		R	OCKY MOUNT, NC 27804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 27	F	309			
		atment procedures for		000			
F 332 SS=D		ON ERROR RATES OF 5%	F	332			11/6/17
	(f) Medication Errors. that its-	The facility must ensure					
	greater;	ates are not 5 percent or					
	Based on observatio	n, record review and staff ailed to have a medication			F332		
	error rate below 5% a				1. Nurse #5 is no longer employed at		
		of 26 opportunities which			Rocky Mount Rehabilitation. Resident #	‡ 5	
		on error rate of 7.7% for 1 of			medications have been reviewed by		
	(Resident #5).	during medication pass			physician and Resident #5 is receiving calcium carbonate and vitamin B-12 as ordered.		
	Findings included:						
	Resident #5 was adm	nitted to the facility on			Residents that reside in the facility has the potential to be affected. Residents	ave	
	12/16/16. His active of				with orders for calcium carbonate and		
		pidemia, and insomnia.			vitamin b 12 will be reviewed by 11-3-20 to ensure the medications are available		
	Review of Resident #	5's physician's orders			and are being administered as per		
	revealed on 4/5/17 ar resident to receive Ca	n order was written for the alcium Carbonate 500			physician's order.		
		s a day. On 4/5/17 Resident			3. Licensed nurses will be re-educated		
	#5 was also ordered micrograms daily. Re	Vitamin B-12 1,000 view of Resident #5's			proper medication administration by the Director of Nursing/designee on 10/27/		
		ders on 10/13/17 revealed			The DON/designee will conduct random		
	both of these medicar as originally written.	tion orders were still in place			medication administration observations 5X weekly for 4 weeks, then 3 times a		
	During a medication a	administration observation			week for 4 weeks to ensure proper medication administration.		

Event ID: M14E11

Facility ID: 953217

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 11/21/2017 MAPPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		. ,	IPLE CONSTRUCTION		E SURVEY IPLETED	
		345260	B. WING	B. WING		C)/13/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
ROCKY MOUNT REHABILITATION CENTER			160 S WINSTEAD AVENUE			
		OLIVIER		ROCKY MOUNT, NC 27804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 332 F 431 SS=D	to give Resident #5 1 Carbonate and 500 m During an interview o Nurse #5 stated that a milligrams of Calcium the physician's order, get clarification of the have been a medicati that she should have B-12 500 microgram dose to be correct. SI give the second table immediately. During an interview o Director of Nursing st should have received Carbonate during the pass of 10/13/17 and milligrams which was was incorrect. She fu microgram dose of Vi given by Nurse #5 wa Director of Nursing fu expectation that the m be less than 5% and administered per the	M, Nurse #5 was observed ,000 milligrams of Calcium nicrograms of Vitamin B-12. n 10/13/17 at 10:18 AM, she gave Resident #5 1,000 of Carbonate. After checking she stated she needed to order but believed it could ion error. She further stated given one more Vitamin tablet to Resident #5 for the he further stated she would it to Resident #5 n 10/13/17 at 10:32 AM the ated that Resident #5 500 milligrams of Calcium medication administration the dose of 1,000 administered by Nurse #5 rther stated that the 500 tamin B-12 Resident #5 was as incorrect as well. The rther stated it was her nedication error rate would that medications would be physician's order. ABEL/STORE DRUGS &	F 3	4. Findings from the observ submitted to the Quality As Committee for further revie recommendations monthly of 3 months and quality mo modified based on the findi	vations will be ssurance w and for a minimum ponitoring will be	11/6/17
	The facility must prov drugs and biologicals them under an agree §483.70(g) of this par	ide routine and emergency to its residents, or obtain				

Facility ID: 953217

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/21/2017 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345260	B. WING		_		C 13/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ROCKY M	OUNT REHABILITATION	CENTER		60 S WINSTEAD AVENUE ROCKY MOUNT, NC 27			
				-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page	29	F 431				
	law permits, but only supervision of a licens						
	that assure the accura dispensing, and admi	cility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and ne needs of each resident.					
	(b) Service Consultati employ or obtain the s pharmacist who	-					
	disposition of all contr	em of records of receipt and olled drugs in sufficient curate reconciliation; and					
	(3) Determines that di that an account of all maintained and period						
		used in the facility must be with currently accepted s, and include the y and cautionary					
	the facility must store locked compartments	n State and Federal laws, all drugs and biologicals in under proper temperature only authorized personnel to					
		rovide separately locked, ompartments for storage of					

Facility ID: 953217

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	· /	SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	A. BUILDING			PLETED
		345260	B. WING			С	
	ROVIDER OR SUPPLIER	545200	STREET ADDRESS, CITY, STATE, ZIP CODE			10	/13/2017
					60 S WINSTEAD AVENUE		
ROCKYM	OUNT REHABILITATION	I CENTER			COCKY MOUNT, NC 27804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page	o 30		431			
1 401				+31			
		d in Schedule II of the gAbuse Prevention and					
		and other drugs subject to					
		the facility uses single unit					
		ution systems in which the					
		nimal and a missing dose can					
	be readily detected.						
		Γ is not met as evidenced					
	by:	and staff interview the			E424		
	Based on observation facility failed to keep			F431			
	cart locked for 1 of 4			1. Nurse #4 was educated on keeping			
	(North Wing Medicati			med cart locked when it is unattended.			
	Findings included:				2. This has the potential to affect all		
	During choose ation of	- 40/42/47 at 2:27 DM tha			residents. An audit was conducted by t		
	-	n 10/13/17 at 2:27 PM the on Cart was observed to be			Director of Nursing on 11/3/17 to ensur all medication carts are secured when	e	
		unlocked and unattended.			unattended. All medication carts were		
		bserved to pass by the			noted to be properly locked.		
		cart at 2:28 PM. At 2:29 PM,					
		the medication cart and			3. Nursing staff will be educated on		
	pulled open a drawer	without having to unlock the			properly securing medication carts by		
	medication cart.				Staff Development Coordinator by		
	_ , .				10/19/17. Staff Development		
	-	on 10/13/17 at 2:30 PM			Coordinator/designee will perform med	I	
		the North Wing Medication ion cart. He further stated			cart audits 5 days a week for 4 weeks then 3 days a week for the next month.		
		of the facility that medication					
		out of the nurses' eyesight			4. Results of weekly med cart audits wi	ill	
		art should have been locked			be submitted to the Quality Assurance		
	and was not.				Committee for further review and		
					recommendations monthly for a minimu		
		on 10/13/17 at 2:40 PM the			of 3 months and quality monitoring will	be	
	Director of Nursing st				modified based on the findings.		
		n medication carts were not					
		sight, they would be locked					
	at all times.						

Facility ID: 953217

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