STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/25/2021 through 11/02/2021. Two of the four compliant allegations were substantiated resulting in deficiencies. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/16/2021 and was removed on 10/30/2021. A partial extended survey was conducted.	F 000		
F 689 SS=J	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, staff interviews and observation, the facility failed to supervise nurse aides (NA) to ensure the nurse aides read and followed the Kardex, a resident care guide, which was based on the most recent care plan prior to providing resident care and indicated the amount of assistance required for the delivery of activities of daily living (ADL) for two of three residents	F 689	RM F689 1-Identified residents: Resident #1 was transferred to the hospital and did not return to the facility Resident #2 was transferred to the hospital for evaluation and was re-admitted with no further incidents since	11/18/21

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

Electronically Signed | 11/18/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 reviewed for falls. (Resident #1, Resident #2). Resident #1 and Resident #2 fell from their raised beds when only one NA provided ADL care, and Resident #1 and Resident #2 were care planned requiring assistance from two nurse aides for bed mobility. Resident #1 received daily anticoagulant therapy that increased risks from falls. Immediate Jeopardy began on 10/16/21 when NA #1 did not provide the level of assistance during ADL care as indicated on the resident ' s care plan. Resident #1 fell from his bed during incontinent care provided by NA #1. This fall resulted in lacerations, right hand fracture, nasal fracture, maxilla fracture and a left subdural hematoma. Resident #1 required hospitalization at a trauma center. The Immediate Jeopardy was removed on 10/30/2021 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level for an "G" (Actual harm that is not immediate) to implement a plan of correction for Resident #2 and ensure monitoring systems put into place are effective. Resident #2 fell from the bed during ADL care provided by NA #2. Resident #2 sustained a small soft tissue hematoma to the back of her head. Findings included: 1. Resident #1 was admitted to the facility on 8/3/2021. Diagnoses included history of falls, displaced fracture of second cervical vertebra, stroke and hemiplegia affecting the left non-dominant side. The admission Minimum Data Set (MDS) assessment dated 8/9/2021 indicated Resident	F 689	re-admission. Resident #1 remains at the facility. 2-All residents have the potential to be affected. Education was conducted from 10/17/2021-10/22/2021 and was completed by the SDC/DON/Nurse management for all facility nurses, CNAs and agency nurses and CNAs. The education included reviewing the care guide (Kardex) prior to providing resident care. The education also included a competency for accessing the care guide. Current residents' care plans and Kardexs were audited by the MDS nurse on 10/18/2021 to ensure ADL assistance was accurate. Modifications were made as needed. The MDS nurse will conduct on-going audits for care plan accuracy during the daily clinical meetings and the weekly care plan meetings. Modifications will be completed as identified. 3-The education will be added to the new hire and agency orientation. The education includes a competency for accessing the care guide. 4-Random daily audits will begin on 10/29/2021 and will be conducted each shift by the nurse management team/designee to observe CNAs accessing the Kardex for care needs prior to resident care. The audits will also ensure the delivery of care correlates with the Kardex. The audits will be conducted daily times 2 weeks, 2 times a week times 4 weeks, then weekly times 4 weeks. 5-Audit results will be reviewed by the QA committee monthly in the QA meeting. Any further monitoring or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2	F 689		

#1 was cognitively intact and required extensive assistance of one person with bed mobility and toileting. The MDS indicated Resident #1 had no upper or lower impairments to the extremities and was frequently incontinent of urine. The MDS further revealed Resident #1 received anticoagulants, a medication to prevent blood from clotting and experienced a fall prior to admission that resulted in a fracture.

Resident #1 was re-admitted to the facility on 10/13/2021. Diagnoses included history of falls, displaced fracture of second cervical vertebra, stroke and hemiplegia affecting the left non-dominant side.

Physician orders dated 10/13/2021 revealed Resident #1 was ordered Apixaban, an anticoagulant medication, five milligram tablet twice a day.

The Resident Data Set assessment, a nursing assessment utilized by the facility for admissions and readmissions, completed by Nurse #3 dated 10/13/2021 indicated Resident #1 was cognitively intact and required one-person assistance with incontinent care and bed mobility.

On 10/25/2021 at 2:56 p.m. in an interview with Nurse #3, she stated she conducted the facility ' s Resident Data Set assessment on re-admission for Resident #1. She stated Resident #1 wore a neck brace and could turn with one-person assistance because he would use his hands to support himself. She stated Resident #1 had no one sided weakness or contractures to the hands and was able to use his telephone and bed control remotes. She stated the Resident Data Set Assessment generated the admission care recommendations will be reviewed to determine the need for further monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

plan and the ADL resident care guide initially, and they were updated by the MDS nurse as needed.

The revised care plan dated 10/14/2021 revealed Resident #1 required extensive to total assistance for two persons to assist with bed mobility and total assistance of one person to assist with toileting.

On 10/26/2021 at 1:59 p.m. in an interview with the MDS nurse, she stated based on the Resident Data Set assessment on re-admission to the facility on 10/13/2021 Resident #1 required one-person assistance with activities of daily living (ADL) and bed mobility. She stated she updated the care plan to total assistance of two-persons for bed mobility on 10/14/2021 after receiving information from the interdisciplinary team meeting held on 10/14/2021. She stated the Kardex automatically updated when changes in the care plan were made for ADLs.

The updated Kardex for Resident #1 reflected the revisions in the care plan created on 10/14/2021 for bed mobility. The Kardex indicated Resident #1 required total assistance of two person with bathing, personal hygiene, bed mobility, transfers and toileting.

On 10/27/2021 at 11:13 a.m. in an interview with NA #3, she stated she had worked with Resident #1 previously, and she reviewed the Kardex after his re-admission, and Resident #1 required one-person assistance for ADL care and bed mobility. She stated during the day shift on 10/15/2021 she provided Resident #1 his ADL care and used one-person assistance to turn Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

On 10/27/2021 at 11:47 a.m. in an interview with NA #4, she stated during the evening shift on 10/15/2021 she assisted Resident #1 with turning without the assistance from other nursing staff. She stated on 10/14/2021 when assigned to Resident #1 she had checked the Kardex that indicated he required one-person assistance with bed mobility. She further stated she had no recollection of the report to NA #1 at the change of shift on 10/15/2021.

On 10/27/2021 at 7:51 a.m. in an interview with NA #1, she stated she was familiar with the computer program the facility used to document care and locate the Kardex, a resident ' s care guide. She stated the night shift on 10/15/2021 was the first time she had worked with Resident #1 and stated she did not look at the Kardex for Resident #1 because the NA #4 reported at the change of shift Resident #1 wore a neck brace and adult briefs and needed assistance with turning. She stated assistance with turning meant one person to her.

Nursing documentation completed by Nurse #1 revealed on 10/16/2021 at 6:15 a.m. NA #1 notified Nurse #1 Resident #1 was on the floor. Nurse #1 entered the room and found Resident #1 on the floor. Nursing documentation revealed while NA #1 was providing morning care Resident #1 reached for his remote and fell off the opposite side of the bed. Nurse #1 assessed Resident #1 with a laceration to the head, nose and face and notified the on-call physician. Resident #1 was transported by Emergency Medical Services (EMS) to the hospital.

On 10/26/2021 at 12:12 p.m. in an interview with Nurse #1, she stated Resident #1 was found on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

the floor lying on the right side of the bed with a laceration to the forehead. She stated Resident #1 had reached for his bed control to raise his head while NA#1 was washing him, and he fell out of the bed. Nurse #1 stated when she asked NA #1 why she didn ' t get help to turn Resident #1, NA #1 stated, "Resident #1 required only one person assistance with turning." Nurse #1 stated NA #1 should have had a second person to provide care to Resident #1 because Resident #1 wore a neck immobilizer and was a two-person assistance with turning.

Hospital records revealed Resident #1 was admitted to the Emergency Department (ED) on 10/16/2021 at 7:37 a.m. neurologically intact with baseline left sided weakness. The hospital ED record documented Resident #1 stated the nursing staff at the facility was turning him in the bed to clean and change him, and he accidentally fell face forward onto the ground. The hospital ED record revealed the repair of a forehead laceration and a nasal fracture, a fractured right hand, a known previous cervical -2 fracture with an abnormal ligament of the posterior arch of the cervical -1 and cervical -2 vertebra and a left subdural acute hemorrhage with possible superimposed acute hemorrhage. Resident #1 was treated with Kcentra, a reverse agent to anticoagulants, and was transferred and admitted to a trauma facility.

A review of the hospital records at the trauma facility dated 10/16/2021 revealed Resident #1 experienced low blood pressure after receiving Kcentra, the reversal agent for anticoagulants, but the low blood pressure was resolved with intravenous fluids. Further diagnostic tests were conducted and revealed a fracture to the upper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

jawbone, decreased subdural collection of fluid and no evidence of an acute cerebral contusion or subarachnoid hemorrhage. Admitting diagnoses included subdural hematoma, laceration to the face, a closed fracture of right fifth metacarpal (bone in the hand), accidental fall and cervical-2 fracture. Resident #1 remains a patient in the trauma facility.

On 10/27/2021 at 1:20 p.m. in an interview with the Director of Nursing (DON) and in a follow up interview on 10/28/2021 at 12:30 p.m., she stated the facility ' s Resident Data Set assessment conducted on re-admission generated Resident #1 ' s care plan, and the care plan generated the Kardex and guided nursing staff in performing ADL care to Resident #1. She stated changes in the care plan were communicated to the nursing staff by the DON or MDS nurse and placed on the dashboard of the Kardex for staff to review. She stated NAs were required to access the Kardex to review the resident care guide before providing care to residents, and NAs used interventions for bed mobility when turning a resident. She stated NA #1 should not have provided care to Resident #1 without assistance if the Kardex indicated Resident #1 required two-person assistance with bed mobility.

The Administrator ' s written statement dated 10/17/2021 at 11:20 a.m. with NA #1 revealed NA #1 stated Resident #1 required one-person assistance and no one had told her he required two-person assistance. NA #1 stated she was standing on Resident #1 ' s right side of the bed that was raised waist high. Resident #1 was positioned on his back with his head lowered. She had opened the adult brief getting ready to change Resident #1 when he asked for his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

remote and threw the right leg over his left leg and fell toward the window off the left side of the bed.

On 10/27/2021 at 2:32 p.m. in an interview with the Administrator and follow up interviews, he stated falls were discussed in interdisciplinary morning meetings, and new interventions were activated as needed and placed on the Kardex during the meeting. He stated he did not recollect what Resident #1 ' s Kardex indicated for bed mobility directly after the fall. He stated if the Kardex stated Resident #1 required two-person assistance for resident care, one person should not perform the care, and NA #1 should have waited until two persons were available to perform Resident #1 ' s care.

On 10/29/2021 at 9:25 a.m., the Administrator was notified of the immediate jeopardy by phone and email.

On 10/29/2021 at 8:30 p.m., the facility ' s credible allegation for the removal of immediate jeopardy was reviewed and accepted.

The facility ' s credible allegation for removal of the immediate jeopardy for providing supervision to prevent accidents included the following:

Rocky Mount Rehabilitation removal plan includes the identification of residents who may have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The failure to supervise nurse aides to ensure the nurse aides read the care guide prior to delivery of care is addressed by the facility with the following actions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8	F 689		

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.
Resident #1 was transferred to the hospital and did not return to the facility.
Resident #2 was transferred to the hospital for evaluation and was re-admitted with no further incidents since re-admission. She remains at the facility.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
Immediate Jeopardy Plan
1. 10/17/21- Licensed and non-licensed staff, to include agency staff were educated by NHA/ Nurse Management Team regarding following care plan and Kardex for interventions. Staff were educated prior to working their next scheduled shift. The education was completed by 10/22/2021. 100% of staff have been educated.

2. 10/18/21- An Ad hoc QAPI was conducted with Medical Director via phone, NHA, DON and 5 other team members participated. The team reviewed the 10/16/2021 incident investigation and immediate interventions that were initiated. The initial QAPI was reviewed and discussed. The interventions included Resident #1 was transferred to the ER, staff education regarding utilizing the Kardex prior to providing care, an audit to be conducted of Kardexes and care plans to ensure the residents ' current ADL Care needs are accurate. The root cause was determined to be that the C.N.A did not review the Kardex prior to providing care. There were no further recommendations at that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

3. 10/18/21- Current residents ' care plans and Kardex-102 total were audited by the MDS Coordinator for assistance needed for ADLs to ensure assistance needed is accurate and completed. An audit of current residents ' MDS assessments comparing to the Kardex will be completed by Nurse Management Team by 10/30/2021.

4. Falls as of 10/16/2021 were reviewed by the Nurse Management Team to ensure an investigation and root cause analysis were completed. An audit of residents at risk for falls was completed on 10/29/2021 by the DON. 8 residents were noted with falls and no issues were identified. This audit will be on-going and a part of the daily clinical meeting.

5. Newly hired staff and agency staff will receive education regarding checking the Kardex for the type of ADL assistance a resident needs and how many staff should provide the care prior to delivering the care as part of their new hire and agency orientation process. There have been no newly hired CNAs since 10/16/2021.

6. Random daily audits will be conducted on each shift by the Nurse Management Team/designee to observe C.N.A ' s accessing the Kardex for resident care needs prior to resident care and ensure they follow through with the delivery of care according to the Kardex. The audits will be conducted daily times 2 weeks, 2 times a week times 4 weeks, weekly times 4 weeks. Audits started 10/29/2021.

Rocky Mount Rehabilitation Center alleges immediate jeopardy was removed on 10/30/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

On 10/29/2021 at 8:30 p.m., the facility ' s credible allegation for the removal of immediate jeopardy was reviewed and accepted.

On 11/2/2021 at 9:30 a.m., an onsite extended survey and the validation of the credible allegation was started. The onsite site extended survey consisted of record review, observations, resident interviews and staff interviews. The Sufficient and Competent Nurse Staffing Review Facility Task and the Quality Assessment and Assurance (QAA) and the Quality Assurance and Performance Improvement (QAPI) Plan Review Facility Task were completed with no concerns which may have contributed to the substandard care identified on the complaint investigation survey. There were also no concerns identified related to Physician Services, Administration and Training Requirements.
A review of the education records revealed the facility had provided educational training to the nurses and nurse aides on how to review and follow resident ' s care plans and the Kardex prior to administration of resident care. Interviews with nurses and nurse aides validated they had attended in-services training regarding the use of the Kardex and the care plan, and they were observed accessing the Kardex for information on the level of assistance required to perform resident care. Observations revealed beds were in low position, use of fall mats, call bell were within reach, and residents were positioned in the middle of the beds. Interviews with random residents dependent on the staff for one person assistance and two-person assistance with ADL care revealed the residents felt the nursing staff were competent in providing ADL care and felt safe when the nursing staff were assisting the resident with turning and repositioning in the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

A review of QAPI meeting dated 10/18/2021 revealed the root call analysis for fall on 10/16/2021 was the nurse aide did not review the Kardex prior to providing care to the resident to determine level of assistance required for bed mobility. The facility provided documented evidence of the following audits completed as stated in the credible allegation of compliance: Kardex and care plan audit, MDS assessments and Kardex audits, review of falls since 10/16/2021 for an investigation and root cause analysis, all residents at risk for falls, list of newly hired nursing staff since 10/16/2021 and their orientation packet and daily audits for each shift observing nurses and nurse aides using the Kardex prior to providing resident care.

On 11/2/2021 at 2:30pm, the facility ' s credible allegation of compliance was validated for the date of 10/30/2021.

2. Resident #2 was admitted to the facility on 8/25/2015. Her diagnoses included postural kyphosis, curvature of the spine, nontraumatic intracerebral hemorrhage and hemiplegia affecting the right dominant side.

The fall assessment dated 8/15/2020 indicated Resident #2 was at high risk for falls.

Resident #2 ' s care plan dated 2/3/2021 indicated Resident #2 was a risk for falls and was unable to perform self-care due to impaired physical mobility. Interventions included Resident #2 required two-person assistance with bathing and bed mobility.

The quarterly MDS assessment dated 3/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

indicated Resident #2 was severely cognitively impaired and required two persons for total assistance with bed mobility and total assistance of one person to perform a bath. The MDS indicated upper and lower impairments to one side of Resident #2 ' s body.

On 10/25/2021 at 3:25 p.m. in an interview with NA #5, she stated Resident #2 did not move without assistance and provided little assistance when turning. She stated she provided one-person assistance ADL care to Resident #2, but some NAs used two-person assistance when turning. NA #2 stated she did not know what the Kardex or care pan indicated for the level of assistance required for bed mobility or ADL care for Resident #2.

A review of the written statement by NA #2 dated 5/4/2021 reported Resident #2 was receiving ADL care and became upset because her sheets were changed. NA #2 wrote Resident #2 was agitated, jerked and fell off the bed. She further wrote she had provided ADL care to Resident #2 for six months and used two-person assistance for transfers.

On 10/26/2021 at 12:00 p.m. in an interview with NA #2, she stated she had worked at the facility almost a year, and she was trained Resident #2 only required one-person assistance with ADL care. NA #2 stated on 5/4/2021 Resident #2 was repositioned on her right side and while washing Resident #2 ' s back side during ADL care, Resident #2 fell out of the raised bed onto the floor. NA #2 stated she had been providing one-person assistance for Resident #2 ' s ADL care as she was trained. She stated she knew about the Kardex prior to the fall incident but did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

not recall being trained on how to use the Kardex prior to the fall. NA#2 stated after the fall incident she received training on how to use the Kardex to document resident care and to check the resident ' s required level of assistance prior to care.

Nursing documentation dated 5/4/2021 at 2:00 p.m. revealed Nurse #2 responded to a code orange, a resident fall, in Resident #2 ' s room and found Resident #2 lying face up on her back on the floor between the two beds. Nursing documentation recorded NA #2 was providing ADL care to Resident #2 when she rolled off the bed to the floor. Nurse #2 assessed Resident #2 with no visible injury, but Resident #2 ' s family requested she be sent to the hospital for an evaluation.

On 10/25/2021 at 3:05 p.m. in an interview with Nurse #2, she stated she heard the call for help and entered Resident #2 ' s room and observed Resident #2 lying face up on her back on the floor between the two beds on 5/4/2021. She stated Resident #2 was assessed with no obvious injury noted. The physician and family were notified, and Resident #2 was sent to the ED for an evaluation. She stated Resident #2 ' s bed was a small regular bed with no bed rails, and Resident #2 did not move independently. She stated based on the Kardex, Resident #2 was a two-person assistance with ADL care, and NA #2 was providing one-person assistance ADL care. Nurse #2 further stated she had never looked at a care plan but knew resident care plans were available and had assisted Resident #2 with ADL care before providing only one-person assistance.

A change in condition report completed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

5/4/2021 for Resident #2 indicated Resident #2 fell, and pain was indicated by facial grimacing.

Hospital records dated 5/4/2021 revealed Resident #2 fell out of her bed onto the right side and presented with right arm in a flexed (bent) position and refused to move the right arm into any other position. Diagnostic tests revealed a small hematoma to the back of the head, no intracranial bleeding and no fractures. Resident #2 was admitted to the hospital, and diagnoses included fall, urinary tract infection and hypertension.

Physician progress notes dated 5/10/2021 recorded Resident #2 rolled out of the bed onto the floor while receiving personal care by NA #2. The progress note revealed Resident #2 was aphasic, unable to speak and could not verbalize pain but was yelling when right arm and right hand was touched. Resident #2 was transferred to the hospital for an evaluation.

On 10/26/2021 at 10:14 a.m. in an interview with the former DON, she stated she responded to the Code Orange, facility ' s code for a resident fall, on 5/4/202, and the resident was observed lying between the two beds in the room on the floor on her back. She stated when NA #2 rolled Resident #2 over to her side during the bath, Resident #2 kept rolling and she was unable to stop her from falling out of the bed. The former DON stated Resident #2 was a two-person assistance with ADL care. In another interview on 10/28/2021 at 12:27 p.m. she stated the use of the Kardex was part of the facility ' s orientation process, but NA #2 was not familiar with the how to use the Kardex. She further stated staffing was not an issue on 5/4/2021 and NA #2 was trying to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

complete ADL care for Resident #2 without the assistance of another staff member.

On 10/26/2021 at 1:43 p.m. in an interview with the former Administrator, she stated Resident #2 ' s fall on 5/4/2021 was a single isolated incident, and the staff member was re-educated on the use of the Kardex to review the level of assistance required for ADL care. She stated Resident #2 was also moved to a private room and placed on a bigger bed.

On 10/27/2021 at 1:20 p.m. in an interview with the current DON and in a follow up interview on 10/28/2021 at 12:30 p.m., she stated she started employment with the facility in June 2021. She stated based on the Kardex, Resident #2 required two-person assistance for bed mobility on 5/4/2021. She stated NAs were to follow Resident #2 ' s care plan and Kardex and two persons needed to be in the room when providing ADL care to Resident #2.

On 10/28/2021 at 1:44 p.m. in an interview with the current Administrator, he stated falls were discussed in interdisciplinary morning meetings, and new interventions were activated as needed and placed on the Kardex during the meeting. He stated if the Kardex indicated residents required two-person assistance for resident care, one person should not perform the care, and NAs should wait until two-person assistance was available to perform resident care.

On 10/25/2021 at 4:30 p.m., NA #5 and NA #6 were observed standing on opposite sides of the bed while providing incontinent care and repositioning Resident #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		11/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker for Nash County level of transmission rate, the facility failed to follow CDC guidance regarding appropriate Personal Protective Equipment (PPE) for counties of high and substantial county transmission rates when 2 of 2 staff members (Nurse #4 and Nurse Aide (NA) #6) failed to wear	F 880	In review of the F880 deficiency related to CDC recommendation for eye protection based on county transmission rate. On 11/2/21 the center employed the “5 whys Method of Root Cause analysis” and determined the following to be the root cause: Interview with the Administrator and the Director of Nursing revealed the new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18 eye protection when observed in a room within three feet of 1 of 1 resident (Resident # 3), and when 2 of 2 staff members (NA #5 and NA #6) failed to wear eye protection when providing incontinent care for 1 of 1 resident (Resident #2). These practices had the potential to affect all residents who receive care from the nursing staff. This failure occurred during a COVID-19 pandemic. Findings included: The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 09/10/21 indicated healthcare providers working in facilities located in counties with substantial or high community level of COVID-19 transmission should be wearing eye protection (i.e. goggles or a face shield that covers the front and sides on the face) during all patient care encounters. The Centers for Disease Control and Prevention(CDC) COVID-19 Data Tracker on 10/25/2021 indicated the county where the facility was located had a substantial level of community transmission for COVID-19. On 10/25/2021 at 4:26 p.m. Nurse #4 and NA #6 were observed in Resident #3 ' s room standing within three feet of Resident #3 wearing face masks only. Neither Nurse #4 nor NA #6 were wearing eye protective wear. On 10/25/2021 at 4:27 p.m. in an interview with Nurse #4, she stated Resident #3 ' s room was located on a hall not part of the quarantine unit.	F 880	guidance had not been completely implemented within the center. All residents had the potential to be affected. No staff or residents were identified as affected by this deficient practice as there have been no positive staff or resident Covid cases in the center in greater than 90 days. On 10/25/21, new PPE guidelines were implemented in the center to reflect the updated eye protection. Eye protection is to be worn in all resident care areas within the center. The decision was made by the IDT to implement eye protection be worn daily. This decision was made to reduce the possibility of non- compliance due to the daily fluctuating county transmission rate. The Administer will monitor the county transmission rate weekly. From 10/25/21 – 11/02/21, the DON/SDC/Designee educated center (clinical staff, dietary staff, maintenance staff, therapy staff, administrative staff, agency staff) of the facility implementation of wearing eye protection daily in resident care areas. All current staff were educated by 11/2/2021. The education was added to the facility staff and agency orientation. Notification of the requirement was posted on the facility entrance door as a reminder. The DON/SDC/Designee will complete daily audits X 2 weeks and then weekly audits and observations of PPE compliance, along with education attestation. The DON/SDC/Designee will report the results of weekly audits to the QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 She stated eye wear was not required, only face masks were required for resident care. On 10/25/2021 at 4:30 p.m., NA #5 and NA #6 were observed standing within three feet of Resident #2 on each side of the bed performing incontinent care wearing face masks and gloves and were not wearing eye protective wear. On 10/25/2021 at 4:35 p.m. in an interview with NA #6, she stated Resident #2 ' s room was not on the quarantine unit, and the required personal protective equipment (PPE) for resident care were face masks and gloves as needed. She stated eye protective wear was required only when working on the quarantine unit. On 10/25/2021 at 5:06 p.m. in an interview with the Director of Nursing (DON), she stated nursing staff were to wear face masks and gloves as needed when providing resident care to residents not located on the quarantine unit. She stated the facility based the use of PPE for resident care on the community level of transmission for COVID-19 and was not aware what the county ' s community level of transmission was for 10/25/2021. She stated she did not know a high to substantial community level of transmission for COVID-19 required the nursing staff to wear protective eye wear with the face masks when performing resident care. The DON further stated the Infection Control Preventionist (ICP) last day of employment was 10/22/21, and the Staff Development Coordinator (SDC) was assuming the ICP role until the ICP position was filled. On 11/2/2021 at 12:34 p.m. in an interview with the Staff Development Coordinator, she stated besides the few notes left by the ICP she had	F 880	meeting monthly X3 months and as needed thereafter. During the QA committee monthly meeting the weekly county transmission rates will be reviewed. The committee will decide when to make changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20	F 880		

received no training on the ICP role. She stated she was not aware what the PPE requirements were for the facility located in a high or substantial county level of transmission.

On 11/2/2021 at 1:49 p.m. in an interview with the Administrator, he stated the facility followed CDC guidance for COVID-19 infection control measures, the county ' s rate of positivity and county ' s level of COVID -19 transmission. He stated the corporate office updated the facility on PPE requirements and testing. He stated he was not sure what the county level of transmission was on 10/25/2021 but if the staff were to wear protective eye wear with high or substantial county level of transmission, the facility had protective eye wear for the staff to wear.