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 06/07/2017

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 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to treat a resident with dignity and respect by failing to respond to a resident's request to provide incontinent care. The facility's failure to provide incontinent care, resulted in 1 of three sampled residents (Resident #1), reviewed for dignity and respect, lying in bed soiled and wet for an extended period of time. The findings included: Resident #1 was admitted to the facility on 4/5/16 with diagnoses including Type 2 Diabetes Mellitus without complications, Peripheral Vascular Disease and Hypertension. According to the most recent Minimum Data Set (MDS) dated 5/24/17, Resident #1's cognition was intact. She required extensive assistance in bed mobility, with one person assistance. In the area of transfers, Resident #1 required extensive assistance with two person assistance. In the area of toileting, Resident #1 required extensive assistance with one person physical assistance. Resident #1 was not on a toileting program and was always incontinent of bowel and bladder. Review of Resident #1's Care Plan dated 4/25/17, revealed Resident #1 had frequent bowel and	F 241	* RI# resident is receiving incontinent care appropriately according to her needs and care plan. There have been no concerns regarding incontinent care. * Current residents who are incontinent have been audited and no concerns have been identified. *Certified nursing staff will be in serviced by nursing management regarding providing timely incontinent care. Charge nurses will monitor for concerns regarding incontinent care provided timely. *Nursing Management will conduct random audits for incontinent care 5 times a week for two weeks, and then twice weekly for one month and then monthly for three months. Results of the audits will be reviewed by the QAPI team to ensure continued compliance. Date of allegation of Compliance:_____6/28_____	6/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/26/2017

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bladder incontinence. The goal was to remain free from skin breakdown due to incontinence and brief use. Interventions included, check every 2 -3 hours and as needed. Resident #1 had impaired physical mobility and a deficit related to limited mobility, pain, impaired balance, non-ambulatory due to bilateral dysfunction.

During an interview on 6/4/17 at 12:10 PM, Resident #1 revealed her care was good and sometimes bad. She stated most of the time her care was bad because it was hard to get a Nursing Assistant to help her. Resident #1 recalled she had to wait to be changed from first shift to second shift on Sunday, 5/21/17. She stated an agency nurse was assigned to help her that day. She recalled the agency nurse gave her a bath before lunch. Resident #1 stated before lunch she was wet and needed to be changed. She revealed a Nursing Assistant came to her room and said the trays were out and she could not change her. She stated after lunch was over, a Nursing Assistant said she would be back in just a minute, but she did not come back. She stated a 2nd shift nursing assistant changed her, and by that time she was wet and had stool on her. She stated the 2nd shift nursing assistant also called the second shift nurse to come down to see her in stool and urine. She stated the second shift nursing assistant washed her and changed her bed.
During another interview on 6/6/17 at 4:55 PM, Resident #1 was asked how she felt when she laid in bed wet and soiled and no one came to change her for a long period of time on 5/21/17. Resident #1 was emotional and tears were in her eyes when she said she felt like she had been thrown away. Resident #1 stated "I felt like I was not human with no dignity left."

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F 241	Continued From page 2	F 241		

During an interview on 6/4/17 at 11:33 AM, Staff Nurse #1 revealed Resident #1 asked for staff to come to her room to change her and she stated she told Resident #1 that staff might be in another room and when they finished the staff person would go to her room. She stated they had an agency nurse who was doing the best she could, but she did go in Resident #1's room. Staff Nurse #1 said she did not recall Resident #1 being wet. She stated Resident #1 did not complain about not being changed that day and if she did, the resident would have told someone. Staff Nurse #1 revealed the last time she worked was the weekend in May and there were no complaints that day. She stated there were three nursing assistants on the hall. Staff Nurse #1 revealed Resident #1 used her call bell if she needed anything. She stated the nursing assistant might have been bathing or assisting someone else. She further stated when Resident #1 called the nurse's station, she would go to get whoever was responsible for assisting Resident #1.

During an interview on 6/4/17 at 2:45 PM Nursing Assistant #1, 2nd shift, revealed Resident #1 had a large bowel movement and urine up her back and down by her knees. Nursing Assistant #1 revealed Resident #1 said she had been asking all day about getting help. She stated Resident #1 said she had asked the nurse on first shift and the nurse told the aides to change her. NA#1 stated she came in about 2:40 PM and saw a Nursing Assistant go into Resident #1's room and turn off Resident #1's call light. She stated that was when Resident #1 asked for her help. She stated she asked the nurse on the hall to come down to look at Resident #1. She stated Resident #1 looked like she had been in that condition for a

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minute, and clarified by saying it looked like she had laid in bed without being changed for four or five hours.

During an interview on 6/4/17 at 2:54 PM, Staff Nurse #2, who worked on second shift acknowledged she saw Resident #1 when she was wet and soiled on 5/21/17. She stated she made her rounds and it was brought to her attention and she went to Resident #1's room to look at her. She stated she turned Resident #1 over and there was stool and urine which had begun to dry because it had been on her for a long time. She revealed the stool and urine were also on Resident #1's sheets. She stated Resident #1 told her that she turned on her call light just before lunch and asked to be changed. She stated Resident #1 told her a person came to her room, turned off the call light and did not return. Staff Nurse #2 revealed Resident #1 usually did not express any concerns about her care on second shift. She stated that was the first time she had observed Resident #1 not being changed. She stated when she came back to work she talked to the Director of Nurses (DON) about the incident.

During an interview on 6/5/17 at 2:40 PM, the Director of Nurses (DON) stated she was off work on Monday, 5/22/17 and she returned to work on Tuesday, 5/23/17. She revealed she was told there was a problem. She revealed an agency aide was assigned to Resident #1 the day of the incident. She stated she called the agency and told them that the Nursing Assistant did not meet the standards of care and she would not be allowed to return to the facility again. She stated Resident #1 did not express any other concerns to her about her care. The DON stated the Nurse Supervisor for Resident #1's hall followed-up regarding any issues related to Resident #1's

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F 241	Continued From page 4 care. During an interview on 6/5/17 at 2:52 PM, the Unit Manager revealed she was not in the building when the incident happened with Resident #1. She stated she followed up with the issue on Monday, 5/22/17 when she returned to work. She revealed second shift staff told her about the incident. The Unit Manager stated staff told her Resident #1 told them she had been soiled since first shift. She stated when Nursing Assistant #1 and Staff Nurse #2 made rounds they found Resident #1 soiled. She stated by her not being in the facility at the time, she revealed she was going on what was reported to her by staff. She stated Resident #1 was being monitored closely and everything was going well. She stated she checked with Resident#1 a couple of days after the incident. During an interview on 6/4/17 at 2:17 PM, Nursing Assistant #2 (NA#2) who was the first shift agency aide assigned to Resident #1 on 5/21/17, recalled on 5/21/17 Resident #1 rung her call light and NA#2 revealed she told Resident #1 the trays were on the hall and when the trays were up after breakfast she would come change her and give her a bath. NA#2 emphasized that she was an agency aide and it was the first time she had worked on Resident #1's end of the hall. She stated Resident #1 did not complain about waiting a long time or anything. During an interview with the Director of Nurses (DON) and the Administrator on 6/7/17 at 5:30 PM, the Administrator revealed he expected staff to treat residents with dignity and respect.	F 241		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out	F 312		6/18/17

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F 312	Continued From page 5 activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to provide incontinent care to 1 of three sampled residents (Resident #1), reviewed for incontinent care, which resulted in the resident lying in bed soiled and wet for an extended period of time. The findings included: Resident #1 was admitted to the facility on 4/5/16 with diagnoses including Type 2 Diabetes Mellitus without complications, Peripheral Vascular Disease and Hypertension. According to the most recent Minimum Data Set (MDS) dated 5/24/17, Resident #1's cognition was intact. She required extensive assistance in bed mobility, with one person assistance. In the area of transfers, Resident #1 required extensive assistance with two person physical assistance. In the area of toileting, Resident #1 required extensive assistance with one person physical assistance. Resident #1 was not on a toileting program and was always incontinent of bowel and bladder. Review of Resident #1's Care Plan dated 4/25/17, revealed Resident #1 had frequent bowel and bladder incontinence. The goal was to remain free from skin breakdown due to incontinence and brief use. Interventions included, check every 2 -3 hours and as needed. Resident #1 had impaired physical mobility and a deficit related to limited mobility, pain, impaired balance, non-ambulatory due to bilateral dysfunction.	F 312	F312 * RI# resident is receiving incontinent care appropriately according to her needs and care plan. There have been no concerns regarding incontinent care. * Current residents who are incontinent have been audited and no concerns have been identified. *Certified nursing staff will be in serviced by nursing management regarding providing timely incontinent care. Charge nurses will monitor for concerns regarding incontinent care provided timely. *Nursing management will conduct random audits for incontinent care 5 times a week for two weeks, and the twice weekly for one month and then monthly for three months. Results of the audits will be reviewed by the QAPI team to ensure continued compliance.	

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F 312	Continued From page 6 During an interview on 6/4/17 at 12:10 PM, Resident #1 revealed her care was good and sometimes bad. She stated most of the time her care was bad because it was hard to get a Nursing Assistant to help her. Resident #1 recalled she had to wait to be changed from first shift to second shift on Sunday, 5/21/17. She stated an agency nurse was assigned to help her that day. She recalled the agency nurse gave her a bath before lunch. Resident #1 stated before lunch she was wet and needed to be changed. She revealed a Nursing Assistant came to her room and said the trays were out and she could not change her. She stated after lunch was over, a Nursing Assistant said she would be back in just a minute, but she did not come back. She stated a 2nd shift nursing assistant changed her, and by that time she was wet and had stool on her. She stated the second shift nursing assistant washed her and changed her bed. During an interview on 6/4/17 at 11:33 AM, Staff Nurse #1 revealed Resident #1 asked for staff to come to her room to change her and she stated she told Resident #1 that staff might be in another room and when they finished the staff person would go to her room. She stated they had an agency nurse who was doing the best she could, but she did go in Resident #1's room. Staff Nurse #1 said she did not recall Resident #1 being wet. She stated Resident #1 did not complain about not being changed that day and if she did, the resident would have told someone. Staff Nurse #1 revealed the last time she worked was the weekend in May and there were no complaints that day. She stated there were three nursing assistants on the hall. Staff Nurse #1 revealed Resident #1 used her call bell if she needed anything. She stated the nursing assistant might have been bathing or assisting someone else.	F 312		

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She further stated when Resident #1 called the nurse's station, she would go to get whoever was responsible for assisting Resident #1.

During an interview on 6/4/17 at 2:45 PM Nursing Assistant #1, 2nd shift, revealed Resident #1 had a large bowel movement and urine up her back and down by her knees. Nursing Assistant #1 revealed Resident #1 said she had been asking all day about getting help. NA#1 stated she came in about 2:40 PM and saw a Nursing Assistant go into Resident #1's room and turn off Resident #1's call light. She stated that was when Resident #1 asked for her help. She stated she asked the nurse on the hall to come down to look at Resident #1. She stated Resident #1 looked like she had been in that condition for a minute, and clarified by saying it looked like she had laid in bed without being changed for four or five hours. During an interview on 6/4/17 at 2:54 PM, Staff Nurse #2, who worked on second shift acknowledged she saw Resident #1 when she was wet and soiled on 5/21/17. She stated she made her rounds and it was brought to her attention and she went to Resident #1's room to look at her. She stated she turned Resident #1 over and there was stool and urine which had begun to dry because it had been on her for a long time. She revealed the stool and urine were also on Resident #1's sheets. She stated Resident #1 told her that she turned on her call light just before lunch and asked to be changed. She stated Resident #1 told her a person came to her room, turned off the call light and did not return. Staff Nurse #2 revealed Resident #1 usually did not express any concerns about her care on second shift. She stated that was the first time she had observed Resident #1 not being changed. She stated when she came back to

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work she talked to the Director of Nurses (DON) about the incident.
During an interview on 6/5/17 at 2:40 PM, the Director of Nurses (DON) stated she was off work on Monday, 5/22/17 and she returned to work on Tuesday, 5/23/17. She revealed she was told there was a problem. She revealed an agency aide was assigned to Resident #1 the day of the incident. She stated she called the agency and told them that the Nursing Assistant did not meet the standards of care and she would not be allowed to return to the facility again. She stated Resident #1 did not express any other concerns to her about her care. The DON stated the Nurse Supervisor for Resident #1's hall followed-up regarding any issues related to Resident #1's care.
During an interview on 6/5/17 at 2:52 PM, the Unit Manager revealed she was not in the building when the incident happened with Resident #1. She stated she followed up with the issue on Monday, 5/22/17 when she returned to work. She revealed second shift staff told her about the incident. The Unit Manager stated staff told her Resident #1 told them she had been soiled since first shift. She stated when Nursing Assistant #1 and Staff Nurse #2 made rounds they found Resident #1 soiled. She stated by her not being in the facility at the time, she revealed she was going on what was reported to her by staff. She stated Resident #1 was being monitored closely and everything was going well. She stated she checked with Resident#1 a couple of days after the incident.
During an interview on 6/4/17 at 2:17 PM, Nursing Assistant #2 (NA#2) who was the first shift agency aide assigned to Resident #1 on 5/21/17, recalled on 5/21/17 Resident #1 rung her call light and NA#2 revealed she told Resident #1 the trays

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F 312	Continued From page 9 were on the hall and when the trays were up after breakfast she would come change her and give her a bath. NA#2 emphasized that she was an agency aide and it was the first time she had worked on Resident #1's end of the hall. She stated Resident #1 did not complain about waiting a long time or anything. During an interview with the Director of Nurses (DON) and the Administrator on 6/7/17 at 5:30 PM, the Administrator revealed he expected staff to provide care on a daily basis.	F 312		