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LUMBERTON HEALTH AND REHAB CENTER	1555 WILLIS AVENUE LUMBERTON, NC 28358

(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 on 07/19/21. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID #GIPR11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertificaton and complaint survey was completed at the facility on 07/19/21 Event ID # GIPR11. 1 out of 5 complaint allegations was substantiated with deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Nurse Practioner interviews, the facility failed to apply a Physician ordered prescribed medication for 1 of 1 residents (Resident #9) observed. Findings included: Resident #9 was admitted to the facility on 01/06/20. Diagnoses included, in part, disorders of the kidney and ureter, neuromuscular dysfunction of bladder requiring a urinary catheter, and chronic kidney disease (stage 3).	F 684	Facility failed to apply a physician ordered prescribed medication for 1 of 1 residents (Resident #9) observed. All residents residing in the facility have the potential to be affected by this practice. On 7/15/21, the Director of Nursing educated Nurses #12, 6, 9,and 1 as well as MA #1 on ensuring that all MD orders are to be carried out as written. Nursing should not	8/13/21

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

Electronically Signed | 08/11/2021

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F 684	Continued From page 1 The Minimum Data Set quarterly assessment dated 07/08/21 revealed the resident was cognitively aware and demonstrated no behaviors. Resident #9 required extensive assistance with one staff physical assistance with bed mobility, dressing and personal hygiene, total dependence with one staff physical assistance with toileting and bathing. Resident #9 had an indwelling urinary catheter and was always incontinent of bowel. A review of an updated urinary catheter care plan on 07/08/21 included the intervention to apply an ointment for vaginal yeast infection as ordered. A Physician ' s order written on 07/08/21 revealed an order for Clotrimazole Cream 1 % (antifungal ointment) apply intravaginally topically every evening until 07/15/21. The electronic medical record within the physician orders revealed the Clotrimazole Cream was on hand, filled and dispensed as ordered on 07/08/21. A review of the Medication Administration Record (MAR) for July 2021 revealed Clotrimazole Cream 1% apply intravaginally topically at night for yeast infection for 7 days with a start on date of 07/08/21 and an end date of 07/15/21. The MAR revealed there were no nursing initials or check mark to indicate the medication was applied on 07/08 and 07/09. On 07/10, Nurse #12 documented the task was completed as evidenced by her initials and a check mark, on 07/11/21 Nurse #12 documented the #8 which indicated to see "other/progress notes" and her initials, on 07/12 and 07/13 nursing initials for Nurse #6 was documented with a check mark to	F 684	document a medication was given if they did not give the medication. If the medication was not available, the nurse needs to research further to ensure the medication is available to carry out the MD order. On 7/15/21, the physician was informed the resident had not received the medication. The medication was obtained and initiated for the resident to be given for the duration of the order. On 7/15/21, a 100% audit of current residents prescribed with topical medications was completed by the SDC and Director of Nursing. The audit was to ensure that orders for topical medications were implemented properly and the medication was available. Any concerns identified were corrected. An in-service was initiated by the Staff Development Coordinator on 7/15/21 with licensed nursing staff related to ensuring that nursing staff must follow and apply a physician's order and document administration on the administration record for the duration of the order. Education with licensed nursing staff was completed on 7/23/21. Beginning the week of 8/2/21, the Unit manager/staff development coordinator will audit 100% of topical medication orders weekly x 4 weeks, then bimonthly x 1, then monthly x 1 utilizing the Topical Medication order audit tool. Any deficient practice identified will result in the licensed nursing staff being	

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F 684	Continued From page 2 indicate it was applied, on 07/14 Nurse #1 documented the #8 which indicated to see "Other/progress notes" and her initials. A review of the progress notes revealed there was no documentation regarding this medication for Resident #9 for 07/11 or 07/14 by Nurse #12 and Nurse #1 as indicated by the #8 on the MAR. An interview with Resident #9 on 07/12/21 at 12:00 PM revealed she had an order for a cream to be applied to her vagina for a yeast infection and no one has applied it yet. She stated it was ordered a few days ago. The resident reported she did not have any pain, but it was itchy. An interview with Resident #9 on 07/14/21 at 10:00 AM revealed she had not received the cream as yet. She reported she had no complaints of pain or itch at this time. An observation of the medication cart for the 100 hall was conducted on 07/15/21 at 2:20. There was no Clotrimazole cream 1% noted to be on the medication cart for Resident #9. An interview was conducted with Medication Aide (MA) #1 on 07/15/21 at 2:20 PM. MA #1 confirmed there was an order for Clotrimazole to be applied and checked her medication cart to see if it was in there. There was no medication by the name of Clotrimazole Cream 1% for Resident #9 located in the medication cart. MA #1 reported it may be on the treatment cart for the Wound Treatment Nurse (WTN) to administer, but then stated it was ordered in the evening so it should be on the medication cart since the WTN does not work in the evening.	F 684	immediately re-trained by the Director of Nursing/Staff Development Coordinator/Unit Manager. The Director of Nursing will review and initial the audit tool weekly x 4 weeks, bimonthly x 1, then monthly x 1 to ensure all areas of concern were addressed. The Director of Nursing will report findings of the topical medication audit tool monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action and recommendations including any additional systematic change or education if needed. After three months of reviewing the audits for sustained compliance, the QAPI Committee will determine ongoing need to review the topical medication audits.	

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An interview was conducted with Nurse #6 on 07/15/21 at 2:42 PM. Nurse #6 reported she signed off on the medication as given on 07/12 and 07/13 as evidenced by her initials and a check mark and added, she assumed the Nursing Aides (NAs) were applying the medication and it was kept at the resident ' s bedside. Nurse #6 stated she should not have assumed the NAs were applying it and confirmed that this order should have been administered by a nurse and not a NA. Nurse #6 stated she did not know where the medication was if it was not at the resident ' s bedside and confirmed the cream should not be on the WTN ' s cart since the medication was to be given in the evening and the WTN did not work evenings. Nurse #6 stated she would look for the cream to be sure it was on the medication cart so the nursing staff could administer it in the evening as ordered. Nurse #6 stated she would report to the Nurse Practioner that the medication was not given in its entirety according to the order.

An interview was conducted with Nurse #1 on 07/15/21 at 3:26 PM. Nurse #1 stated she was working on the 100 hall on the night of 07/14/21 and in the middle of the night when she was charting, she realized she did not administer this medication as ordered to be given in the evening. Nurse #1 reported at that time, she proceeded to administer the medication and checked her medication cart and did not see the medication on the cart, so she did not administer it and instead documented the #8 to indicate she wrote a progress note regarding the rationale as to why she did not give it. Nurse #1 reviewed the progress notes and stated she must have forgotten to put a note. Nurse #1 stated when she realized the medication was not on the cart

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and it was not given she should have notified the physician that it was not available. Nurse #1 stated she should have passed on report the medication was not on the cart and not given as ordered. Nurse #1 added the resident had no complaints of pain or itch during her shift.

An interview was conducted with Nurse #9 on 07/15/21 at 4:35 PM. Nurse #9 reported she had not administered the medication as ordered on 07/08/21 or 07/09/21 because it was not on the medication cart. Nurse #9 stated she should have notified the Unit Manger or Supervisor the medication was not available to be given.

During an interview with Resident #9 on 07/15/21 at 4:40 PM. Resident #9 stated since the NA was performing catheter care at this time she requested to get the cream that was ordered applied.

An interview with Nurse #9 on 07/15/21 at 4:40 PM revealed she could not administer it at this time because the medication did not come with an applicator to insert the cream and they were in the process of obtaining an applicator from the local pharmacy.

An interview was conducted with the Director of Nursing (DON) at 4:48 PM on 07/15/21. The DON reported she had to send someone to the local pharmacy to purchase an applicator to apply the ordered medication because the medication did not come with an applicator.

An interview was conducted with the DON via phone on 07/17/21 at 11:20 A. The DON stated her expectation was that all orders should be carried out as written. The DON added nurses

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F 684	Continued From page 5 should not document a medication was given if they did not give it and if the medication was not available, they should find out where the medication was and ensure the medication was obtained to carry out the order. An interview was conducted with the Nurse Practioner (NP) via phone on 07/19/21. The NP stated she had not been aware the medication was not given until 07/15/21. The NP stated sometimes when she ordered a medication it may not be available at the pharmacy and if the nursing staff had let her known, she could have ordered an alternative medication.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Nurse Practioner and Wound Physician interviews, the facility failed to notify the Nurse Practioner or Physician to obtain an order to treat a Stage II pressure ulcer for 1 of 4 residents	F 686	Facility failed to notify the Nurse Practitioner or Physician to obtain an order to treat a Stage 2 pressure ulcer for Resident #142.	8/13/21

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F 686	Continued From page 6 (Resident #142) reviewed for pressure ulcers. Findings included: Resident #142 was admitted to the facility on 04/30/21. Diagnoses included, in part, diabetes, end stage renal disease (ESRD), dementia, and Alzheimer ' s. The Minimum Data Set (MDS) significant change assessment dated 06/25/21 revealed the resident was severely cognitively impaired and required extensive assistance with one staff physical assistance with dressing and personal hygiene. Resident #142 was always incontinent of bladder and bowel and had an unstageable pressure ulcer which was facility acquired and was on dialysis. A care plan updated on 06/25/21 revealed a plan of care for pressure ulcers and at risk for developing further pressure ulcers related to immobility, incontinence, and decreased oral intake and appetite. Interventions included to administer treatments as ordered, assist with repositioning using wedge, wound healing supplements and followed by the wound care provider. A plan of care for nutritional problems related to diagnosis of ESRD and dementia was in place for decreased oral intake and appetite. The weekly skin assessment dated 06/07/21 revealed there were no new skin areas or existing skin conditions noted. A progress note written on 06/12/21 revealed Nurse #10 went into the resident ' s room and the resident asked if the nurse would look at her dressing on her buttocks to see if it needed to be	F 686	All residents residing in the facility have the potential to be affected by this practice. Immediate education provided to Nurse #10, the WTN, NA #11, NA #10, NA #7, and NA #6 that it is the expectation of the nursing staff to notify the Wound Treatment Nurse and the Nurse Practitioner/Physician when a new skin area is noted on a resident. Nurse #11 was terminated by Administration on 6/11/21 related to the incident. Education was initiated to nursing assistants that they are to report all changes in a resident's skin integrity to their charge nurse/nurse supervisor. The Director of Nursing/Staff Development Coordinator then educated remaining licensed nurses that they are to obtain a physicians order to monitor and treat any pressure ulcer/skin impairment noted on a resident. Education complete on 7/23/21. On 7/15/21, a 100% audit of current residents that have pressure ulcers was conducted to ensure that the Nurse Practitioner/Physician was aware and that treatment orders were in place. The Director of Nursing/Staff Development Coordinator corrected any concerns identified during the audit. An in-service related to the skin care management system with focus on proper treatment, MD notification, monitoring and management of a resident's skin condition was initiated by the Staff Development Coordinator/Director of Nursing on	

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changed. The nurse looked and noted two pink dressings that were falling off. The treatment nurse was in the facility and was called to the room to assess the residents ' buttocks due to this nurse was not able to find a treatment order for Resident #142. Nurse #10 notified the Responsible Party (RP) and the Nurse Practioner (NP), and a treatment order was put on the Treatment Administration Record per the treatment nurse.

The June Treatment Administration Record (TAR) revealed there were no treatment orders in place prior to 06/12/21 for a Stage II pressure ulcer. The TAR revealed on 06/12/21 an order was written for a treatment to include, apply collagen powder and cover with dry protective dressing daily and to off load wound.

The initial wound evaluation and management summary report from the Wound Physician dated 06/21/21 revealed Resident #142 had an unstageable (due to necrosis) sacrum for at least 14 days duration. Resident with multiple comorbidities to include diabetes, ESRD, and dementia with decreased mobility requiring assistance, elevated blood sugars, anemia, and weight loss. Preventive care measures were in place with good skin care, maintaining nutrition with vitamins and protein supplementations and use of pressure reduction surfaces. Despite the preventive measures and in consideration of the underlying clinical conditions identified, development and progression of this pressure ulcer was an unavoidable outcome of the resident ' s overall medication condition.

The July TAR revealed the Wound Physician had changed the order on 07/05/21 to collagen sheet

7/15/21 with nursing staff.

Beginning the week of 8/2/21, residents with pressure areas will be monitored by the Unit Manager/Staff Development Coordinator weekly x 4 weeks, bimonthly x 1, then monthly x 1 utilizing the Audit Treatment and Services to Prevent/Heal Pressure Ulcers tool. If concerns are identified, the responsible employee will be re-trained by the Unit Manager/Staff Development Coordinator. The Director of Nursing will review and initial the Treatment and Services to Prevent/Heal Pressure Ulcer Tool weekly x 4, bimonthly x 1, then monthly x 1 to ensure all areas of concerns were addressed. All newly hired employees and agency staff will also receive this education.

The Director of Nursing will report findings of the Audit Treatment and Services to Prevent/Heal Pressure Ulcers tool monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action and recommendations including any additional systematic change or education if needed.
After three months of reviewing the audits for sustained compliance, the QAPI Committee will determine ongoing need to review the audits.

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with silver apply once daily for 30 days and cover with dry protective dressing.

An observation of Resident #142 for a pressure ulcer dressing change was conducted on 07/15/21 at 8:30 AM. The resident was noted to be lying on her left side with a wedge tucked underneath her right buttock. The Wound Treatment Nurse (WTN) was noted to have remove the existing dressing and the resident was noted to have an unstageable pressure ulcer to her buttocks measuring 8.5 X 10 with moderate serosanguinous drainage. The necrotic tissue covered about 40 % of the wound and 40% of the wound had granulated tissue (healthy.) The wound measurements included 3 small areas; one was noted to be the size of a nickel located on the bottom of the right buttock, and an area on the bottom of the left buttock which was the size of a tip of an index finger, and an unopened area near the rectum. The WTN cleansed the areas with normal saline and applied the collagen sheet with silver and covered the areas with a dry protective dressing.

An interview was conducted with Nurse #10 via phone on 07/16/21 at 4:49 PM. Nurse #10 reported on 06/12/21 she had responded to the resident who was requesting to have her dressings changed to her bottom. She stated she assessed her buttocks and noted there were 2 pink foam dressings in place. Nurse #10 reported she went to view the physician orders to see what was in place for her and noticed there were no orders for a dressing. Nurse #10 stated the WTN was in the facility that day and she had asked her to come and assess Resident #142. The WTN stated she was not aware of this skin breakdown and obtained an order for treatment

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for the resident at that time. Nurse #10 stated she only worked on weekends and she did not recall Resident #142 having any wounds on 06/05 and 06/06/21. Nurse #10 stated if a nursing assistant had identified an area on the resident on 06/05 or 06/06/21, they would have notified her to let her know and she would have obtained an order to treat the wound.

An interview was conducted with the Wound Treatment Nurse via phone on 07/16/21 at 5:00 PM. She reported she was made aware of the wound on 06/12/21 and obtained orders to initiate a treatment. She stated usually if a nurse or nurse aide identified any type of skin concern, they would notify her. She stated the wound did worsen but she felt it was primarily due to the resident ' s poor oral intake. The WTN stated she started to be followed by the Wound Physician on 06/21/21 due to slow healing. The WTN stated she did not know how long the Stage II pressure ulcer had been on Resident #142 but stated if it had been there for awhile she would have thought that nurse aides or other nursing staff would have told her.

An interview was conducted with the Administrator in training (AIT) on 07/16/21 at 5:10 PM. The (AIT) reported when she was made aware of the wound and the dressings that were applied without an order from Nurse #10, she investigated it and spoke with Nurse #11 who was working the day shift from Monday through Friday the week of 06/07/21 through 06/11/21. The AIT stated when she addressed the treatment that was in place without an order, Nurse #11 denied putting the treatment in place. The AIT stated the nurse was terminated. The AIT stated she could not determine how long Resident #142 had the

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Stage II pressure ulcer. The AIT stated she completed an investigation from the Nurses and Aides and none of the nursing staff could recall a dressing or a wound on Resident #142 on the weekend of 06/05 and 06/06/21. The AIT stated she believed the dressing was applied during the week of 06/07/21 through 06/11/21.

An interview was conducted with Nursing Assistant (NA) #11 via phone on 07/16/21 at 5:47 PM. NA #11 stated she worked on 06/07/21 and was assigned to Resident #142. She stated she did not notice any wounds on the resident ' s buttocks or anywhere else while bathing and providing incontinent care and if she had she would have reported it to the Nurse.

An interview was conducted with NA #10 on 07/16/21 at 5:56 PM. NA #10 reported she worked on 06/08/21 on the first shift and when she assisted Resident #142 with incontinent care she noticed there was a brownish colored dressing on her buttocks. NA #10 stated she assumed Nurse #11 knew about the wound since there was a dressing in place and that was the first time she had seen this dressing.

An interview was conducted with the Wound Physician on 07/16/21. The Wound Physician stated she had started following Resident #142 on 06/21/21 due to the wound not healing despite supplements, off loading and treatments with collagen. She stated the resident had very poor oral intake and was losing weight, was on dialysis and had dementia. She stated she felt the wound was going to worsen inevitably due to her poor nutrition and added that the nurse should have notified the physician per protocol to obtain a treatment order for Resident #142 when she

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F 686	Continued From page 11	F 686		

identified the area to ensure the right treatment was in place.

An interview was conducted with NA #7 on 07/17/21 at 9:54 AM via phone. NA #7 reported she worked the weekend of 06/05 and 06/06/21 on the first shift and she was not able to recall if there was a dressing in place or even if Resident #142 had any wounds. NA #7 stated she did not think so, but that she could not remember. NA #7 stated if she identified any skin issues on the resident she would have notified Nurse #10.

An interview was conducted with NA #6 on 07/17/21 at 9:59 AM via phone. NA #6 reported she worked the weekend of 06/05/and 06/06 on the 2nd shift. She stated she had taken care of Resident #142, but she did not recall any dressings on her buttocks. NA #6 stated if she had seen any dressings, she would have asked the nurse about the dressings.

An interview was conducted with Nurse #11 on 07/17/21 at 10:05 AM via phone. Nurse #11 stated the day the NA came to her to tell her Resident #142 had a wound on her buttock, she told the WTN. Nurse #11 stated she could not remember the NA who told her or what day it was. Nurse #11 stated it was the responsibility of the WTN to put a dressing on the wound and she never did. Nurse #11 denied every applying a dressing on Resident #142.

An interview was conducted with the Nurse Practioner (NP) via phone on 07/19/21 at 10:20 AM. The NP stated she would have expected the nurse to notify her or the Physician to obtain an order for a treatment when she identified the area on the resident ' s buttocks so that the wound

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F 686	Continued From page 12 could be monitored, and the appropriate treatment cold be ordered. An interview was conducted with the Director of Nursing (DON) on 07/19/21 via phone at 11:20 AM. The DON stated her expectation of the nursing staff was to notify the WTN and the NP or Physician whenever a new skin area was found on the residents. The DON stated nurses were not to be initiating treatment orders for wounds unless they obtained an order from the NP or Physician or Wound Physician.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		8/13/21

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F 690	Continued From page 13 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and Nurse Practioner interviews, the facility failed to secure the catheter tubing per the physician order on 2 of 2 residents observed for urinary catheters. (Resident #9 and Resident #69.) Findings included: Resident #9 was admitted to the facility on 01/06/20. Diagnoses included, in part, disorders of the kidney and ureter, neuromuscular dysfunction of the bladder requiring an indwelling urinary catheter, and chronic kidney disease (Stage 3.) The Minimum Data Set (MDS) quarterly assessment dated 07/08/21 revealed the resident was cognitively aware and demonstrated no behaviors. Resident #9 required extensive assistance with one staff physical assistance with bed mobility, dressing and personal hygiene, and total dependence with one staff physical assistance with toileting and bathing. Resident #9 had an indwelling urinary catheter and was always incontinent of bowel.	F 690	The facility failed to secure the catheter tubing per the physician order on 2 of 2 residents observed for urinary catheters. (Resident #9 and Resident #69.) Residents residing in the facility with indwelling urinary catheters have the potential to be affected by this practice. On 7/15/21, a 100% audit of all residents residing in the facility with indwelling urinary catheters was conducted to ensure the tubing is secured to prevent injury to the resident and maintain urine flow. Any concerns identified during the audit were immediately corrected and addressed with the employee by the Director of Nursing. An in-service was initiated by the Staff Development Coordinator/Director of Nursing on 7/14/21 related to residents with indwelling urinary catheters having a securing device in place to anchor the tubing, prevent injury/pulling on tubing, and to maintain adequate urine flow.	

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F 690	Continued From page 14 A review of the care plan revealed a plan of care for a Foley Catheter related to neuromuscular dysfunction of the bladder with interventions to include, in part, anchor catheter to prevent excess tension. A Physician ' s order written on 04/26/21 revealed an order to use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow every shift and rotate site of securement as needed. A review of the Treatment Administration Record (TAR) revealed an order to ensure catheter securing device was in place each shift. The TAR revealed Nurse #3 documented that the securing device was in place as evidenced by her initials and a check mark on 07/14/21. An observation was conducted on Resident #9 on 07/14/21 at 10:00 AM. The indwelling urinary catheter tubing was noted to be unsecured to the resident ' s leg. The tubing was lodged under the resident ' s right leg. An interview was conducted with Resident #9 at 10:00 AM. Resident #9 reported she was supposed to have a leg band on her leg to secure the tubing, but she has not had one for quite a while. She stated she believed it may be in the laundry or something. An interview was conducted with Nurse #3 on 07/14/21 at 12:14 PM. Nurse #3 reported she had not secured the catheter tubing to Resident #9 ' s leg and should not have documented that the task was completed until she completed the task.	F 690	Additionally, nursing should not document an order is in place without verifying the order is in place. Education was completed by 7/23/21. Newly hired employees and agency staff will also receive this education. Beginning the week of 8/2/21, residents residing in the facility with indwelling urinary catheters will be monitored by the Unit Manager/Staff Development Coordinator weekly x 4 weeks, bimonthly x 1, then monthly x 1 utilizing the Indwelling Urinary Catheter Audit Tool. Any concerns identified will be immediately corrected and the responsible employee will be re-trained. The Director of Nursing will review and initial the Urinary Catheter Audit tool weekly x 4, bimonthly x 1, then monthly x 1 to ensure all areas of concern were addressed. The Director of Nursing will report findings of the Indwelling Urinary Catheter audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action and recommendations including any additional systematic change or education if needed. After three months of reviewing the audits for sustained compliance, the QAPI Committee will determine ongoing need to review the Indwelling Urinary Catheter audits.	

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An interview was conducted with the Director of Nursing (DON) on 07/17/21 via phone at 11:20 AM. The DON revealed her expectations of the nursing staff was to ensure they completed an ordered task before documenting that they had done it. The DON stated there was an order in place to secure the catheter and the nursing staff should have secured the catheter and they should understand the importance of this in order to prevent injury to the resident and to maintain the urine flow.

An interview was conducted with the Nurse Practioner (NP) via phone on 07/19/21 at 10:00 AM. The NP reported her expectation of the nursing staff was to secure and anchor the catheter tubing to prevent the tubing from pulling, prevent injury and to maintain urine flow.

Resident #69 was admitted to the facility on 08/18/16. Diagnoses included, in part, infection and inflammatory reaction related to internal left hip prosthesis, pressure ulcer to lumbar sacral region, and neuromuscular dysfunction of the bladder requiring an indwelling urinary catheter.

The MDS quarterly assessment dated 07/01/21 revealed the resident was cognitively aware. She did not demonstrate any behaviors and required extensive assistance with one staff physical assistance with bed mobility and dressing, total dependence with one staff physical assistance with personal hygiene and toileting and total dependence with two staff physical assistance with transfers. Resident #69 had no impairments to upper extremities and impairment to both sides to lower extremities, used a wheelchair, had an indwelling urinary catheter and was continent of bowel. Resident #69 had a stage 4 pressure

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F 690	Continued From page 16	F 690		

ulcer (facility acquired) and a venous arterial ulcer.

A care plan review revealed the resident had a plan of care for a Foley Catheter related to diagnoses of neuromuscular dysfunction of the bladder, hydronephrosis and bilateral urethral stents placed. An intervention included, in part, to anchor catheter to prevent excess tension.

A Physician order written on 06/15/21 revealed an order to use catheter securing device to reduce excessive tension of the tubing and facilitate urine flow, and rotate site of securement as needed.

A review of the Treatment Administration Record (TAR) revealed an order to ensure catheter securing device was in place each shift. The TAR revealed Nurse #3 documented the securing device was in place as evidenced by her initials and a check mark on 07/14/21.

An observation of Resident #69 on 07/13/21 at 9:00 AM revealed the resident did not have the catheter tubing secured to her leg. The tubing was noted to be lying over her left leg.

An observation of Resident #69 on 07/14/21 at 8:40 AM during a wound care observation revealed the resident did not have the catheter tubing secured to her leg. The tubing was noted to be lodged under her leg.

An interview with Resident #69 on 07/14/21 at 9:00 AM was conducted. Resident #69 reported the staff was supposed to secure the tubing and she did not know why they did not secure it.

An observation of Resident #69 on 07/14/21 at

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F 690	Continued From page 17 11:30 AM revealed the resident did not have the catheter tubing secured to her leg. The tubing was noted to be lodged under her leg. An interview was conducted with Resident #69 on 07/14/21 at 11:30 AM and she stated no nursing staff have been in to secure her catheter tubing this morning. An interview was conducted with Nurse #3 on 07/14/21 at 12:00 PM. Nurse #3 confirmed that she did not secure the tubing to the resident ' s leg. She stated she should not have documented the task as being completed since she had not completed it yet. An interview was conducted with the Director of Nursing (DON) on 07/17/21 via phone at 11:20 AM. The DON revealed her expectations of the nursing staff was to ensure they completed an ordered task before documenting that they had done it. The DON stated there was an order in place to secure the catheter and the nursing staff should have secured the catheter and they should understand the importance of this in order to prevent injury to the resident and to maintain the urine flow. An interview was conducted with the Nurse Practioner (NP) via phone on 07/19/21 at 10:00 AM. The NP reported her expectation of the nursing staff was to secure and anchor the catheter tubing to prevent the tubing from pulling, prevent injury and to maintain urine flow.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		8/13/21

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F 761	Continued From page 18 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to: a) dispose of a bottle of aspirin with an illegible expiration date on the bottle, b) failed to dispose of two expired insulin pens, c) failed to dispose of unidentified loose pills found in the medication cart, and d) failed to secure an unattended medication cart for 2 for 4 medication carts observed. Findings included: a) An observation of a medication pass on 07/14/21 9:12 AM on the 100 Hall revealed Nurse	F 761	The facility failed to a)dispose of a bottle of aspirin with an illegible expiration date on the bottle, b) failed to dispose of two expired insulin pens, c)failed to dispose of unidentified loose pills found in the medication cart, and d)failed to secure an unattended medication cart for 2 of 4 medication carts observed. On 7/14/21, the nurse obtained a new bottle of aspirin that was not expired. The nurse disposed of the two expired insulin pens. No residents received these expired	

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F 761	Continued From page 19 #3 was noted to have placed one tablet of an 81 milligram (mg) aspirin in the medication cup to be administered. The nurse was observed not checking the expiration on the bottle date prior to placing the aspirin in the medication cup. The aspirin bottle was noted to have an illegible expiration date on the bottle of aspirin. During an interview with Nurse #3 on 07/14/21 at 9:12 AM, she confirmed the expiration date was illegible and had another nurse (Nurse #4) who was passing by look for the expiration date on the bottle. Nurse #4 stated it was illegible. Nurse #3 discarded the bottle of aspirin and disposed of the aspirin tablet that was in the medication cup. She stated since the expiration date was not legible she was not certain when it expired so it was best to dispose of it. b) An observation of a medication cart on 07/14/21 at 9:31 AM on the 100 hall revealed the Novolog Insulin Pen for Resident #9 was expired on 06/23/21 and a Lispro Insulin pen for Resident #1 was opened on 05/22/21 and did not have an end date. An interview was conducted with Nurse #3 on 07/14/21 at 9:33 AM. Nurse #3 confirmed the Novolog Insulin Pen was expired and should not have been on the medication cart. Nurse #3 disposed of the Novolog Insulin Pen and stated Resident #9 did not receive any Novolog on 07/14/21. Nurse #3 confirmed the Lispro Insulin Pen was only good for 4 weeks after opening and it had expired since it was opened on 5/22/21. Nurse #3 stated Resident #1 did not receive any Lispro Insulin on 07/14/21. Nurse #3 disposed of the Lispro Insulin pen and stated it should not have been on the cart. Nurse #3 reported she	F 761	medication. The medication cart with unidentified loose pills was cleaned to dispose of the loose pills. Nurse #1 was immediately educated by the Director of Nursing that it is the expectation that the medication cart must be locked when unattended. On 7/14/21, a 100% audit of all medication carts was completed to ensure there were no expired medications, medications were labeled and dated properly, no expired insulin pens, and no loose pills were inside the medication carts. Additionally, unattended medication carts were audited for being locked while unattended. Any identified concerns were immediately corrected. An in-service was initiated by the Staff Development Coordinator/Director of Nursing on 7/14/21 with licensed nursing staff related to expired medications, medications being labeled and dated properly, including insulin pens, and that no loose pills are to be left in the cart. Education with licensed nursing staff complete on 7/23/21. Newly hired licensed staff and licensed agency staff will also receive this education. Beginning the week of 8/2/21, the medication carts will be monitored by the Unit Manager/Staff Development Nurse/Designated Nurse weekly x 4 weeks, bimonthly x 1, then monthly x 1 using the Medication Storage Audit Tool. Any identified areas of concern will be corrected immediately and the	

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believed the medication carts were checked weekly by the Staff Development Coordinator (SDC) nurse and not usually by the nurses who were on the carts. Nurse #3 stated she should have checked her medication cart for expired medications at the beginning of her shift.

c) An observation of a medication cart on 07/14/21 at 10:03 AM on the 400 Hall revealed there were two unknown loose medications in the medication cart.

An interview with Nurse #8 on 07/14/21 at 10:05 AM revealed she tried to check the cart daily to ensure there were no loose medications or expired medications in the cart each shift. She stated I must have just missed them.

d) An observation of a medication cart on 07/14/21 at 3:58 PM located on the 400 hall revealed the medication cart was left unattended and unlocked.

An interview with Nurse #1 at 4:00 PM revealed she was in a resident's room behind a closed door, and she got distracted. She stated it was not common practice for her to leave her medication cart unlocked and added any time she was not with her medication cart it should be secured.

An interview was conducted with the Director of Nursing (DON) on 07/19/21 at 11:30 AM. The DON reported her expectation of the nursing staff was to check their carts at the start of each shift to ensure all the medications that were opened were dated and there were no expired medications or loose pills in the medications cart. The DON stated she expected the nurses to keep

responsible licensed nurse will be re-trained. The Director of Nursing will review and initial the Medication Storage Audit Tool weekly x 4 weeks, bimonthly x 1, then monthly x 1 to ensure all areas of concern were addressed.

The Director of Nursing will report findings of the Medication Storage Audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action and recommendations including any additional systematic change or education if needed. After three months of reviewing the audits for sustained compliance, the QAPI Committee will determine ongoing need to review the Medication Storage Audits.

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F 761	Continued From page 21 their cart locked at all times when not in use or unattended.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and the Regional Dietary Consultant interview the facility failed to a) routinely monitor and document food temperatures on the steam table by not checking and recording food temperatures of the hot and cold foods prior to serving meals to residents b) failed to cover food plates on an open food cart during transportation and distribution to residents c) failed to follow the cleaning schedule for the stovetop, front oven, and deep fryer when a buildup of grease and residue was observed on the equipment. These	F 812	Based on observations, record review, staff interviews, and the Regional Dietary Consultant interview, the facility failed to: a)routinely monitor and document food temperatures on the steam table by not checking and recording food temperatures of the hot and cold foods prior to serving meals to residents b)cover food plates on an open food cart during transportation and distribution to residents and	8/13/21

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F 812	Continued From page 22	F 812		

practices had the potential to affect all residents who received oral nutrition.

Findings included

1a) During the initial tour of the kitchen on 07/12/21 at 12:00 PM the steam table was observed holding hot and cold food items. Staff were observed plating foods for lunch. The foods on the steam table included sliced turkey, rice, glazed carrots, mashed potatoes, gravy, and marbled cake. The alternate was a ham sandwich with potato chips. Staff began plating foods at 12:05 PM. The food temperatures were not checked prior to plating the foods and delivering the meals into the dining room.

An interview was conducted on 07/12/21 at 12: 10 PM with Cook #1. He stated he did not check the food temperatures prior to plating the lunch meals. He left the serving line to go locate a thermometer and returned several minutes later with a thermometer and began checking temperatures of the hot and cold food items. He checked the temperatures of the sliced turkey, glazed carrots, and rice, which were found to be at the appropriate temperatures, but he did not check the mashed potatoes and gravy.

A follow up interview was conducted with Cook #1 on 07/12/21 at 12:25 PM. He stated he knew he had to check food temperatures on the steam table before serving the food to residents, but he gets busy and doesn't always get it done.

An interview was conducted on 07/12/21 at 12:30 PM with the Assistant Dietary Manager. She stated food temperatures on the steam table were not checked with every meal, but she knew

c)follow the cleaning schedule for the stovetop, front oven, and deep fryer when a buildup of grease and residue was observed on the equipment.

These practices had the potential to affect all residents who received oral nutrition.

Seasoned dietary staff from sister facilities were immediately called in to assist with food preparation, delivery, and cleaning of the kitchen. A more experienced dietary manager has been assigned to the facility to supervise the kitchen.

a)100% of current dietary staff members were in-serviced on procedures for properly obtaining and recording food temperatures on 7/12/21 by the District Manager. Thermometers will be calibrated to 32 degrees and temperatures will be properly recorded and placed in a binder. The Dietary manager will check the binder daily for compliance x 4 weeks. The Administrator will check the binder weekly x 4 weeks. The District Manager will monitor progress and compliance on monthly visits.

b)100% of current dietary staff members were in-serviced on procedures for transporting of meal carts on 7/12/21 by the District Manager. The Dietary manager will monitor all meals 3xdaily for compliance x 4 weeks. The administrator will randomly observe the transporting of meal carts weekly x 4 weeks to ensure food plates are covered during transport.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345234	A. BUILDING _____ B. WING _____	C 07/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON HEALTH AND REHAB CENTER	1555 WILLIS AVENUE LUMBERTON, NC 28358

(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 812	Continued From page 23 they were checked some days. She acknowledged that food temperatures on the steam table were required to be checked before serving each meal. She reported she couldn't find any record of the previous food temperature logs maintained by the facility. A follow up interview was conducted on 07/13/21 at 12:55 PM with the Assistant Dietary Manager. She provided temperature log sheets dated 07/01/21 - 07/08/21. The dates on the temperature logs did not correlate with the day of the week. She indicated she could not provide documentation of temperature log readings prior to July. A follow up interview was conducted on 07/14/21 at 11:30 AM with the Assistant Dietary Manager. She stated she came in to work at 6:45 AM due to a kitchen aid calling out. She reported there was sufficient kitchen staff when everyone showed up for work, but they did have frequent call outs or staff running late, and things get missed. She stated there were also new staff members. She reported all new staff received training, then staff would be oriented to the kitchen, then new staff followed a seasoned staff member for additional training, and stated staff does know to check food temperatures before each meal. She reported that after they could not provide documentation of the temperature logs prior to the survey she called the Dietary Manager who was off for the week, and the dietary manager asked her to record readings on the temperature logs to provide to the surveyor. b). During the initial tour of the kitchen on 07/12/21 at 12:05 PM staff were observed loading the food cart with plated foods containing sliced	F 812	The District Manager will monitor progress and compliance on monthly visits. c)100% of current dietary staff members were in-serviced on procedures for cleaning assignments for weekly/daily/monthly cleaning schedule on 7/12/21 by the District Manager. Employees will be assigned to specific cleaning duties. The dietary manager will review the task of the completion prior to the employee clocking out. The dietary manager will sign off on the schedule stating that cleaning assignments were completed accurately. The administrator will monitor the cleaning schedule weekly x 4 weeks. The District Manager will monitor progress and compliance on monthly visits. The Dietary Manager will present the findings of the daily monitoring to the QAPI Committee monthly for 2 months for tracking and trending purposes with all follow up action and recommendations including any additional systematic change or education if needed. After two months of reviewing the audits for sustained compliance, the QAPI Committee will determine if there is an ongoing need to review the dietary audits.	

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F 812	Continued From page 24	F 812		

turkey, rice, glazed carrots, and the dessert plates with marbled cake which were on the bottom shelf of the cart near the floor. Dietary staff were observed rolling the opened cart (not an enclosed meal cart) with uncovered plates of food into the dining room to distribute to the residents that were seated in the dining room. The food cart was left sitting in the dining room for a brief period until a staff member began distributing the food.

A follow up interview was conducted on 07/14/21 at 12:30 PM with the Assistant Dietary Manager. She stated staff were aware that food was required to be covered before it left the kitchen. She stated some of the staff were new however they had received training on food safety and stated the food should have been covered before leaving the kitchen.

c). During the initial tour of the kitchen on 07/12/21 beginning at 11:30 AM, the stove was observed with layers of heavy grease residue and dried food on the stove top including the burners, and on the front of the oven door and the oven door handles. There were two dirty deep fryer baskets sitting on the stovetop beside a pot of gravy that was being served for lunch. The deep fryer located bedside of the stove had built up grease and residue and the fryer grease were very dark, dirty, and appeared it had not been changed recently.

In an interview with the Assistant Dietary Manager on 07/12/21 at 11: 45 AM, she stated she wasn't sure when the deep fryer grease was last changed. She stated the fryer baskets had not been used that day and she was unsure of when

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F 812	Continued From page 25	F 812		

they were used last or how long the dirty fryer baskets had been sitting on the stove top.

A follow up interview was conducted on 07/14/21 at 11:30 PM with the Assistant Dietary Manager. She stated it was obvious to her that the weekend staff had not conducted proper cleaning when she arrived Monday morning (07/12/21). She stated the cleaning schedules were put out every Friday and the weekend staff were responsible for getting it done, then they signed off on the check list that the items had been cleaned, then the cook was required to go behind staff to assure the cleaning was done and then the cook signed off on the checklist. She acknowledged the stove top and deep fryer had not been cleaned recently.

An interview was conducted on 07/13/21 at 4:54 PM with the Administrator along with the Administrator in Training and the Director of Nursing (DON). The Administrator stated he observed the kitchen daily and asked for a test tray daily. He stated he expected the food temperatures on the steam table to be checked prior to each meal, and he was not aware that temperatures were not being checked properly. He stated the kitchen staff should be keeping an accurate log of the food temperatures. He indicated the stove and deep fryer should be cleaned according to the schedule.

A follow up interview was conducted on 07/15/21 at 5:00 PM with the Administrator along with the Administrator in Training and the DON. The Administrator stated he was aware of the concerns identified in the Kitchen. He stated he conducted rounds in the kitchen and asked for a test tray during the lunch meal daily. He stated he

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F 812	Continued From page 26 had not identified any concerns with food temperatures, or palatability of the test trays he sampled. He stated his expectation was that kitchen staff were following the facility policy and checking food temperatures prior to each meal and covering food items before leaving the kitchen. He stated he expected the kitchen equipment to be cleaned according to the facility policy and schedule.	F 812		