STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	12/20/2018

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ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		1/11/19

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

Electronically Signed | 01/07/2019

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with the resident and staff and record review the facility failed to provide the resident a regular plate and eating utensils when it was determined he was not at risk for suicide for 1 of 2 residents (Resident #70) reviewed for dignity. The findings included: Resident #70 was admitted to the facility on 10/16/18 with diagnoses which included chronic kidney disease on hemodialysis, protein calorie malnutrition, diabetes and depressive disorder. A review of the 30 day Minimum Data Set (MDS) dated 11/11/18 revealed Resident #70 was cognitively intact, had no behaviors and no rejection of care. He was independent for transfers and required supervision for eating. A review of the physician's orders for Resident #70 revealed an order dated 10/30/18 which read, "Pt (patient) is NOT suicidal. Negative suicide screen." The order revealed Unit Manager #1 received the order. During an observation of the meal service on 12/18/18 at 11:48 AM the resident's meal tray was located on his over the bed table. Resident #70's food items were served on a foam hinged tray and he had plastic utensils. During an observation of the meal service on 12/19/18 at 8:25 AM the breakfast meal was served on a foam hinged tray and the eating utensils were plastic.	F 550	Roanoke River Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. Roanoke River Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that led to this deficiency was the facility failed to provide the resident a regular plate and eating utensils when it was determined the resident was not at risk for suicide for 1 of 2 residents reviewed for dignity (resident #70) On 12/20/18 resident #70 care plan/care guide was updated to reflect resident not	

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F 550	Continued From page 2 On 12/19/18 at 8:25 AM Nursing Assistant (NA) #2 stated Resident #70 received his food on a foam tray and received plastic ware instead of regular eating utensils because he was on suicide precautions. During an observation of the breakfast meal on 12/20/18 at 8:05AM Resident #70's meal was again served on a foam hinged tray with plastic eating utensils. During this meal observation Resident #70 stated at one time when he first arrived he did receive food on a regular plate at meals. He said he did not know why he now received his food in the foam hinged container or why he only received plastic utensils which would not cut his food. He stated he felt embarrassed. He added the food was not very warm most of the time but it was what he had to eat. He also stated he did have snacks in his room which he could eat but he was confused as to why his food was always on a foam plate. On 12/20/18 at 8:30 AM NA #1 stated Resident #70 was getting food on a foam plate because he was a suicide risk. Unit Manager #1 was interviewed on 12/20/18 at 8:55 AM. She stated the physician talked to the resident and determined Resident #70 was not at risk to harm himself. She stated a psychiatric consult was completed. Unit Manager #1 said Resident #70 did not need to receive plastic utensils or a foam plate. On 12/20/18 at 9:00 AM the Director of Nursing stated numerous interventions were put into place immediately when the resident was first identified as risk for suicide including plastic utensils and a	F 550	at risk for suicide and care plan/care guide was updated by the Minimum Data Set Nurse (MDS) for use of regular plate and eating utensils. On 12/20/18 the meal tray card for resident #70 was updated by the Dietary Manager to reflect use of regular plate and eating utensils. On 12/20/18 100% audit of all residents care planned for use of plastic ware and eating utensils to include resident #70 was completed by the Director of Nursing to ensure appropriateness for use of plastic ware. All areas of concern were immediately addressed by the MDS nurse to include assessing resident for appropriate use of plastic ware, referral to MD for any resident who no longer meets criteria for use of plastic ware, updating care plan/ care guide for use of regular plate and eating utensils when indicated and updating meal tray card to reflect use of regular plate and eating utensils. There were three areas of concern corrected. On 12/21/18 100% audit of all lunch meal trays to include resident #70 was completed by the Unit Manager to ensure no plastic silverware/plates were used unless on care plan for resident. Any issues identified was corrected and appropriate silverware/plates provided On 12/20/18 100% in-service was initiated by the Staff Facilitator with all staff in regards to dignity and Respect to include: 1. Definition of Dignity	

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F 550	Continued From page 3 foam plate. She said all the interventions should have changed back because he was no longer deemed to be at risk on 10/30/18. She stated she was not aware Resident #70 was still receiving the plastic utensils and foam plate at all of his meals. During an interview on 12/20/18 at 9:14 AM the Dietary Manager stated she had not received a diet change order slip to allow Resident #70 to receive regular plates and regular eating utensils at meals. She said diet changes were only made when dietary received a diet order slip from nursing which specified what changes needed to occur.	F 550	2. Ways to maintain dignity to include not imposing limitations or restrictions unnecessarily such as use of plastic ware. In-service will be completed by 1/03/19. After 1/03/19 no staff will be allowed to work until in-service is completed. All newly hired personnel will be in-serviced during orientation by the Staff Facilitator in regards to Dignity and Respect to include: 1. Definition of Dignity 2. Ways to maintain dignity to include not imposing limitations or restrictions unnecessarily such as use of plastic ware. 25% of meal trays to include resident #70 during breakfast, lunch and dinner will be completed by the Unit Managers to ensure residents are provide appropriate eating utensils and that any resident utilizing plastic ware is care planned appropriately for its use utilizing the Utensil Audit Tool 3 times a week for 2 weeks, weekly x 2 weeks then monthly x 1 month. All areas of concern will be immediately addressed by the Director of Nursing to include assessment of resident for appropriate use of plastic ware, referral to MD for any resident who no longer meets criteria for use of plastic ware, updating care plan/ care guide for use of regular plate and eating utensils when indicated and updating meal tray card to reflect use of regular plate and eating utensils. The Director of Nursing (DON) will review and initial the Utensil Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern	

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F 550	Continued From page 4	F 550	were addressed. 100% of all residents care planned for use of plastic ware will be reviewed weekly x 8 weeks then monthly x 1 month by the Director of Nursing (DON) utilizing the Dignity-Plastic Ware Audit Tool to ensure that reason for use of plastic ware continues with supporting documentation for use of plastic ware in the electronic record. All areas of concern will be immediately addressed by the ADON to include assessment of resident for appropriate use of plastic ware, referral to MD for any resident who no longer meets criteria for use of plastic ware, updating care plan/ care guide for use of regular plate and eating utensils when indicated and updating meal tray card to reflect use of regular plate and eating utensils. The DON will review and initial the Dignity-Plastic Ware Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will forward the results of the Utensil Audit Tool and the Dignity-Plastic Ware Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Utensil Audit Tool and the Dignity-Plastic Ware Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		1/11/19

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F 641	Continued From page 5 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code hospice status, antipsychotic use, and discharge location status for 3 of 24 minimum data set assessments reviewed. (Resident #99, Resident #27, and Resident #97) Findings included: 1. Resident #99 was admitted to the facility on 4/3/18. His active diagnoses included malignant neoplasm of the prostate. Review of Resident #99's hospice election form dated 10/18/18 revealed the resident began hospice care on 10/18/18. Review of Resident #99's significant change minimum data set assessment dated 10/26/18 revealed the resident was assessed under section O0100 as not receiving hospice services. During an interview on 12/19/18 at 3:31 PM the MDS Coordinator stated the significant change minimum data set assessment dated 10/26/18 was completed because Resident #99 had elected hospice. She further stated hospice should have been marked as yes in section O0100 and it was not. During an interview on 12/19/18 at 3:36 PM the Director of nursing stated it was her expectation that minimum data set assessments be accurate. She further stated the assessment on 10/26/18	F 641	The process that led to this deficiency was the facility failed accurately code hospice status, antipsychotic use and discharge location status for 3 of 24 minimum data set assessments reviewed (Resident #99, Resident #27 and Resident #97. On 12/19/18 the MDS Coordinator completed a modification of a significant change dated 10/26/18 for resident #99 to reflect accurate coding of hospice status. On 12/19/18 the MDS Coordinator completed a modification of a quarterly assessment dated 10/11/18 for resident #27 to reflect accurate coding of antipsychotic medication use. On 12/19/18 the MDS Coordinator completed a modification of a discharged return not anticipated assessment dated 10/12/18 for resident #97 to reflect accurate coding of discharge location. On 12/20/18 the Assistant Director of Nursing (ADON) completed 100% audit of the most recent MDS assessment section “O” from 10/1/18 to 12/19/18 for all residents receiving hospice to include Resident #99 to ensure all MDS’s assessments completed are coded accurately to include all residents that are receiving hospice services. No additional concerns identified.	

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F 641	Continued From page 6 was not accurate and should have reflected Resident #99's hospice status. 2. Resident #27 was admitted to the facility on 7/12/13. Her active diagnoses included chronic kidney disease, cognitive communication deficit, hallucinations, and schizophrenia. Review of Resident #27's physician orders revealed on 10/4/18 the resident was ordered Abilify 5 milligrams by mouth every night. Review of Resident #27's medication administration record for October 2018 revealed Resident #27 received Abilify as ordered. Review of Resident #27's minimum data set assessment dated 10/11/18 revealed the resident was coded in section N0410 question A as having received an antipsychotic 7 of the previous 7 days. In section N0450 question A the resident was coded as having received no antipsychotics. During an interview on 12/19/18 at 3:31 PM the MDS Coordinator stated the minimum data set assessment dated 10/11/18 for Resident #27 should had been marked as yes for section N0450 question A because Resident #27 did receive antipsychotic medication during the reference period of the assessment. She concluded the minimum data set assessment was inaccurate. During an interview on 12/19/18 at 3:36 PM the Director of Nursing stated it was her expectation that minimum data set assessments be accurate. She further stated the assessment on 10/11/18 was not accurate and should have reflected Resident #27's antipsychotic use.	F 641	On 12/20/18 100% audit of the most recent MDS assessment section “N” from 10/1/18 to 12/19/18 was completed by the Assistant Director of Nursing (ADON) for all residents’ prescribed antipsychotic medication to include Resident #27 to ensure all MDS’s assessments completed are coded accurately to include all residents that are receiving antipsychotics. The MDS nurses will complete modifications during the audit for any identified area of concern with the oversite from the DON. No additional concerns identified. On 12/20/18 100% audit of the most recent MDS assessment section “A” from 10/1/18 to 12/19/18 was completed by the Assistant Director of Nursing (ADON) for all residents’ discharged to include Resident #97 to ensure all MDS’s assessments completed are coded accurately to include where resident is discharged. The MDS nurses will complete modifications during the audit for any identified area of concern with the oversite from the DON. There was one area of concern. On 12/20/18 a 100% in-service on MDS Assessments and Coding was completed by the Director of Nursing (DON) with all MDS nurses and MDS Coordinator to include MDS #1 and #2, regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis on residents receiving hospice services, residents on	

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F 641	Continued From page 7 3. Resident # 97 was admitted to the facility on 1/6/18 with diagnoses that included: diabetes mellitus, congestive heart failure and hypertension. Review of a progress note dated 10/12/18 revealed Resident #97 was discharged from the facility to home. Review of Resident #97's discharge Minimum Data Set (MDS) assessment dated 10/12/18, indicated Resident #97 was discharged to an acute hospital. During an interview on 12/20/18 at 10:03 AM the MDS Coordinator stated Resident #97 was discharged home on 10/12/18. She further stated the assessment should have been coded to reflect Resident #97 was discharged home. The MDS Coordinator indicated stated she was unsure how the error occurred and she would correct the assessment. An interview was conducted on 12/20/18 at 10:07 AM with the Director of Nursing who stated it is her expectation that MDS assessments are coded accurately.	F 641	antipsychotic mediation and location of resident discharge location status. All newly hired MDS Coordinator or MDS nurses will be in-serviced in regards to MDS Assessments and Coding during orientation by the Staff Facilitator to include proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis on residents receiving hospice services, residents on antipsychotic mediation and location of resident discharge location status. 10% audit of completed MDS assessments, to include assessments for resident # 27 and resident #97 utilizing the MDS Accuracy Tool will be completed by the ADON and Staff Facilitator weekly x 8 weeks then monthly x 1 month to ensure accurate coding of the MDS assessment to include residents that are receiving hospice services, residents receiving antipsychotic medications and discharge locations. All identified areas of concern will be addressed immediately by the DON to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review and initial the MDS Accuracy Tool weekly x 8 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The QA nurse will forward the results of MDS Accuracy Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet	

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F 641	Continued From page 8	F 641	monthly x 3 months and review the MDS Accuracy Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	