STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification Survey was conducted 7/8/19 to 7/11/19. The facility was found in compliance with the requirement CFR483.73, Emergency Preparedness. Event ID #GP6H11.	E 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to complete a comprehensive assessment for 2 of 2 resident's reviewed for significant changes, (Resident #13 and Resident #74). Resident #13 had significant weight loss and a change in ability to perform activities of daily living, such as, turning in bed, transferring to and from the bed, eating, and toileting; and Resident #74 was admitted to Hospice Services. Findings included: 1. Resident #13 admitted to the facility on	F 637	1) Corrected action for those affected by the deficient practice: A) A significant change assessment was complete on resident #13 on 7/11/2019 for improvement in activities of daily living. B) A significant change assessment was completed for resident #74 on 3/12/2019 due to admission to Hospice services 2) How the facility will identify other residents having potential to be affected by deficient practice: A) All residents are at risk for the same deficient practice B) Interdisciplinary team (IDT) will complete an audit of 100% of MDS assessments	8/8/19

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

Electronically Signed | 07/30/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 1 10/22/18 with diagnoses of arthritis, cognitive impairment, hypertension, and hypothyroidism. Resident #13's recorded weights were 198 pounds for 10/23/18 and 158.2 pounds for 4/2/19. An admission MDS Assessment dated 10/29/18 revealed Resident #13 required extensive assistance of staff for bed mobility, transfers, and toilet use; and was could feed himself with set up of his meal tray. The most recent Minimum Data Set (MDS) Assessment, a quarterly assessment, dated 4/12/19 revealed Resident #13 did not require assistance with bed mobility, transfers, eating, or toileting. The assessment further revealed Resident #13 had significant weight loss during the assessment period. During an interview on 7/10/19 at 9:11 am Resident #13 stated he was able to complete all his activities of daily living, such as, turning in bed, transferring to his wheelchair, toileting, and eating without assistance. Resident #13 also stated he had weight loss recently but had started to gain some weight back. An interview with the Senior Resident Care Specialist on 7/11/19 at 12:21 pm revealed she had not completed the quarterly MDS assessment dated 4/12/19 for Resident #13. She stated the MDS Coordinator that completed the assessment no longer worked at the facility. The Senior Resident Care Specialist stated the 4/12/19 quarterly assessment was coded as Resident #13 having significant weight loss and identified an improvement in all of Resident #13's activities of daily living since the admission Assessment dated 10/28/19. The Senior	F 637	completed in the last 30 days and documented on audit tool. 3) What measures will be put into place or systemic changes to ensure deficient practice will not re-occur: A) The current Interdisciplinary team (IDT) personnel will receive education by the Staff Development Coordinator and/or Administrator to include criteria for need to complete a significant change assessment and time frame significant change assessment must be completed. The IDT team includes the Resident Care Specialists, Business Office Manager, Director of Nursing, Social Services Director, Dietary Manager, Activities Director and Rehab Program Manager. B) Any new employees hired for any IDT position will receive education by Staff Development Coordinator or designee regarding significant change assessment criteria/timing during new employee orientation. C) A random audit of 10 MDS assessments will be reviewed monthly by the Director if Nursing (DON) and/or Administrator and discussed by Interdisciplinary team (IDT) to ensure Significant Change Assessment completed if criteria met. 4) How will the facility monitor changes: The results of audits will be submitted to Quality Assurance Performance Improvement committee (QAPI) monthly x 3 months to evaluate need for ongoing audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 2	F 637		

Resident Care Specialist stated she had noticed the improvement in Resident #13's activities of daily living and had planned a significant change assessment for 7/11/19. She stated she was not working at the facility when the quarterly assessment was completed for 4/12/19 but she would have completed a significant change assessment instead of a quarterly assessment.

An interview with the Dietician on 7/11/19 at 1:41 pm revealed Resident #13 had a significant weight loss recorded on the 4/12/19 quarterly MDS assessment. She stated Resident #13 had a 20% weight loss during the assessment period. The Dietician stated the Dietary Manager had completed dietary section, section K, of the 4/12/19 quarterly assessment.

The Dietary Manager was interviewed on 7/11/19 at 2:02 pm and stated he had completed the section K for the quarterly MDS assessment for Resident #13 dated 4/12/19 and had coded Resident #13 as having a significant weight loss. The Dietary Manager stated the facility discussed all residents with weight loss weekly and the MDS Coordinator attended the meeting and would have been aware of Resident #13's weight loss. The Dietary Manager stated the MDS Coordinator would have made the decision to make the 4/12/19 assessment a significant change.

An interview with the Administrator on 7/11/19 at 3:04 pm revealed she felt the failure to complete a significant change assessment for the weight loss and change in ability to complete the activities of daily living for Resident #13 was human error and had been missed by the previous MDS Coordinator. She stated she expected a significant change assessment to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 3	F 637		

completed on any resident with a change in condition that warranted a significant change assessment to be done.
2. Resident # 74 was admitted to the facility on 09/07/2018 with diagnoses that included dementia, hypertension (HTN), anxiety, peripheral vascular disease (PVD), lymphedema, depression and diabetes mellitus type 2 (DM 2).

A review of the medical record for Resident # 74 revealed a Notice of Hospice Care form that Resident # 74 was admitted to hospice care on 01/18/2019. The medical record of Resident # 74 included a hospice certification form dated initiated on 01/18/2019 through 04/17/2019. Was placed on Hospice services for dementia.

The medical record for Resident # 74 included that hospice services were billed beginning 02/01/2019.

Resident # 74 had an admission MDS (Minimum Data Set) dated 09/15/2018 with no hospice services coded. A significant change in status (SCSA) MDS dated 03/12/2019 was coded that Resident # 74 received Hospice services. Resident # 74 was also coded that she had a disease or condition that may have led to a life expectancy of 6 months or less.

An interview conducted with the Business Office Manager (BOM) was conducted on 07/11/2019 at 8:53 AM revealed that Resident # 74 had a signed hospice contract dated 01/18/2019. The BOM revealed that that was the date that Hospice care began and the MDS nurse was notified of this change as soon as it took place. The BOM could not explain why the billing status of Resident # 74 was not updated until 02/01/2019.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 4 A telephone interview conducted with the Director of Operations (DO) at Community Care and Hospice on 07/11/2019 at 9:07 AM. 07/11/19 09:07 AM. The DO confirmed that hospice services were initiated on 01/18/2019 and that is when hospice services were the pay source for Resident # 74. On 07/11/2019 at 9:27 AM an interview was conducted with the Senior Care Specialist (SCS). The SCS revealed that she was the corporate consultant for MDSs and that she had been present in the facility for about 2 weeks to assist MDS nurse # 1 with MDS completion and that she would remain at the facility for a temporary period of time. The SCS revealed that MDS nurse #1 had just left for a scheduled vacation. The SCS revealed that she was not familiar with Resident # 74 and needed to review the medical record and make MDS changes if needed. The SCS revealed that Resident # 74 should have had a SCSA MDS completed to reflect the change to hospice services for Resident # 74 within 14 days of that change and that she was not able to explain why the facility did not complete a SCSA for Resident # 74 by day 14 of that change. On 07/11/2019 at 2:33 PM an interview was conducted with the facility administrator. The administrator revealed that it was her expectation that a SCSA MDS be completed for any resident placed on hospice services within 14 days of the change to hospice care as directed by the RAI (Resident Assessment Instrument).	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		8/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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, resident observation, and staff interviews the facility failed to accurately code the Minimum Data Set Assessment for 1 of 4 residents reviewed for tobacco use (Resident #11) and failed to accurately code the Minimum Data Set Assessment for 1 of 1 residents reviewed for limited range of motion (Resident #63). Findings included: 1. Resident #11 was admitted to the facility on 9/3/14 with diagnoses of paraplegia, pressure ulcer, peripheral vascular disease, depression and anxiety. A Minimum Data Set (MDS) assessment, an annual assessment, dated 6/26/19 revealed Resident #11 was cognitively intact and did not use tobacco. Review of the Smoker List (updated 7/8/19) revealed Resident #11 was an independent smoker. An interview on 7/10/19 at 9:20 am with Resident #11 revealed she smoked cigarettes and went out to smoke frequently. During an interview with the Senior Resident Care Specialist on 7/11/19 at 12:21 PM she stated she had completed the 6/26/19 Annual assessment and she had not coded Resident #11 as using tobacco. She stated Resident #11 did smoke and	F 641	1) Corrected action for those affected by the deficient practice: A) A modification to MDS section J for resident #11 was completed on 7/11/2019 to accurately reflect resident□s smoking status. B) A modification for MDS section G for resident #63 was completed on 7/12/2019 to accurately reflect resident□s range of motion status. 2) How the facility will identify other residents having potential to be affected by deficient practice: All residents are at risk for the same deficient practice 3) What measures will be put into place or systemic changes to ensure deficient practice will not re-occur: A) The current Resident Care Specialists will receive education regarding coding accuracy to reflect accurate resident status. B) Any new employee hired as a Resident Care Specialist will receive education on coding accuracy during new employee orientation. C) A random audit of 10 MDS assessments will be reviewed by the Director if Nursing (DON) monthly to ensure accuracy of assessment. 4) How will the facility monitor changes: The results of audits will be submitted to Quality Assurance Performance Improvement committee (QAPI) monthly x 3 months to evaluate need for ongoing audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6	F 641		

should have been coded as using tobacco. She stated she would complete a correction of the 6/26/19 assessment immediately.

An interview with the Administrator on 7/11/19 at 3:06 pm revealed she felt the incorrect coding of Resident #11 as not using tobacco was just human error. She stated the facility maintained a list of residents that used tobacco products. The Administrator stated she expected the Minimum Data Set assessments to be coded with the correct information.

2. Resident #63 was admitted to the facility on 12/4/2018 with diagnoses to include stroke, left-sided paralysis and depression.

The admission Minimum Data Set (MDS) assessment dated 12/11/2018 assessed Resident #63 to be cognitively intact and documented limited range of motion (ROM) on one side of his lower body.

The Care Area Assessment (CAA) notes from the 12/11/2018 MDS were reviewed and the CAA documented left-sided hemiplegia (paralysis) for Resident #63.

Nursing notes dated 12/25/2018 were reviewed and the note documented left-sided weakness for Resident #63.

The quarterly MDS dated 3/1/2019 assessed Resident #63 to be cognitively intact. The MDS documented Resident #63 had limited ROM on one side of his lower body.

The quarterly MDS dated 5/29/2019 assessed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7	F 641		

Resident #63 to be cognitively intact. The MDS documented Resident #63 had limited ROM on one side of his lower body.

A review of the occupational therapy evaluation dated 6/21/2019 noted Resident #63 had left-sided paralysis related to a stroke and required occupational therapy to provide services related to left handed swelling and splint application. The evaluation further documented Resident #63 had a contracture of his left hand and the ROM of his left shoulder was limited.

An occupational therapy discharge note dated 7/2/2019 was reviewed and the note documented Resident #63 was discharged with a splint to the left hand and arm for positioning and contracture management.

Resident #63 was observed on 7/8/2019 at 11:28 AM in bed. Resident #63 had no movement of his left arm or hand. During the observation, Resident #63 reported he had a stroke and was unable to move his left arm at all.

Nursing assistant (NA)#1 was interviewed on 7/10/2019 at 9:09 AM. NA #1 reported Resident #63 had no movement of the left arm or hand.

Nurse #1 was interviewed on 7/10/2019 at 11:17 AM and she reported Resident #63 had no movement in his left arm or hand.

The Rehabilitation Director was interviewed on 7/11/2019 at 9:46 AM and she reported Resident #63 had trace left shoulder movement and no active ROM of his left elbow or hand.

The Senior Resident Care Specialist (SRCS) was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 8 interviewed on 7/11/2019 at 11:00 AM. The SRCS reported the nurse who completed the MDS assessments for Resident #63 was not available for interview and she was not certain why Resident #63 ' s limited ROM of his upper body was not coded on the MDS assessments. The Administrator was interviewed on 7/11/2019 at 1:40 PM and she reported it was her expectation the MDS were coded accurately for all residents.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		8/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to implement care plan interventions by not performing quarterly smoking evaluations and failed to provide an unsafe smoker a protective smoking apron as specified by their care plan for 1 of 2 residents reviewed for smoking (Resident #106). Findings included: A review of the facility smoking policy dated 8/29/2018 revealed residents who were assessed to be unsafe smokers were to have a protective smoking apron applied and were to be supervised during smoking. a. Resident #106 was admitted to the facility on 3/9/2015 with diagnoses to include high blood pressure, kidney failure and depression. The most recent quarterly Minimum Data Set (MDS) assessment dated 6/18/2019 assessed Resident	F 656	1) Corrected action for those affected by the deficient practice: A smoking evaluation was completed on 7/10/2019 for resident #106. 2) How the facility will identify other residents having potential to be affected by deficient practice: A) All residents who smoke are at risk for the same deficient practice. B) Smoking evaluations for all current residents who smoke were completed on 7/24/2019 and care plans updated as needed by nursing management. 3) What measures will be put into place or systemic changes to ensure deficient practice will not re-occur: A) All staff will receive education from the Staff Development Coordinator and/or Designee regarding facility smoking policy/Offering smoking aprons. B) All direct care staff will be educated by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10 #106 to be severely cognitively impaired. The annual MDS dated 8/21/2018 documented Resident #106 used tobacco products. A care plan dated 5/31/2016 was reviewed and the care plan addressed Resident #106 ' s smoking status and interventions included to perform a smoking evaluation and to reassess Resident #106 quarterly. The medical record was reviewed, and a smoking assessment had been completed for Resident #106 on 8/5/2018. The smoking assessment revealed Resident #106 was an unsafe smoker and required supervision. The medical record did not have any smoking evaluations performed after 8/5/2018. The Director of Nursing was interviewed on 7/11/2019 at 12:07 PM and she reported she expected the smoking assessment to be completed quarterly for all residents who used tobacco products. The Senior Care Specialist was interviewed on 7/11/2019 at 12:10 PM and she reported the safety assessments, including the smoking assessment, should be completed quarterly. An interview was conducted with Nurse #4, a unit manager, on 7/11/2019 at 12:18 PM and she reported she and the two other unit managers were responsible for completing the quarterly smoking assessments. Nurse #4 went on to explain the electronic medical record system should have triggered the smoking assessment to be completed with the quarterly MDS assessment. Nurse #4 reported she was not certain why the system did not trigger the	F 656	Staff Development Coordinator and/or Designee regarding following care plan interventions and completion of smoking evaluations per plan of care. Direct care staff includes CNAs, Nurses and Therapy staff C) A random audit of resident smoking area will be conducted by Administrator and/or Designee daily x 30 days and then 3 times weekly x 4 to ensure care plan being followed as written pertaining to offering smoking apron. 4) How will the facility monitor changes: The results of audits will be submitted to Quality Assurance Performance Improvement committee (QAPI) monthly x 3 months to evaluate need for ongoing audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 11	F 656		

assessment for Resident #106.

The Administrator was interviewed on 7/11/2019 at 1:40 PM and she reported it was her expectation the safety assessments were completed as the care plan specified.

b. A care plan dated 5/31/2016 was reviewed and the care plan included an intervention added on 7/9/2019 for Resident #106 to wear a protective smoking apron for safety when smoking.

Nursing assistant (NA) #2 was observed to supervise Resident #106 smoking on 7/10/2019 at 10:27 AM. NA #2 lit Resident #106 ' s cigarette and did not offer her a protective smoking apron.

NA #2 was interviewed on 7/10/2019 at 10:27 AM. NA #2 reported she had received supervised smoking education and she supervised the 10:00 AM smoking breaks several times per week. She reported she did not have enough protective smoking aprons for all unsafe smokers and because Resident #106 had not burned herself smoking in the past, NA #2 had not offered her an apron.

The Administrator was interviewed on 7/11/2019 at 1:40 PM and she reported the facility had enough protective smoking aprons to apply to all the unsafe smoking residents. The Administrator went on to explain all staff and residents had been educated on the smoking policy and procedures and she reported she expected all staff to have a good understanding of the smoking policy and procedures and apply protective smoking aprons to residents who were assessed to be unsafe smokers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to ensure chemicals were not left unsupervised in 1 of 5 resident's rooms (Resident #111) reviewed for accidents. Findings included: Resident #111 was admitted to the facility on 4/11/18 with diagnosis of asthma. The most recent quarterly Minimum Data Set (MDS) assessment dated 6/3/19 revealed Resident #111 was cognitively intact and required extensive assistance with transfers to and from bed and could move about the unit in her wheelchair without assistance. An observation of Resident #111 on 7/8/19 at 12:40 pm revealed she was not in her room. The door of Resident #111's room was open and there was a large (approximately 1 liter) bottle of Alcohol 70% (Isopropyl Alcohol) and a bottle of Hydrogen Peroxide (approximately 1 liter) sitting on the resident's floor beside the sink. The label of the Alcohol 70% bottle could be read by the surveyor standing in the hallway. The Hydrogen Peroxide 3% warning label stated if swallowed,	F 689	1) Corrected action for those affected by the deficient practice: Resident #111 was provided with a lock on closet door for storage of personal items. 2) How the facility will identify other residents having potential to be affected by deficient practice: All residents are at risk for the same deficient practice. 3) What measures will be put into place or systemic changes to ensure deficient practice will not re-occur: A) All staff will receive education from Staff Development Coordinator and/or designee to include resident environment remaining as free of accidents as is possible to include storage of chemicals. B) All new employees will receive education from Staff Development Coordinator and/or designee on resident environment remaining as free of accidents as is possible to include storage of chemicals during new employee orientation. C) An audit will be conducted by Administrator and/or designee daily x 7 days then 3 times weekly x 8 and documented on facility rounds sheet. 4) How will the facility monitor changes:	8/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 get medical help or contact Poison Control Center right away, for external use only. The Alcohol 70% warning label states in case of accidental ingestion, seek medical help or contact poison control immediately. During an observation on 7/8/19 at 4:04 pm the Alcohol 70% and Hydrogen Peroxide remained on the floor of Resident #111's room. On 7/9/19 at 9:01 am an observation of Resident #111's room revealed she was in the room in her wheelchair and the Alcohol 70% and Hydrogen Peroxide remained on the floor with the door open. An interview with Resident #111 on 7/9/19 at 9:49 am revealed she used the Alcohol 70% and Hydrogen Peroxide in her room to clean her earrings. She stated she keeps the bottles on the floor. On 7/10/19 at 9:23 am Resident #111 was observed in her room in her wheelchair. She was able to roll herself about the room and turned her television on without assistance. The Alcohol 70% and Hydrogen Peroxide observed on previous observations continued to be in sight of residents and staff outside the door. The Alcohol 70% continued to sit on the floor and the Hydrogen Peroxide had been moved to an open shelf. Resident #111 left her room in her wheelchair and left the room door open. The items on the floor and the shelf were visible from the hallway. During an interview with Nurse #5 on 7/10/19 at 2:21 pm she stated she had no idea Resident #111 had a bottle of Alcohol 70% and Hydrogen Peroxide in her room. She stated she did not	F 689	The results of audits will be submitted to Quality Assurance Performance Improvement committee (QAPI) monthly x 3 months to evaluate need for ongoing audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 know what she would be using them for and stated her Family Member may have brought them to her. An interview with Nurse Aide #3 on 7/10/19 at 2:32 pm revealed she had not noticed the Alcohol 70% or Hydrogen Peroxide Resident #111 had sitting on the floor in her room. During an interview with the Administrator on 7/10/19 at 4:10 pm she stated residents should not store chemicals in their rooms and if they needed to keep a chemical the facility would store it for them and keep the chemical locked. The Administrator stated she had no idea how Resident #111 had obtained the chemicals in her room. An interview with the Director of Nursing on 7/11/19 at 9:30 am revealed she expected the staff to maintain the safety of all residents in the building. She stated she was not aware Resident #111 had chemicals sitting out in her room until it was brought to her attention by the Administrator. The Director of Nursing stated the chemicals should be locked for the safety of confused residents. A follow up interview with the Administrator on 7/11/19 at 3:09 pm was conducted. The Administrator stated she expected all chemicals to be stored properly and should not be stored in a resident's room, to protect confused residents.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		8/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 15 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 8% (2 errors out of 25 opportunities) (Resident #69 and Resident #80). Findings included: 1. Resident #69 ' s physician orders were reviewed, and ferrous sulfate (iron) 325 milligrams (mg) one tablet was ordered 3/8/2018 for administration once daily. There were no orders to crush medications for Resident #69 and no documentation on the medication administration record (MAR) to specify not to crush iron. A review of the medication information for ferrous sulfate revealed ferrous sulfate should not be crushed, broken or chewed. A medication administration was observed on 7/10/2019 at 8:13 AM with Nurse #2 for Resident #69. Nurse #2 dispensed the ferrous sulfate tablet and crushed the medication. Nurse #2 was interviewed on 7/10/2019 at 9:45 AM and she reported she was aware she should not have crushed the ferrous sulfate for Resident #69 and she would contact the physician to prescribe a liquid form of ferrous sulfate for Resident #69. Nurse #2 noted Resident #69 was unable to swallow pills whole and all her	F 759	Corrected action for those affected by the deficient practice: A) The nurse notified the physician regarding crushing resident #69□s Ferrous Sulfate and an order was received to change it from the pill form to liquid. Nurse #3 was re-educated regarding medications that cannot be crushed. B) There was no negative outcome and no new orders received for resident #82. The nurse (nurse #3) was re-educated on how to administer insulin utilizing the insulin pen. How will the facility identify others at risk for the same deficient practice: All residents who receive medications are at risk for the same deficient practice. What measures will be put into place or systemic changes to ensure deficient practice will not re-occur: A) The nurses will receive education from the SDC and or his/her designee on or by 8/7/2019 regarding the National Pharmacy list of medications that cannot be crushed. This education will also be added to the general orientation of newly hired nurses. B) All nurses will receive education from the SDC and or his/her designee on proper administration of insulin utilizing the insulin pen on or by 8/7/2019. This education will also be highlighted in the general orientation of newly hired nurses. C) The National Pharmacy list of medications that cannot be crushed will be added to the narcotic books as a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 16 medications were crushed prior to administration. Nurse #2 concluded by noting no instructions were on the MAR regarding administration of iron tablets. The Regional Nurse Consultant (RNC) and Director of Nursing (DON) were interviewed on 7/11/2019 at 9:26 AM. The RNC reported the facility had identified medication administration errors as a concern and the facility had developed a Quality Improvement plan that addressed medication errors. The DON went on to explain the facility nurses had been trained and educated regarding medication administration and she had been performing medication administration audits and observations. The RNC reported the facility used a national pharmacy list of medications (dated 11/2018) that should not be crushed as a reference and iron was listed as a medication to not be crushed. The DON concluded by reporting it was her expectation the nursing staff administered the correct medications to the right resident, at the right time, the right dose, the right route and documented the administration correctly. The Administrator was interviewed on 7/11/2019 at 1:40 PM and she reported the facility had a Quality Improvement plan in place related to medication administration and her expectation was the nurses followed recommended guidelines for medication administration. 2. Resident #80 ' s physician orders were reviewed and Novolog (insulin) was ordered on 5/14/2019 to be administered by injection subcutaneously four times per day as needed for blood glucose levels over 200 milligrams per deciliter (mg/dl).	F 759	reference for all nurses. How will the facility monitor changes: A) The current Medication Administration QAPI will be updated on or before 8/7/2019 to reflect an extension of medication administration observations performed by the SDC, Director of Nursing and or his/her designee(s) with added focus on insulin pen administration and crushing of medications that should not be crushed. B) Random Medication observations for crushing of medications that shouldn□t be crushed and insulin pen administration will be completed 5 times a week for 4 weeks and then 3 times a week for 4 weeks. B) All information will be tracked and trended by the Director of Nursing and or his/her designee and the results will be reviewed in the monthly QAPI meetings. Further monitoring will be determined by the Interdisciplinary Quality Assurance Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 17	F 759		

The instruction manual for the insulin pen injector revised on June 17, 2016 was reviewed and the instructions directed the insulin pen injector to remain pressed to the skin for 5 seconds after the injector trigger was pressed to ensure the entire insulin dose was administered.

Resident #80 blood glucose was checked by Nurse #3 on 7/10/2019 at 4:19 PM and the results were 299 mg/dl. The order for Novolog insulin for the results of 299 mg/dl were to administer 7 units of Novolog.

Nurse #3 was observed injecting the insulin via a pen injector, and she removed the injector as soon as she pressed the injector trigger.

Nurse #3 was interviewed on 7/10/2019 at 4:33 PM and she reported she was not aware the pen injector should remain pressed to the skin for 5 seconds after the injector trigger was pressed.

The Regional Nurse Consultant (RNC) and Director of Nursing (DON) were interviewed on 7/11/2019 at 9:26 AM. The RNC reported the facility had identified medication administration errors as a concern and the facility had developed a Quality Improvement plan that addressed medication errors. The DON went on to explain the facility nurses had been trained and educated regarding medication administration and she had been performing medication administration audits and observations. The DON further reported all nursing staff had been given the instruction manual for the proper use and administration of insulin via a pen injector. The DON concluded by reporting it was her expectation the nursing staff administered the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 18 correct medications to the right resident, at the right time, the right dose, the right route and documented the administration correctly. The Administrator was interviewed on 7/11/2019 at 1:40 PM and she reported the facility had a Quality Improvement plan in place related to medication administration and her expectation was the nurses followed recommended guidelines for medication administration.	F 759		