PRINTED: 12/04/2018 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345164	B. WING _				C / 25/2018	
	ROVIDER OR SUPPLIER RIVER NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	TS .	F	000				
F 585	Tags 622 and 690 v 10/25/2018. Howev result of the recertif investigaion that w time as the revisit. compliance. Grievances	vere corrected as of er, new tags were cited as a ication survey and complaint as conducted at the same The facility is still out of	F {	585			11/19/18	
SS=C	§483.10(j) Grievance §483.10(j)(1) The regrievances to the fathat hears grievance reprisal and without reprisal. Such griev respect to care and furnished as well as furnished, the beha residents, and othe facility stay. §483.10(j)(2) The refacility must make presolve grievances accordance with thi	ces. esident has the right to voice esident has the right to voice estility or other agency or entity es without discrimination or afear of discrimination or ances include those with treatment which has been es that which has not been vior of staff and of other or concerns regarding their LTC esident has the right to and the brompt efforts by the facility to the resident may have, in a paragraph. estility must make information						
	to the resident. §483.10(j)(4) The far grievance policy to of all grievances recontained in this par provider must give a to the resident. The	acility must establish a ensure the prompt resolution garding the residents' rights ragraph. Upon request, the a copy of the grievance policy grievance policy must						
ARORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATUI	SE.		TITI F		(X6) DATE	

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(0
		345164	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER RIVER NURSING AND R	EHABILITATION CENTER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	facility of the right to formation grievances anonymore of the grievance officing can be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the confidependent entities to be filed, that is, the polymer of the filed, that is, the	ndividually or through a locations throughout the ile grievances orally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone expected time frame for or of the grievance; the right cision regarding his or her with whom grievances may extinent State agency, Organization, State Surveying-Term Care Ombudsman and advocacy system; ance Official who is evering the grievance process, grievances through to their any necessary investigations ining the confidentiality of all d with grievances, for of the resident for those anonymously, issuing isions to the resident; and expecific allegations; ing immediate action to tial violations of any resident	F	585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							c l	
		345164	B. WING			10/	/25/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE			
				1341 P	ARADISE ROAD P O BOX 566			
CHOWAN	RIVER NURSING AN	D REHABILITATION CENTER		EDEN'	TON, NC 27932			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 585	Continued From page	age 2	F!	585				
		ministrator of the provider; and						
	as required by Sta	•						
	(v) Ensuring that a	Il written grievance decisions						
		e grievance was received, a						
	summary statemer	nt of the resident's grievance,						
		investigate the grievance, a						
		ertinent findings or conclusions						
		dent's concerns(s), a statement						
		grievance was confirmed or not						
		rective action taken or to be						
		y as a result of the grievance, ritten decision was issued;						
		riate corrective action in						
		tate law if the alleged violation						
		ghts is confirmed by the facility						
		tity having jurisdiction, such as						
		gency, Quality Improvement						
	Organization, or lo	cal law enforcement agency						
		n for any of these residents'						
		ea of responsibility; and						
		vidence demonstrating the						
		nces for a period of no less than						
	1 -	suance of the grievance						
	decision.	NT is not met as evidenced						
	.	in is not met as evidenced						
	Dy: Based on record r	review and interviews, the		C	howan River Nursing and Rehabilita	ation		
		ovide a grievance book which			knowledges receipt of the Statemen			
		nce records for a period of 3			eficiencies and proposes this Plan of			
	years.	·			orrection to the extent that the sumr			
				of	findings is factually correct and in c	rder		
	The findings include	de:			maintain compliance with applicabl			
					les and provisions of quality of care	of		
		rievances revealed there were			sidents. The Plan of Corrections is			
	no grievances mai	ntained prior to 7/8/18.			bmitted as a written allegation of mpliance.			
	During an interview	v on 10/25/18 at 11:45 AM, the						
		g (DON) revealed she did not			nowan River Nursing and Rehabilita			
	know what happer	ned to the grievance book. She		res	sponse to this Statement of Deficier	ncies		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345164	B. WING _			C 10/25/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/2	20/2010
				13	341 PARADISE ROAD P O BOX 566		
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER			DENTON, NC 27932		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	revealed she began e 6/28/18, and she spet to the building and the retired and a new Adr day. She stated they book and could not fir previous Administrate and when the Administrate book was no where to During an interview o current Administrator would be that the faci	employment at the facility on that a couple of days orienting the former Administrator ministrator started the next clooked for the grievance and it. She revealed the for handled all grievances strator retired the grievance to be found. In 10/25/18 at 12:07 PM, the revealed his expectation clity adequately investigated pt records of grievances for	F	585	does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Chowa River Nursing and Rehabilitation resenthe right to refute any of the deficiencies on this Statement of Deficiencies throu Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F585 The process that led to this deficiency was the facility failed to provide a grievance book which maintained grievance records for a period of 3 yea On 11/7/18 a 100% audit of all grievance x 30 days was completed by the Medic Records Coordinator to ensure all resident grievance logs were maintaine according to facility protocol, the grievance was investigated completely and that the resident or resident representative (RR) was informed of the grievance summary. All areas of concewere immediately addressed by the Administrator to include completion of grievance investigation, grievance summary follow up with resident/reside representative and maintaining of the grievance log. On 11/7/18 an in-service was complete by the Facility Nurse Consultant with the Administrator, Director of Nursing (DOI Assistant Director of Nursing (ADON), Medical Records Coordinator and the Social Worker in regards to the Reside	rs. ces al ed ern ent	

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			D MANAGO			С	
		345164	B. WING _			10/2	25/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHOWAN RIVER NURSING AND REHABILITATION CENTER		EHABILITATION CENTER			341 PARADISE ROAD P O BOX 566		
				Е	DENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE		
F 585	Continued From page	÷ 4	F	585	Concerns and Grievance Guidelines to include the Administrator's responsibilit to ensure all grievances are investigate completely, that upon completion of the grievance investigation a grievance summary follow up is completed with the resident and/or resident representative and that the facility maintains all grieval logs/files for a period of 3 years per factorotocol. All newly hired Administrators, DON, ADON, Medical Records Coordinator as Social Worker will be in-serviced during orientation by the Staff Facilitator in regards to the Resident Concerns and Grievance Guidelines to include the Administrator's responsibility to ensure grievances are investigated completely that upon completion of the grievance investigation a grievance summary folloup is completed with the resident and/or resident representative and that the factorial maintains all grievance logs/files for a period of 3 years per facility protocol. 10% of Resident Grievances will be reviewed weekly for 8 weeks, then monthly for one month by the Medical Records Coordinator to ensure all grievances are investigated completely that upon the grievance investigated completely that upon the grievance investigation a grievance summary follow up is completed with the resident and/or resident representative and that the factorial factorial protocol utilizing the Grievance Summary Audit Tool. Any areas of	ed e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL' IDENTIFICATION NUMBER: A. BUILDI			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345164	B. WING			1	C 25/2018
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 107.	23/2010
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER			1 PARADISE ROAD P O BOX 566 ENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	S483.21(b) Comprehe §483.21(b)(1) The fact implement a comprehe care plan for each resident rights set fort §483.10(c)(3), that incobjectives and timeframedical, nursing, and	omprehensive Care Plan ensive Care Plans cility must develop and ensive person-centered cident, consistent with the h at §483.10(c)(2) and			concern will be immediately addressed the Administrator/DON during the audit include completion of grievance investigation, grievance summary follow up with the resident or resident representative notification, completion the grievance log and/or additional staft training. The Medical Records Coordinator will forward the results of the Grievance Summary Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 month and review the Grievance Summary Au Tool to determine trends and / or issue that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursi will be responsible for the implementati of corrective actions to include all 100% audits, in services, and monitoring relation to the plan of correction.	to w of ff as udit s ing ion	11/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	1 , ,	(X3) DATE SURVEY COMPLETED	
		345164	B. WING _		1	C 0/25/2018	
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 1341 PARADISE ROAD P O BOX EDENTON, NC 27932	IP CODE	0/20/20 10	
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F 656	describe the follow (i) The services the or maintain the res physical, mental, a required under §48 (ii) Any services th under §483.24, §4 provided due to the under §483.10, inc treatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations findings of the PAS rationale in the res (iv)In consultation resident's represer (A) The resident's desired outcomes. (B) The resident's future discharge. F whether the reside community was as local contact agent entities, for this pu (C) Discharge plan plan, as appropriat requirements set for section. This REQUIREME by: Based on record r interviews, the faci	comprehensive care plan must ring - at are to be furnished to attain aident's highest practicable and psychosocial well-being as 33.24, §483.25 or §483.40; and at would otherwise be required 83.25 or §483.40 but are not a resident's exercise of rights aluding the right to refuse 483.10(c)(6). It is services or specialized aces the nursing facility will of PASARR If a facility disagrees with the BARR, it must indicate its ident's medical record. With the resident and the attative(s)-goals for admission and appreference and potential for facilities must document and the sessed and any referrals to cies and/or other appropriate	F	F656 The process that led to was the facility failed to plan for 1 of 2 residents accidents. (Resident #8)	follow the care reviewed for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP CODE		720/2010	
				1341 PARADISE ROAD P O BOX 566			
CHOWAN	RIVER NURSING AND I	REHABILITATION CENTER		EDENTON, NC 27932			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	diagnoses include ce dysphagia, gastrosto muscle weakness, al depression. Resident #87's Care indicated "Falls: Do rommode (BSC) una beside resident within BSC." Resident #87's urina revised on 1/31/18, in BSC unattended." Resident #87's falls of indicated "Do not lead Her most recent qual (MDS) dated 9/25/18 cognitively intact. Shextensive assistance with toilet noted as frequently in occasionally incontinuous been noted. Nursing documentatic indicated the nurse her with the BSC. Resident of the BSC. Resident of the BSC. Resident of the right of the right of the right for left knee. Neurole	renewellar ataxia, dysarthria, any, autonomic neuropathy, chormal posture, anxiety and a Guide, revised on 2/1/17, not leave on bedside attended, attendant to stay in reach of resident while on a reach of sunattended." The resident while on a reach of resident was a recontinent of urine and a reach of bowel. No falls had a reach of bowel. No falls had a reach of sident #87 lying on floor in a reach of reach and an abrasion to right side of the reach of the reach of the reach of the responsible party (RP) had reach a resident responsible party (RP) had	F 65	On 11/1/18 100% audit of all in reports to include resident # 8 completed by the Assistant Din Nursing (ADON) to ensure all had been investigated for the and appropriate interventions initiated, MD/RR notified and oplan/care guides were update of concern were immediately aby the ADON, Administrative Nouality Assurance nurse (QA) investigating root cause, initiate appropriate interventions, noti MD/RR and updating care pla guide. Audit will be completed 11/12/18. On 11/5/18 100% audit of all recare plan/care guide to include 87 was completed by the Minimage Set nurse (MDS) to ensure all are care planned and have upguide for appropriate safety in MDS nurse will update care guilan for any identified areas of There were no areas of concern on 11/6/18 100% Resident Cawith all nurses and NAs to include and resident # 87 in regards to handling and following care guinitiated by the Staff Facilitator include: 1. Care guide reviewed prior care 2. Care provided according to include toileting with appropriate include toileting with appropriate include toileting with appropriate according to include toileting with appropriate a	7 was rector of incidents root cause were care d. All areas addressed Nurses and o to include ting fication of n/ care by esidents e resident # mum Data residents idated care terventions. uide/care f concern. em noted. are Audit lude NA #1 o safe uides was r (SF) to r to initiating to care guide		
	On 10/22/18 at 11:11	AM an interview with Nurse		interventions	mate dalety		

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		345164	B. WING				C 25/2018	
NAME OF D	ROVIDER OR SUPPLIER	0.0.0.	1	97	FREET ADDRESS, CITY, STATE, ZIP CODE	10/	25/2016	
NAIVIE OF F	ROVIDER OR SUFFLIER							
CHOWAN	RIVER NURSING AND	REHABILITATION CENTER			841 PARADISE ROAD P O BOX 566			
				E	DENTON, NC 27932			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC 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 656	Continued From pa	ge 8	F 6	656				
	Aide (NA) #1 was c	conducted. The NA stated			3. If care performed incorrectly, staff			
	` ′	alert, oriented and able to			member retrained regarding:			
	express her needs.				C C			
					All areas of concern will be immediatel	y		
	On 10/22/18 at 2:30	0 PM an interview was			addressed by the SF, Administrative			
	conducted with Res	sident #87. She stated that on			nurses and ADON. Resident Care Aud	its		
		A #1 had assisted her to the			will be completed by 11/19/18.			
		allen while the NA was not in						
		ed NA #1 had been new to her			On 11/6/18 100% in-service was initiate			
		nk the NA knew how to care for			by the Staff Facilitator with all nurses a			
	her.				NA staff to include NA # 1 in regards to			
	Op 10/23/19 at 10:4	55 AM an interview with the			Safe Handling and Movement Policy to include:	,		
		who had cared for Resident			iliciade.			
		fell was conducted. The NA			1. Resident handling and movement			
	-	e fall was the first day she had			activities			
		#87. She stated the previous			a. Activities of daily living			
	NA had told her Re	sident #87 had been able to			b. Repositioning in bed or chair			
	stand and pivot for	transfers. The NA stated she			c. Providing treatments			
		care guide and it was not			d. Transfers			
	·	expected it to have been,			e. Ambulation			
		's close door. The NA stated it			f. Obtaining weights			
		ident #87 had fallen when she			g. Toileting-assisting resident or not			
		ides were now located in the			leaving resident unattended while on to	ollet		
		n learned Resident #87 was			per care guide			
	not to be left unatte	ended while on the BSC.			h. Any other activity which involves movement of resident			
	An interview with th	ne Director of Nursing (DON)			 Ensuring safety interventions are i 	n		
		10/24/18 at 2:58 PM. The			place in accordance with resident care			
		her expectation of staff to			guide			
		n when they are caring for a			3. Use of any other appropriate and			
		ot familiar with or to ask the			reasonable assistive devices and/or			
	nurse. She also sta	ted it was her expectation of			techniques when moving or repositioni	ng		
		esident #87 while she was			residents			
	sitting on the BSC.				4. Checking and following care guide	;		
					each time care is provided			
					In-service will be completed by 11/19/1 After 11/19/18 no nurse or NA will be	8.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345164	B. WING			C	5/2018
	ROVIDER OR SUPPLIER RIVER NURSING AND R	EHABILITATION CENTER		1341 PARAD	DRESS, CITY, STATE, ZIP CODE DISE ROAD P O BOX 566 , NC 27932	1 10/23	5/2016
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	PROVIDER'S PLAN OF CORRECTION IX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 656	Continued From page	9	F	allower completed All new trained oriental Movem 1. Refactivities a. Act b. Ar movem 2. Err place in guide 3. Us reason technic resider 4. Creach till 25 % F. Safe H. will be to inclunurses x 4 we utilizing	why hired nurses and NAs will be a by the Staff Facilitator during attion on the Safe Handling and ment Policy to include: esident handling and movement esectivities of daily living epositioning in bed or chair roviding treatments eansfers mbulation betaining weights oileting-assisting resident or not gresident unattended while on to re guide easy other activity which involves ment of resident ensuring safety interventions are in accordance with resident care see of any other appropriate and mable assistive devices and/or ques when moving or repositioni	oilet in ng e oes staff e ekly	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345164	B. WING _			C 10/25/2018	
	ROVIDER OR SUPPLIER RIVER NURSING AND R	EHABILITATION CENTER		13	REET ADDRESS, CITY, STATE, ZIP CODE 441 PARADISE ROAD P O BOX 566 DENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658 SS=D	S483.21(b)(3) Compr. The services provided as outlined by the commust- (i) Meet professional This REQUIREMENT by: Based on observatio interviews, the facility	eet Professional Standards (i) ehensive Care Plans d or arranged by the facility, mprehensive care plan, estandards of quality. is not met as evidenced ms, record review and staff failed to follow professional medication administration		656	movement policy and use appropriate safety interventions when providing car All areas of concern will be immediately addressed with staff retraining by the S Facilitator. The Administrator/DON will review and sign the Resident Care Aud Tool for completion weekly x 8 weeks the monthly x 1 month to ensure that all are of concern are addressed appropriately. The DON will forward the results of the Resident Care Audit Tool to the Executing QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Resident Care Audit Tool to determine trends and / or issues that may need further interventions put into place and determine the need for further and / or frequency of monitoring. F658 The process that led to this deficiency was the facility failed to follow professions standards care during medication administration observation for 1 of 9 residents observed. (Resident #7)	y taff lit hen eas /. ive e	11/19/18

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		345164	B. WING _			C 10/25/2018
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
CHOWAN	DIVED NUDCING AND I	DELIABILITATION CENTED		1341 PARADISE ROAD P O BOX	C 566	
CHOWAN	RIVER NURSING AND I	REHABILITATION CENTER		EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	(X5) COMPLETION DATE	
F 658	Continued From pag	e 11	F 6	58		
F 658	Resident #7 had beed diagnoses included in gastrostomy status, or infarction, and mild of the control of the co	n admitted on 1/3/18. His hypertension, diabetes, dysphagia following cerebral ognitive impairment. PM an interview with Nurse he nurse stated the nurse y medication the Medication lowed to give. Deservation was conducted with the second of the MA second of the medication. She check the tube placement of the medication. She liters (ml) of water through the She then administered on 650 milligrams (mg) and of water, then a 200 ml MA then reconnected the medication. The MA stated she had nister gastrostomy feeding	F6	On 10/24/18 Medication immediately in-serviced Nursing (DON) in regar Aide Scope of Practice medications and the fact for Med Aide's compliant practice when administry on 10/24/18 Medication initiated by the DON with include MA #1 to ensure administer medications of practice. All areas of immediately addressed Assistant Director of Nu Staff Facilitator (SF) to re-education of the Medications for Med Aid with scope of practice with s	I by the Director of the to Medication for administering cility's expectation for expectation may be a supported by the DON, arising (ADON), include dication Aides in ctice and facility's ide's compliance when administering of the physician resident. Audit with the Medication Aides in ctice and facility's ide's compliance when administering of the physician resident. Audit with the Medication Aides in ctice and facility's ide's compliance when administering of the physician resident. Audit with the Medication Aides in ctice and facility's ide's compliance when administering and the physician resident. Audit with the Medication Aides in ctice and facility's ide's compliance when administering and the physician resident. Audit with the Medication Aides in the physician resident. Audit with the Medication and the Medication Aides in the	of Inserting Ins
	she was allowed to a complaint of pain and	(NAII) training. She stated dminister acetaminophen for the nurse would check the tion administration for relief		Registered Nurse on 10 Gastrostomy tube place were no areas of conce changes noted. The ph notified of assessment.	ement and there ern or acute	r
	Nurse #1 was condu facility used the serv stated MAs were not via gastrostomy tube trained, according to stated if a MA gave r	AM an interview with the cted. The nurse stated the ices of MAs. The nurse to administer medications, even if the MA was NAII the facility policy. The nurse nedications via gastrostomy of their scope of practice. The		The DON notified Agen 10/25/18 in regards to N Scope of Practice and f expectation of MA compof practice. The Agency facility with proof of Mescope of Practice in-se Medication Aides and n	Medication Aide facilities pliance with scop will supply the dication Aide rvice training of a	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345164	B. WING			1	25/2018
	ROVIDER OR SUPPLIER RIVER NURSING AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932		<u> 107.</u>	25/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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 658	nurse stated only lice administer mediations On 10/25/18 at 11:25 Director of Nursing (DON stated she expetheir scope of practice nurses to know the set they are supervising, not allowed to admini	AM an interview with the DON) was conducted. The ected staff to work within and for the supervising cope of practice for the staff The DON stated MAs were	F	658	assignment to the facility. On 10/25/18 the DON notified the Direct of Staffing Agency that MA #1 was to be indefinitely removed from facility staffing. 100% interviews with all medication aid to include MA #1 was completed on 10/25/18 by Staff Facilitator in regards Medication Aide Scope of Practice to include: 1. Have you ever administered medications through a Gastrostomy Tut (PEG) in this facility? 2. Have you ever administered inject to a resident in this facility? 3. If yes to any question the MA will be immediately re-trained in regards to: Medication Aide Scope of Practice All areas of concerns were immediately addressed by the DON, ADON, SF to include re-training of Medication Aides regards to scope of practice. In-service was initiated by DON on 10/24/18 with all nurses, medication aid to include MA #1 and agency staff in regards to Medication Aide Scope of Practice for administering medications and the facility's expectations for Med Aide's compliance with scope of practice when administering medications. In-service will be completed by 11/19/18 whot be allowed to work until in-service is completed.	des to to to the ions oe while des ce so to to the ions oe the ions oe the ions of the ion	

AND PLAN OF CO	DEFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	VIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932	10/25/2018
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F 689 SS=D C	FR(s): 483.25(d)(1)(483.25(d) Accidents the facility must ensured	ards/Supervision/Devices (2)	F 689	100% Medication Pass Audits will be completed by the Administrative nurses with all Medication Aides weekly x 8 weeks then monthly x 1 month to ensu that Medication Aides administer medications per scope of practice and facilities expectations. All areas of concern will be addressed by the DON ADON, SF to include re-education of si and assessment of resident and notification of MD. The DON will review and initial all Medication Pass Audits to ensure all areas of concern were addressed. The Administrator will forward the result of the Medication Pass Audits to the Executive QA Committee monthly x 3 months. The Executive QA Committee meet monthly x 3 months and review the Medication Pass Audits to determine trends and / or issues that may need further interventions put into place and determine the need for further and / or frequency of monitoring. The Administrator and Director of Nurs will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring relator to the plan of correction.	taff will ne to

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	G COMF	
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	ROVIDER OR SUPPLIER RIVER NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932	ODE	10/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	§483.25(d)(2)Each risupervision and assistance accidents. This REQUIREMEN by: Based on record revinterviews, the facility to prevent a resident commode for 1 of 2 accidents (Resident Findings included: Resident #87 had be diagnoses include of autonomic neuropatic abnormal posture, a Resident #87's Care indicated "Falls: Do commode (BSC) unabeside resident within BSC." Resident #87's urinarevised on 1/31/18, in BSC unattended." Resident #87's falls indicated "Do not lead Her most recent qual (MDS) assessment of was cognitively intacrequired extensive accidents."	esident receives adequate istance devices to prevent T is not met as evidenced view, resident and staff y failed to provide supervision t's fall from a bed side residents reviewed for	F 6	The process that led to this was the facility failed to pro supervision to prevent a restrom a bed side commode for residents reviewed for accidents reports to include resident reports to include resident reports to include resident recompleted by the Assistant Nursing (ADON) to ensure had been investigated for the and appropriate intervention initiated, MD/RR notified and plan/care guides were updated of concern were immediate by the ADON, Administrativenty Quality Assurance nurse (Converting and updating care puides) and updating care puides. Audit will be completed 11/12/18. On 11/5/18 100% audit of a	vide sident's fall for 1 of 2 dents. Ill incident # 87 was Director of all incidents he root cause his were hid care ated. All areas ly addressed we Nurses and A) to include tiating hotification of blan/ care tied by	
	was noted as freque occasionally incontir noted.	ion dated 9/29/18 at 4:28 PM,		care plan/care guide to incl 87 was completed by the M Set nurse (MDS) to ensure are care planned and have guide for appropriate safety	ude resident # linimum Data all residents updated care	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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		345164	B. WING		•	0/25/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE			
CHOWAN	RIVER NURSING AND E	REHABILITATION CENTER		1341 PARADISE ROAD P O BOX 566				
OHOWAIT	NIVER NOROMO AND I	CHABIETATION SERVER		EDENTON, NC 27932				
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F 689	689 Continued From page 15		F 68	39				
	called to Resident #8 room, the nurse obse floor in front of the BS assessed and noted side of forehead, right gums, bruising to the abrasion to her left kn were initiated. The ph party (RP) had been On 10/22/18 at 11:11 Aide (NA) #1 was con Resident #87 was all express her needs. On 10/22/18 at 2:30 liconducted with Resident #87 assisted her to the BS the NA was not in the	dent #87. She stated that on fell, Nurse Aide (NA) #1 had SC and she had fallen while room. She stated NA #1		MDS nurse will update care plan for any identified areas There were no areas of con On 11/6/18 100% Resident with all nurses and NAs to i and resident # 87 in regards handling and following care initiated by the Staff Facilitatinclude: 1. Care guide reviewed p care 2. Care provided according to include toileting with appointerventions 3. If care performed incommember retrained regarding All areas of concern will be addressed by the SF, Admi	concern. Care Audit Include NA #1 Is to safe Is guides was lator (SF) to Incorrior to initiating Ing to care guide Irropriate safety Irrectly, staff Ig: Immediately Initiative			
	knew how to care for On 10/23/18 at 10:55 Nurse Aide (NA) #1 v #87 on the day she for stated the day Reside she had cared for her NA had told her Reside stand and pivot for tra had looked for the car posted where she ex inside the resident's of had been after Resid learned the care guid computer. She then I	and she did not think the NA her. AM an interview with the who had cared for Resident ell was conducted. The NA ent #87 fell was the first day r. She stated the previous dent #87 had been able to ansfers. The NA stated she re guide and it was not pected it to have been, closet door. The NA stated it ent #87 had fallen when she les were now located in the earned Resident #87 was ded while on the BSC.		nurses and ADON. Resider will be completed by 11/19/ On 11/6/18 100% in-service by the Staff Facilitator with a NA staff to include NA # 1 in Safe Handling and Moveme include: 1. Resident handling and activities a. Activities of daily living b. Repositioning in bed or c. Providing treatments d. Transfers e. Ambulation f. Obtaining weights g. Toileting-assisting residents	e was initiated all nurses and negards to ent Policy to movement			

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NAME OF PROVIDER OR SUPPLIER CHOWAN RIVER NURSING AND REHABILITATION CENTER 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			345164	B. WING _				
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F 689 Continued From page 16 On 10/24/18 at 10:35 AM an interview with Nurse #2 was conducted. She stated when Resident #87 had fallen, staff came and got her. Resident #87 was observed on the floor of her room and the NA had stated the resident had fallen off of the BSC. Resident #87 had a laceration to her right forehead and a butterfly bandage had been applied, an abrasion to her left knee was covered with a small bandage and her mouth had been rinsed. Resident #87 had stated she felt alright, had no pain and her neurological checks had been stable so she was not sent to the Emergency Department (ED). An interview with the Director of Nursing (DON) was conducted on 10/24/18 at 2:58 PM. The DON stated it was her expectation of staff to review the care plan when they are caring for a resident they are not familiar with or to ask the nurse. She also stated it was her expectation of staff to stay with Resident #87 while she was sitting on the BSC. In Resident handling and movement activities a. Activities of daily living b. Repositioning in bed or chair c. Providing treatments d. Transfers e. Ambulation f. Obtaining weights g. Tolleting-assisting resident or not leaving resident unattended while on toilet per care guide h. Any other activity which involves movement of resident 2. Ensuring safety interventions are in place in accordance with resident care guide and cordance with resident care guide each time care is provided In-service will be completed by 11/19/18. After 11/19/18 no nurse or NA will be allowed to work until in-service has been completed. All newly hired nurses and NAs will be trained by the Staff Facilitator during orientation on the Staff Handling and Movement Policy to Include: 1. Resident handling and movement activities 2. Ensuring safety interventions are in place in accordance with resident care guide	F 689	On 10/24/18 at 10:35 #2 was conducted. Si #87 had fallen, staff of #87 was observed on the NA had stated the BSC. Resident #8 right forehead and a lapplied, an abrasion with a small bandage rinsed. Resident #87 had no pain and her ribeen stable so she with the was conducted on 10 DON stated it was hereview the care plant resident they are not nurse. She also state staff to stay with Resident was with Resident with the was conducted on 10 DON stated it was hereview the care plant resident they are not nurse. She also state staff to stay with Resident was conducted on the review the care plant resident they are not nurse. She also state staff to stay with Resident was observed on the review the care plant resident they are not nurse. She also state staff to stay with Resident was observed on the part of the properties of the part of the	AM an interview with Nurse he stated when Resident fame and got her. Resident the floor of her room and e resident had fallen off of 87 had a laceration to her putterfly bandage had been to her left knee was covered and her mouth had been had stated she felt alright, neurological checks had as not sent to the ent (ED). Director of Nursing (DON) /24/18 at 2:58 PM. The r expectation of staff to when they are caring for a familiar with or to ask the d it was her expectation of	F6		leaving resident unattended while on to per care guide h. Any other activity which involves movement of resident 2. Ensuring safety interventions are in place in accordance with resident care guide 3. Use of any other appropriate and reasonable assistive devices and/or techniques when moving or repositioning residents 4. Checking and following care guide each time care is provided In-service will be completed by 11/19/19 After 11/19/18 no nurse or NA will be allowed to work until in-service has bee completed. All newly hired nurses and NAs will be trained by the Staff Facilitator during orientation on the Safe Handling and Movement Policy to include: 1. Resident handling and movement activities a. Activities of daily living b. Repositioning in bed or chair c. Providing treatments d. Transfers e. Ambulation f. Obtaining weights g. Toileting-assisting resident or not leaving resident unattended while on to per care guide h. Any other activity which involves movement of resident 2. Ensuring safety interventions are in place in accordance with resident care	n ng e 8. en	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SI COMPLE	
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CHOWAN	RIVER NURSING AND R	ENABILITATION CENTER		EDENTON, NC 27932			
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F 761 SS=E	Continued From page Label/Store Drugs an CFR(s): 483.45(g)(h)	d Biologicals	F 6	3. Use of any other appropriar reasonable assistive devices are techniques when moving or represidents 4. Checking and following careach time care is provided 25 % Resident Care Audit in regulations and following care will be completed with nurses at to include NA # 1 by the Admininurses 3 times a week x 4 week x 4 weeks, then monthly x 1 moutilizing the Resident Care Audiensure staff follow safe handling movement policy and use approsafety interventions when provided All areas of concern will be immaddressed with staff retraining be addressed with staff retraining be a facilitator. The Administrator/Dereview and sign the Resident Care and for concern are addressed approximately x 1 month to ensure the of concern are addressed approximately x 1 month to ensure the concern are addressed approximately x 3 months and review Resident Care Audit Tool to the QA Committee monthly x 3 months and review Resident Care Audit Tool to determine the need for further a frequency of monitoring.	re guide gards to re guides gards to re guides nd NA si strative ks, week onth t Tool to g and opriate ding care nediately by the St OON will are Audi weeks th at all are opriately s of the Executive the ermine need need are and t	s taff kly e. , taff it nen eas	1/19/18
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	A. BUILDING		OMPLETED			
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	ROVIDER OR SUPPLIER RIVER NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932	'	
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F 761	Drugs and biological labeled in accordance professional principal appropriate accessor instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In accessed in the second professional principal appropriate accessor instructions, and the applicable. §483.45(h)(1) In accessor in the second professional locked temperature controls personnel to have a second per	of Drugs and Biologicals Is used in the facility must be be with currently accepted es, and include the bry and cautionary expiration date when of Drugs and Biologicals cordance with State and colity must store all drugs and compartments under proper s, and permit only authorized coess to the keys. Accility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the nimal and a missing dose can T is not met as evidenced on, record review and staff by failed to maintain the 3 medication refrigerators in refrigerator #1 on D-hall gerator #1 in the main and failed to secure 1 of 2 cotic boxes reviewed (A-hall cotic box).	F 7	F761 The process that led to this defi was the facility failed to maintai temperature for 2 of 3 medicatic refrigerators reviewed (medicat refrigerator #1 on the D hall and medication refrigerator #1 in the medication room), and failed to of 2 medication cart narcotic bo reviewed (A-hall medication car box)	n the con	

PRINTED: 12/04/2018 FORM APPROVED OMB NO. 0938-0391

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TVAIVIL OF T	TOVIDER OR OUT LIER				_		
CHOWAN	RIVER NURSING AND	REHABILITATION CENTER		1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932			
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F 761	Continued From pag	je 19	F 76	61			
	medication refrigerat temperature of 32 de The temperature log temperature range some temperature range some temperature range some temperature refrigerator temperatures recent temperatures recent temperatures recent temperatures recent temperatures recent temperatures refrigerator refrigerator temperatures refrigerator refriger	tor was observed with a egrees Fahrenheit (F). indicated the refrigerator hould be 35-41 degrees F. ecorded on the log revealed tures within range with the ature check completed on		On 10/25/18 100% audit of all temperature logs from 10/1/18 was completed by the Director to ensure refrigerator temperature within acceptable ranges. All concern were immediately ad the Director of Nursing (DON) Director of Nursing (ADON) a Administrative nurses to inclus adjustment of refrigerator temperature acceptable range, notification Maintenance Director for any repair/replacement, and remormedications/labs if indicated.	8-10/25/18 or of Nursing atures were areas of dressed by), Assistant nd de operature to of related		
	1- Tuberculin purifier milliliter (ml) vial. The indicated to store at 6- Bisacodyl suppos medication packagir 68-77 degrees F. 3- Insulin glargine per packaging indicated 1- Darbepoetin alfa (11 ml. The medication store at 35-46 degree 9- Insulin detemir in packaging indicated On 10/25/18 at 12:4 Director of Nursing (12 Director of Nursing (13 per	itories 10 milligram (mg). The ng indicated to store between ens. The medication to refrigerate. 60 microgram (mcg) injection in packaging indicated to		On 10/25/18 the following me were removed from refrigerate by nursing staff: (1) Tubercul protein injection 5/0.1 milliliter bisacodyl suppositories 10 mi (3) insulin glargine pens, (1) E alfa 60 microgram (mcg) inject and (9) insulin detemir injection to temperatures recorded out acceptable temperature range. On 10/25/18 the following me were removed from refrigerate main medication storage room nursing staff: (1) 10ml vial of indetemir, (1) 3ml vial of Humul insulin, (4) Promethegan supping, (1) Latanooprostene 0.24 ophthalmic solution, (1) influe 5ml vial, (1) insulin glargine 1 dose vial, (69) Formoterol net treatment 20 mcg, (10) Cefaz in 0.9% normal saline (NS) 10	or #1 D-hall in purified (ml) vial, (6) Illigram (mg), Darbepoetin ction 1ml, on pens due of e. dications or #1 on the n by the nsulin in regular cositories 25 !% nza afluria Oml multi pulizer olin injection		

Facility ID: 923018

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		345164	B. WING		1	C 0/25/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		0/25/2016
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CHOWAN	RIVER NURSING AND I	REHABILITATION CENTER		EDENTON, NC 27932		
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F 761	Continued From pag	e 20	F 76	61		
	abnormal findings. 2. On 10/25/18 at 12 main medication store the Assistant Director Refrigerator #1 was of 19 degrees Fahre The temperature log temperature ranges. The temperatures refrigerator temperatures refrigerator temperatures recent temperatures and 10/24/18, AM. Medications in the material refrigerator #1 included 1- 10 milliliter (ml) via	:27 PM refrigerator #1 in the rage room was reviewed with r of Nursing (ADON). observed with a temperature nheit (F). indicated the refrigerator hould be 35-41 degrees F. corded on the log revealed ures within range with the ture check completed on		intravenous infusion, (1) insuli (1) pneumococcal 13 valent or vaccine vial, (1) Epoetin alfa 1 1ml vial, (5) insulin glargine per insulin aspart insulin pens Nov pen, and (2) Tuberculin purifier injection 5/0 1ml vials. On 10/25/18 the temperature refrigerator #1 D-hall and refrigmain medication storage room adjusted by the Director of Numaintain acceptable temperate for medication storage. On 11/8/18 100% in-service with all include nurse #4 in regards to Temperatures to include:	onjugate 0, 000 unit ens 3ml, (8) volog flex ed protein for gerator #1 n was rsing to ure range ras initiated nurses to	
	medication packagin refrigerated, do not f 4- Promethegan sup (mg). Packaging indi 1- Latanooprostene Packaging indicated 1- Influenza afluria 5 packaging indicated 1- Insulin glargine 10 medication packagin degrees F. 69- Formoterol nebu doses. The medicatiostore at 36-77 degre 10- Cefazolin injectic 100 ml for intravenoulabel indicated to reference of the prometric store at 36-77 degre 10- Cefazolin injectic 100 ml for intravenoulabel indicated to reference in the prometric store at 36-77 degre 10- Cefazolin injectic 100 ml for intravenoulabel indicated to reference in the prometric store at 36-77 degre 10- Cefazolin injectic 100 ml for intravenoulabel indicated to reference in the prometric store in	positories 25 milligrams cated to refrigerate. 0.24 % ophthalmic solution. to refrigerate. ml vial. The medication to store at 36-46 degrees F. ml multi dose vial. The g indicated to store at 36-46 lizer treatment 20 mcg on packaging indicated to es F. mn in 0.9% normal saline (NS) as infusion. The pharmacy rigerate. The medication packaging		1. Acceptable temperature remedication storage is 36-46 degrees 2. Acceptable temperature restorage is 36-46 degrees 3. Refrigerator temperatures monitored daily by the assigned and documented on the refrigetemperature log. 4. If a refrigerator temperature within acceptable temperature assigned hall nurse must discemedications that are affected temperature range and adjust temperature setting to maintain temperature within acceptable 5. If abnormal temperature recontinue after adjusting setting assigned nurse must submit a request to the Maintenance Di	egrees ange for lab s should be ed hall nurse erator are is not erange the ard any by abnormal n erange. eadings gs, the awork order	

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345164	B. WING _				C 25/2018	
NAME OF PR	ROVIDER OR SUPPLIER		'	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
				13	341 PARADISE ROAD P O BOX 566			
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		E	DENTON, NC 27932			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
F 761		valent conjugate vaccine	F 7	761	The DON must be notified for any concerns related to refrigerator			
	vial. The medication packaging indicated do not freeze, store at 36-46 degrees F. 1- Epoetin alfa 10,000 unit 1 ml vial. The medication packaging indicated to store between 35-46 degrees F. 5- Insulin glargine pens 3 ml. The medication packaging indicated to refrigerate 36-46 degrees F unopened. 8- Insulin aspart insulin pens Novolog flex pen.				temperatures in regards to medication and/or lab storage. 7. Assigned hall nurse will notify			
					pharmacy of any medications affected that needs to be discarded so supply cobe restocked.	an		
	The pharmacy label in 2- Tuberculin purified	ndicated to refrigerate. protein injection 5/0.1			In-service will be completed by 11/17/1 After 11/17/18 no nurse will be allowed work until in-service has been complete	to		
	milliliter (ml) vials. The medication packaging indicated to store at 35-46 degrees F. On 10/25/18 at 12:47 PM an interview with the				All newly hired nurses will be in-service during orientation by the Staff Facilitatoregards to Refrigerator Temperatures to	or in		
	Director of Nursing (Director	DON) was conducted. The DON) stated it was the vening shift to check the			include: 1. Acceptable temperature range for			
	temperatures of the nany concerns were id	nedication refrigerators. If lentified, the DON would			medication storage is 36-46 degrees 2. Acceptable temperature range for	lab		
	expect the nurse to reabnormal findings.	eport the concern of			storage is 36-46 degrees 3. Refrigerator temperatures should I monitored daily by the assigned hall nu			
	medication cart was o	01 AM a review of the A-hall conducted with Nurse #3. narcotic box easily opened			and documented on the refrigerator temperature log.4. If a refrigerator temperature is not within acceptable temperature range the			
	_	se #3 was conducted on			assigned hall nurse must discard any medications that are affected by abnor			
	the medication cart w she always uses the box. She stated she h could be opened with	I. The nurse stated she locks when she steps away and key to unlock the narcotic had not noticed the box minimal shaking. The nurse counted the narcotics at the			temperature range and adjust temperature setting to maintain temperature within acceptable range. 5. If abnormal temperature readings continue after adjusting settings, the assigned nurse must submit a work orc	der		
		and the count had been			request to the Maintenance Director. 6. The DON must be notified for any concerns related to refrigerator			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345164	B. WING _				C 25/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10/	23/2010
				13	41 PARADISE ROAD P O BOX 566		
CHOWAN	RIVER NURSING AND R	REHABILITATION CENTER			DENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	e 22	F 7	761			
F 761	Narcotics observed w 4- Fentanyl 100 micro 7- Fentanyl 12 mcg/h 300- Oxycodone 10 r 84- Tramadol 50 mg 15- Oxycodone/aceta tablets 155- Oxycodone 5mg 114- Lorazepam 0.5 r 28- Hydrocodone/aceta tablets 8- Clonazepam 0.5 m 34- Brivaracetam 75 On 10/25/18 at 12:47 Director of Nursing (E DON stated it was he	within this box included: ogram/per hour (mcg/hr) or patches milligrams (mg) tablets tablets aminophen 7.5-325 mg og tablets etaminophen 5-325 mg og tablets etaminophen 5-325 mg og tablets etaminophen 5-325 mg og tablets etaminophen 5-425 mg og tablets e	F 7	761	temperatures in regards to medication and/or lab storage. 7. Assigned hall nurse will notify pharmacy of any medications affected that needs to be discarded so supply cobe restocked. On 10/25/18 100% audit of all medicatiock systems to include narcotic lock be was completed by the Staff Facilitator tensure all lock systems were working properly. All area of concerns were immediately addressed by the DON to include initiating work order for any system failures and securing medications/narcotics in an alternative secured location. On 10/25/18 all narcotic medications were moved from A-hall medication cart arstored in a double lock system by the Administrative Nurse on C-hall medicaticatr until the lid of the locked narcotic back-hall medication cart could be repaired on 10/26/18 the lid of the locked narcotic box A-hall medication cart was repaired and all narcotic medications were returned to A-hall medications were returned to A-hall medication cart by the staff Facilitator with all nurses to include nurse #3 in regards to Securing Narcotic Medications to include: 1. All narcotics should be stored in a double lock system 2. It is the nurses responsibility to	on ox oo ere and tion oox d. tic d	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING COMPLE				
		345164	B. WING			1	C 25/2048
NAME OF D	ROVIDER OR SUPPLIER	343104	5::	QTD!	EET ADDRESS, CITY, STATE, ZIP CODE	10/2	25/2018
NAME OF F	ROVIDER OR SUFFLIER						
CHOWAN	RIVER NURSING AND R	REHABILITATION CENTER		I PARADISE ROAD P O BOX 566 ENTON, NC 27932			
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	e 23	F		ensure all narcotics are stored appropriately 3. Nurses should report to the DON immediately any concerns related to locking mechanism related to securing medications/narcotic medications 4. Anytime there is a failure in the locking mechanism related to securing medications/narcotics, the nurse must secure medications in an alternate seculocation until medication cart can be repaired. In-service will be completed by 11/19/1 After 11/19/18 no nurse will be allowed work until in-service is completed. All newly hired nurses will be in-service during orientation by the Staff Facilitator regards to Securing Narcotic Medication to include: 1. All narcotics should be stored in a double lock system 2. It is the nurses responsibility to ensure all narcotics are stored appropriately 3. Nurses should report to the DON immediately any concerns related to locking mechanism related to securing medications/narcotic medications 4. Anytime there is a failure in the locking mechanism related to securing medications/narcotics, the nurse must secure medications in an alternate seculocation until medication cart can be repaired. 100% audit of refrigerator temperatures	8. to ed or in ons	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	PLE CONSTRUCTION IG	_	(X3) DATE SURVEY COMPLETED
		345164	B. WING			C 10/25/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, S 1341 PARADISE ROAD P EDENTON, NC 27932		10/23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)	
F 761	Continued From pag	e 24	F	will be completed nurses 5 times a v x 4 weeks then m the Refrigerator T ensure all refriger within acceptable concern will be im the Administrative adjustment of refr acceptable range Maintenance Dire repair/replacemer medications/labs re-education of st and initial the Ref Log weekly x 8 w month to ensure a addressed appropriate and in the Administrative weeks then month Medication Cart Sensure all lock syproperly. All area immediately addressed administrative nurver work orders for an securing medicati alternate secured review and initial Security Audit Too monthly x 1 month concern were add.	ector for any related ont, removal of if indicated and staff. The DON will reviewers then monthly x 1 all areas of concern where the complete tive nurses weekly x 8 hly x 1 month utilizing Security Audit Tool to estems are working of concerns will be	iew e to iew e to iew e to ithe iew e to iew e t

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUC G		(X3) DATE COMP	SURVEY LETED
		345164	B. WING				25/2018
	ROVIDER OR SUPPLIER RIVER NURSING AND R	EHABILITATION CENTER			RESS, CITY, STATE, ZIP CODE SE ROAD P O BOX 566 NC 27932	1 107.	23/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E IOSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page		F 7	Executive months. meet months. Refriger Medicat determined funded for frequency for frequency frequency for frequency for frequency for frequency frequency for frequency freque	ve QA Committee monthly x 3. The Executive QA Committee onthly x 3 months and review trator Temperature Log and the tion Cart Security Audit Tool to ne trends and / or issues that nother interventions put into place determine the need for further a uency of monitoring.	ne nay e	11/19/18
SS=D	infection prevention a designed to provide a comfortable environm development and trar diseases and infection §483.80(a) Infection program. The facility must esta and control program a minimum, the follow §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visit providing services un arrangement based us conducted according accepted national states §483.80(a)(2) Written	blish and maintain an and control program a safe, sanitary and ment and to help prevent the asmission of communicable ans. brevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, and controlling infections seases for all residents, ors, and other individuals der a contractual apon the facility assessment to §483.70(e) and following and ogram, which must include,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345164	B. WING		C 10/25/2018		
	NAME OF PROVIDER OR SUPPLIER CHOWAN RIVER NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932	10/29/2016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION		
F 880	Continued From pag	ge 26 billance designed to identify	F 880				
	possible communication infections before the persons in the facilit (ii) When and to who communicable disease reported; (iii) Standard and trate to be followed to pre (iv) When and how is resident; including b (A) The type and du depending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected a contact with residen contact will transmit (vi) The hand hygien by staff involved in contact with residen contact with residen contact will transmit (vi) The hand hygien by staff involved in contact with residen contact with residen contact with residen contact will transmit (vi) The hand hygien by staff involved in contact with residen corrective actions tates \$483.80(a)(4) A systidentified under the corrective actions tates \$483.80(e) Linens. Personnel must han transport linens so a infection.	able diseases or by can spread to other by; can possible incidents of ase or infections should be ansmission-based precautions event spread of infections; colation should be used for a cut not limited to: ration of the isolation, infectious agent or organism that the isolation should be the sible for the resident under the escape with a communicable skin lesions from direct the disease; and the procedures to be followed direct resident contact. Item for recording incidents facility's IPCP and the ken by the facility. In the disease is and the store, process, and the store, process, and the store, process, and the store prevent the spread of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		345164	B. WING_				C / 25/2018
NAME OF P	ROVIDER OR SUPPLIER	1	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	20/2010
CHOWAN	DIVED MUDOING AND	DELIA DII ITATIONI CENTED		13	341 PARADISE ROAD P O BOX 566		
CHOWAN	RIVER NURSING AND I	REHABILITATION CENTER		Е	DENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From pag	e 27	F 8	880			
F 880	Based on observation facility failed to preven between residents by bottle of wound clean cleaning, for 2 of 4 re #60) observed for wo failed to complete and data to track and trenduring the previous Erebruary, July, August The findings included 1. A continuous wound Resident #49 and Reson 10/24/2018 from Nurse #1. On 10/24, gathered her supplies wax paper and took froom and laid them on Nurse #2 washed the Nurse #2 assisted Nurse #2 assisted Nurse #2 assisted Nurse #2 to get the wound cart. Nurse #2 left the plastic bottle of wour the bottle with her glocal cleanser on the sacrounderneath Resident on the bed, not on the wiped the wound with the wound with the sacrounderneath Resident on the bed, not on the wiped the wound with	on, and staff interviews, the ent cross contamination y taking a multi-use plastic user between rooms without esidents (Resident #49 and bound care. The facility also d document surveillance and infections in the facility of 10 months (January, est and September 2018).	F	380	The process that led to this deficiency was the facility failed to prevent cross contamination between residents by taking a multi-use plastic bottle of wour cleanser between rooms without cleanifor 2 of 4 residents (Resident #49 and #60) observed for wound care. The faciliso failed to complete and document surveillance and data to track and trendinfections in the facility during the previmage of 10 months (January, February, Jul August and September 2018.) On 10/25/18 wound care for resident # and # 60 was completed by the assignmental nurse observing appropriate aseptite technique. Resident's wounds were assessed with no identified areas of concern. On 11/8/18 100% Resident Care Audit-Treatments was initiated with all nurses to include nurse #1 by the Staff Facilitator to ensure nurses were utilizing appropriate aseptic technique during dressing changes to include cleaning items per facility protocol between use, areas of concern will be immediately addressed by the Administrative nurse. Staff Facilitator and Assistant Director of Nursing (ADON) to include providing	ility dous y, 49 ed ic	
	wound a second time on the bed. The nurs wound, closed the ba	e and placed the bottle back e finished dressing the ag of trash, washed her om to get supplies for the			additional wound care utilizing appropri technique, cleaning of supplies per faci protocol and education of staff. Reside Care Audit will be completed by 11/19/ After 11/19/18 No nurse will be allowed provide wound care until audit is	lity nt 18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						,	С
		345164	B. WING			10/	25/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHOWAN	DIVED MUDGING AND F	DELIA DII ITATIONI CENTED		1:	341 PARADISE ROAD P O BOX 566		
CHOWAN	KIVEK NUKSING AND F	REHABILITATION CENTER		E	DENTON, NC 27932		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	 E	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	<u>.те</u>	DATE
F 880	Continued From page	e 28	F	880			
	At 10:22AM, Nurse #	1 returned to Resident #49s			completed.		
		rapped in a sheet of wax			Compressed.		
		pplies on the bed. The			On 11/8/18 100% in-service was initiate	- d	
		of wound cleanser left on			by the Staff Facilitator with all nurses to		
		the residents left face with			include nurse #1 in regards to Clean		
		ced the bottle back on the			Technique During Dressing Changes to	,	
		ent was completed, the			include:	,	
		f trash and bottle of wound			moldde.		
	_	area sat them down and			1. When applying or changing		
		Nurse #1 then took the bag			dressings, an aseptic technique or clea	ın	
		d of it at her treatment cart			technique is used in order to avoid	.11	
						on	
	-	of wound cleanser on top of			introducing infections into a wound. Ev		
		he nurse took a beach wipe			if a wound is already infected, an asept		
		Fungicidal, Tuberculocidal			or clean technique should be used as i	. 15	
		utes," and cleaned her			important that no further infection is		
		en used in the room and			introduced.	1	
		of the scissors with the wipe			2. Always place clean items onto a cl		
		cart. The bottle of wound			barrier such as wax paper, chux or othe		
		ouched. The nurse then			clean barrier system. Contaminated ite	ms	
	· •	esident #60 room and went			must be placed on a separate barrier		
		dent for a wound treatment			system as to not contaminate clean iter		
	to her heel.				3. If at any time you feel you may have		
					interrupted a clean system you must st	op,	
		:36 AM, Nurse #1 took			obtain new clean supplies or provide		
		nd care wrapped in a sheet of			cleaning per facility protocol of any		
		ame bottle of wound cleanser			contaminated items. This would include		
		om and laid the supplies on			multiple use spray bottles, dressing iter	ns,	
		e #1 was asked where she			scissors or other items.		
		bottle of wound cleanser, the					[
		uld put the bottle on the bed			All muti-use items must be cleaned price	r	
		so she could reach it. When			to leaving the room and per facility		
	asked about cleaning				protocol before using on the next patie	nt.	[
		eplied, "I already cleaned it,					[
	but if you want it clea	ned again, I can do that too".			In-service will be completed by 11/19/1		[
	The Nurse took the b	ottle of wound cleanser to			After 11/19/18 no nurse will be allowed	to	
	the treatment cart an	d used a bleach wipe to wipe			work until in-service has been complete	∍d.	
	the nozzle, handle ar	nd body of the bottle off for			·		
		conds and then threw the			All newly hired nurses will be in-service	:d	
	wipe away. The nurs				during orientation by the Staff Facilitato		

OL. TILIT	C I CIT III EDIO/ II LE C	MEDIO/ (ID CEITVICE)					3. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _			С
		345164	B. WING			1	/25/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHOWAN	DIVED NUDCING AND E	DELLA DIL ITATIONI CENTED		1:	341 PARADISE ROAD P O BOX 566		
CHOWAN	RIVER NURSING AND R	REHABILITATION CENTER		E	DENTON, NC 27932		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFI	·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
F 880	Continued From page	e 29	F	880			
	considered the bottle	ready to be taken into the			regards to Clean Technique During		
		the nurse replied, "well I			Dressing Changes to include:		
		o 99% of the germs were					
	killed." When the nur	rse was asked about the			When applying or changing		
	directions for the wipe	e and the 4-minutes listed on			dressings, an aseptic technique or clea	an	
	the label, the nurse re	eplied the bottle needed to			technique is used in order to avoid		
	be wet for 4 minutes	and it wasn't wet that long,			introducing infections into a wound. Ev	en	
	so she would just use	e a bottle of unopened			if a wound is already infected, an asep		
	normal saline to clear	n the wound. At 10:47 AM			or clean technique should be used as i	t is	
	Nurse #1 went back i			important that no further infection is			
		ng change and was back to			introduced.		
		11:04 AM. The nurse took a			Always place clean items onto a c		
		ed the plastic bottle of wound			barrier such as wax paper, chux or oth		
	_	rapped the nozzle and			clean barrier system. Contaminated ite	ms	
		pe, and the body of the			must be placed on a separate barrier		
	bottle with another bl	· · · · · · · · · · · · · · · · · · ·			system as to not contaminate clean ite		
		the bottom of the bottle			3. If at any time you feel you may ha		
		se #1 was asked if she			interrupted a clean system you must st	op,	
		f the bottle was sitting on a			obtain new clean supplies or provide		
		urse replied, "yes, I had not			cleaning per facility protocol of any contaminated items. This would include	_	
	thought about cross t	contamination, my bad."			multiple use spray bottles, dressing ite		
	On 10/24/2018 at 2:2	4 PM, an interview was			scissors or other items.	.113,	
		irector of Nursing (DON).			scissors of other items.		
		had expectations that her			All muti-use items must be cleaned price	or	
		erence of what was clean			to leaving the room and per facility	J.	
		nd how to maintain infection			protocol before using on the next patie	nt.	
		rther stated she believed			protocol soloro sollig oli silo liola pasio		
		bottle of wound cleanser if			On 11/15/18 a review of all events that		
	she said she cleaned				meet criteria of infection per facility		
					protocol x 60 days was completed by t	he	
	2. Review of the fac	ility's policy title Infection			Staff Facilitator to include performing		
		noted the responsibilities of			surveillance for the identification,		
	the Infection Control	Preventionist (ICP) dated			investigation and documentation of fac	ility	
	9/2014, included the				acquired infections, community acquire	∌d	
	surveillance for the id	lentification, investigation,			infections and communicable disease.		
	and documentation o	f facility acquired infections,			infections were assessed for trending t	.0	
	community acquired	infections, and			include utilizing a color code system. A	JI .	
	communicable diseas	se outbreaks as necessary.			identified areas of concerns were		

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X3) DATE (COMP		SURVEY LETED				
		345164	B. WING _			1	25/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10//	23/2010
				13	41 PARADISE ROAD P O BOX 566		
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		E	DENTON, NC 27932		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	e 30	F8	380			
F 880	Review of the Infection revealed no trending January, February, Justracking reports were 2018. On 10/24/2018 at 4:3 conducted with the Down who stated the infection July 2018, right after facility. The DON standaministrative nurse facility. The DON was unabled January, February, Justra and was unable to producted with the Acceptode of the Acceptode of the Infection of the Infe	e data monthly for reviews." on Control records for 2018, reports for the months of ally, and September. No available for August of 3 PM, an interview was irrector of Nursing (DON), on control nurse resigned in the DON had started at the ted she was the only trying to cover all areas. To provide trending data for ally, and September of 2018, ovide tracking data for 25 PM, an interview was dministrator who stated he uitable infection control d for it to be implemented	F8	880	immediately addressed by the ADON/DON. Audit will be completed by 11/19/18. On 11/9/18 100% in-service was completed with Unit Nurse Managers, Quality Assurance Nurse (QA) and the ADON by the DON in regards to Infection Control to include but not limited to: 1. Performing surveillance for the purpose of identifying, investigating and documentation of facility acquired infections, community acquired infectionand communicable disease 2. Tracking and trending facility acquired infections, community acquired infectionand communicable diseases utilizing the color code system 3. Implementing preventative and corrective measures for any related trein regards to infections 4. The facility will discuss during Cardinal IDT meeting all newly acquire infections to identify potential trends or concerns. 5. The facility Infection Control Preventionist will maintain logs of facility acquired infections, community acquired infections and communicable disease logs along with documentation of tracking/trending monthly for a period designated per facility protocol.	ion d ns ired ns ne nds d	
					All newly hired Unit Nurse Managers, On Nurse and ADON will be in-serviced by the Staff Facilitator in regards to Infecti Control to include but not limited to:	,	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG		(X3) DATE SUI COMPLET	
						С	
		345164	B. WING _			10/25/	/2018
	ROVIDER OR SUPPLIER RIVER NURSING AND I	REHABILITATION CENTER		STREET ADDRESS, CITY, STA 1341 PARADISE ROAD P O I EDENTON, NC 27932			
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F 880	Continued From pag	e 31	F	1. Performing surve purpose of identifyin documentation of far infections, communicand communicable of the color code system of the code system of the color code system of the	ig, investigating and cility acquired ty acquired infection disease ending facility acquired ty acquired infection diseases utilizing the reventative and a for any related trees on the construction of the construction of the community acquired potential trends or the community acquired interest and the community acquired potential trends or the community acquired interest and the community acquired interest and the community acquired interest and the community acquired into the control of the community acquired into the control of the contr	ons dired ons he ends ends ends dity ed fith ate al kly x	

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		345164	B. WING _		10	/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		1341 PARADISE ROAD P O BOX 566		
OHOWAN	MIVER HOROMO AND I	ELIABILITATION GENTER		EDENTON, NC 27932		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	Continued From page	÷ 32	F 8	nurse #1 weekly x 8 weeks then mor 1 month by the Administrative nurses ensure nurses are utilizing appropria aseptic technique during dressing changes. All areas of concern will be immediately addressed by the Administrative nurses and Staff Faci to include providing additional wound utilizing appropriate technique, clear supplies per facility protocol and education of staff. The DON/ADON review and initial the Resident Care weekly x 8 weeks then monthly x 1 nto ensure all areas of concern were addressed appropriately. The DON will forward the results of the Resident Care Audit-Treatments and Infection Control Log to the Executive Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Resident Care Audit-Treatments and Infection Control Log to determine the need for further and / or issues that may need further interventions put into place and to determine the need for further and / frequency of monitoring.	itator I care ing of vill Audit nonth ne the e QA	