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	345215	A. BUILDING ______ B. WING ______	C 07/26/2024

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/23/2024 through 07/26/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # TU5711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/23/2024 through 07/26/2024. Event ID# TU5711. The following intakes were investigated NC00217090, NC00218536, NC00218860, NC00219257 and NC00219808. 12 of the 12 complaint allegation(s) did not result in deficiency.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		8/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/10/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and resident interviews, the facility failed to incorporate residents and/or resident representatives in the care planning process for 2 of 2 residents reviewed for care plans (Resident #9 and #24).

Findings included:

1. Resident #9 was admitted to facility on 1/24/2019 with diagnoses that included heart disease and Alzheimer's dementia.

A review of Resident #9's annual Minimum Data Set (MDS) dated 5/14/24 revealed she was severely cognitively impaired.

A review of Resident #9's Social Service progress notes revealed the last documented Interdisciplinary (IDT) care plan meeting was held on 11/23/22.

An interview with the Social Worker on 7/26/24 at 8:59 AM revealed she did not know why the resident hadn't had a care plan meeting since 11/23/22 as they should be held quarterly.

In an interview with the Director of Nursing (DON)

F 657

F657 Care Plan Timing and Revision

On 8/9/2024, the Director of Nursing and Administrator scheduled a care plan meeting for resident # 9 and mailed a letter of invitation to resident # 9 representative. The care plan meeting will be held on 8/15/2024.

On 8/9/2024, the Director of Nursing and Administrator scheduled a care plan meeting for resident # 24 and mailed a letter of invitation to resident # 24 representative. The care plan meeting will be held on 8/15/2024.

On 8/5/24, the Minimum Data Set Nurse (MDS) initiated audit all residents most recent care plans. This audit is to ensure care plans were held at least quarterly per facility protocol and that the resident representative was invited to attend scheduled care plan meetings. The MDS nurse, Director of Nursing and/or Administrator will address all concerns identified during the audit to include scheduling care plan meeting per facility

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on 7/26/24 she stated care plan meetings should have been held quarterly. She was unaware Resident #9 had not had a care plan meeting since 11/23/22.

In an interview with the Administrator on 7/26/24 she stated she was unaware there had not been a care plan meeting for Resident #9 since 11/23/22. She further stated care plans should be reviewed quarterly and Social Work was responsible for scheduling care plan meetings.

2. Resident #24 was admitted to the facility on 6/1/23.

Review of Resident #24's Minimum Data Set assessment dated 4/29/24 revealed he was assessed as moderately cognitively impaired (Brief Interview for Mental Status score of 11).

Review of Resident #24's medical record revealed his care plan was last reviewed and updated on 9/21/23.

During an interview on 7/24/24 at 8:14 AM Resident #24 stated he had not had a care plan meeting in a very long time.

During an interview on 7/26/24 at 7:51 AM the Administrator stated Resident #24 had not had a care plan review and meeting since 9/21/23. She stated she did not know why he had not had a care plan meeting since then and care plans should be reviewed and updated quarterly or with any significant changes.

During an interview on 7/26/24 at 8:59 AM the Social Worker stated she did not know why the resident's care plan meetings were missed off the

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protocol and mailing invitation to the resident/resident representative with documentation in the clinical record. The audit will be completed by 8/12/24.

On 8/5/24, the Staff Development initiated an in-service with the Administrator, Director of Nursing, Assistant Director of Nursing, and MDS nurse regarding Care Plans with emphasis on scheduling care plan meetings at least quarterly to include a written invitation of resident and/or resident representative with documentation of invitation mailed, response of resident and/or resident representative to the invitation and attendance of care plan meeting in the electronic record. The newly hired Social Worker will be educated on hire regarding Care Plans. In-service will be completed by 8/12/24. After 8/12/24, any Social Worker, Director of Nursing, Assistant Director of Nursing or MDS nurse who has not worked or completed the in-service will complete it upon the next scheduled work shift. All newly hired Social Workers, Director of Nursing, Assistant Director of Nursing and MDS nurses will be in service during orientation regarding Care Plans.

The Assistant Director of Nursing and/or MDS nurse will audit 10% of residents most recent care plans to include resident # 9 and Resident #24 utilizing the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure resident care plan was held at least quarterly per facility protocol and that the

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F 657	Continued From page 3 schedule. She concluded care plans should be reviewed and updated quarterly.	F 657	Social Worker mailed a written invitation to the resident and/or resident representative for all care plan meetings with documentation of invitation mailed, response of the resident and/or resident representative to the invitation and attendance of the meeting in the electronic record. The Assistant Director of Nursing and/or MDS nurse will address all concerns identified during the audit to include re-scheduling the care plan meeting if indicated and re-training of staff. The Administrator and/or DON will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Director of Nursing will forward the Care Plan Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 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	F 690		8/12/24

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F 690	Continued From page 4 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 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 physician interviews the facility failed to ensure an indwelling urinary catheter drainage bag did not rest on the floor. This was for 1 of 2 residents (Resident #51) whose indwelling urinary catheters were reviewed. This placed Resident #51 at increased risk for infection of the urinary system. Findings included: Resident #51 was admitted to the facility on	F 690	F690 483.25 Bowel/Bladder Incontinence, Catheter, UTI On 7/25/2024 resident #51 Catheter bag was repositioned by nurse #1 so that catheter bag was not positioned or touching the floor. On 8/5/24, the ADON initiated an audit of all residents to include resident # 51 with catheter bags to ensure no catheter bag was positioned on or touching the floor. All	

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6/6/24 with a diagnosis of chronic obstructive uropathy (a condition in which the flow of urine is blocked).

A review of Resident #51's care plan revealed in part a focus area initiated on 6/6/24 for altered pattern of urinary elimination with indwelling urinary catheter at risk for infection. The goal was for Resident #51 to be free from urinary tract infection through the next review. An intervention was to observe for signs and symptoms of urinary tract infection.

A review of his admission Minimum Data Set (MDS) assessment dated 6/12/24 revealed he was moderately cognitively impaired. Resident #51 required maximal assistance with toileting hygiene. He had an indwelling bladder catheter. He received antibiotic medication during the look-back period of the assessment.

On 7/25/24 at 10:38 AM a continuous observation of bathing activity was conducted for Resident #51. Resident #51's urinary catheter bag was observed to have a privacy cover in place. His bed was observed to be in a low position, with approximately one half of his urinary catheter drainage bag resting on the floor at the beginning of the activity. Nurse Aide (NA) #1 was observed to raise Resident #51's bed for the bathing activity, which raised his urinary catheter bag up off of the floor. At 11:12 AM, upon completion of Resident #51's bathing activity, NA #1 was observed to lower Resident #51's bed back down to a low position. This resulted in approximately one half of Resident #51's urinary catheter drainage bag coming to rest on the floor. In an interview with NA #1 at that time she stated because Resident #51's bed was in a low position

F 690

areas of concern were immediately corrected during the audit by the ADON to include repositioning the catheter bag, so it was not positioned on or touching the floor and the education of staff. There were no identified areas of concern.

On 8/5/24, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants (NA) to include regarding Positioning of Catheter Bags to include Foley catheter bags are not to be positioned on or touching the floor. If a resident□s bed must be in the lowest position possible then the catheter bag should be placed inside a black catheter sleeve to decrease the risk of infection. Attach the catheter bag to the foot of the bed and elevate the foot of the bed to a height so that the catheter bag is not positioned on or touching the floor. The in-service will be completed by 8/12/24. After 8/12/24, any nurse or nursing assistant who has not worked or completed the in-service will complete it upon the next scheduled work shift. All newly hired nurses and NAs will be in-serviced regarding Positioning of Catheter Bags during orientation by the Staff Development Coordinator.

The Staff Development Coordinator and the Unit Managers will audit of all residents with catheter bags to include resident # 51 utilizing the Catheter Bag Audit Tool 3 times a week x 4 week, then monthly x 1 month to ensure catheter bags are not positioned on or touching the floor. The Staff Development Coordinator

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his urinary catheter drainage bag would rest on the floor. NA #1 was then observed to leave Resident #51's room, and report to Medication Aide (MA) #1, who was standing outside Resident #51's room, that Resident #51 requested medication for pain. At 11:20 AM, MA #1 was observed to enter Resident #51's room to administer his medication, and as she left Resident #51's room, her left foot was observed to brush Resident #51's urinary catheter drainage bag which remained with approximately one half of the bag resting on the floor.

On 7/25/24 at 11:27 AM an interview with MA #1 indicated she had not noticed Resident #51's catheter bag when she administered his medication.

On 7/25/24 at 11:28 AM an observation of Resident #51's urinary catheter bag resting on the floor was conducted with Nurse #1. An interview with Nurse #1 at that time indicated although she was the nurse supervising MA #1, she had not provided any care to Resident #51 that day. She stated Resident #51's urinary catheter drainage bag was definitely resting on the floor, and it should not be. Nurse #1 was observed to raise the knee height of Resident #51's bed, which resulted in Resident #51's urinary catheter bag being positioned up off of the floor.

On 7/25/24 at 11:30 AM a follow-up interview with NA #1 indicated she thought that because Resident #51's catheter bag had a cover on it, it was okay for it to rest on the floor.

On 7/25/24 at 3:31 PM an interview with the Infection Preventionist (IP) indicated urinary catheter drainage bags should never rest on the

F 690

and Unit Managers will immediately correct during audit any identified areas of concern to include repositioning of catheter bag, so it is not positioned on or touching the floor and/or re-training of staff. The DON will review the Catheter Bag Audit Tool 3 times a week x 4 week, then monthly x 1 month to ensure all areas of concern have been addressed.

The DON will forward the results of Catheter Bag Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

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F 690	Continued From page 7 floor no matter what position a resident's bed was in. She stated this was an infection control concern which could put the resident at increased risk for urinary infection. In an interview on 7/25/24 at 3:34 PM the Director of Nursing stated resident's urinary catheter drainage bags should never be in contact with the floor. She stated this was an infection control concern. On 7/25/24 at 4:24 PM a telephone interview with Physician #1 indicated he did not feel Resident #51 experienced any ill effects or urinary tract infection as a result of his urinary catheter drainage bag resting on the floor. In an interview on 7/25/24 at 4:34 PM the Administrator stated for infection control purposes, resident's urinary catheter bags should never be resting on the floor.	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 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	F 761		8/12/24

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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 secure resident medications stored in an unattended medication cart (400 hall) for 1 of 5 medication carts.

A continuous observation was conducted of the Wing D medication cart on 7/25/24 from 4:27 PM until 4:32 PM. The cart was parked midway down the hall near room 406, facing out. The cart was visible from the nurse's station; however, no staff were at the station at that time. The medication cart was observed to have the red dot on the push lock was visible, which meant the push lock was not engaged. There was no staff member with the medication cart. Two Nurse Aide's, one cognitively intact resident, and 2 visitors were observed walking past the unlocked medication cart. Medication Aide #1 came out of resident room number 409 which was approximately 2 doors down the hall on the opposite side. He returned to the medication cart at 4:32 PM. Medication Aide #1 opened the top drawer without having to unlock the cart. During an interview with Medication Aide #1 at 4:32 PM he stated he left the medication cart unlocked. He further stated the cart should be locked any time

F 761

F761 Label/Store Drugs and Biologicals

On 7/25/2024, the DON immediately educated medication aide #1 regarding locking the medication cart when not in direct supervision. The medication cart was locked and secured per facility protocol.

On 8/5/2024, the ADON initiated an audit of all medication carts to include the medication cart 400 hall. The audit is to ensure the medication cart is locked when not under the direct supervision of the nurse or medication aide. All identified areas of concern were addressed by the ADON during the audit to include securing medications per facility protocol and education of staff.

On 8/5/24, the Staff Development Coordinator initiated an in-service with all nurses and medication aides to include medication aide # 1 regarding Medication Storage with emphasis on storage of

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he was not using it.

An interview with the Director of Nursing (DON) on 7/25/24 4:45 PM was completed. The DON stated the medication cart should have been secured and locked unless the nurse was present at the cart. The DON further stated the Medication Aide or Nurse assigned to the medication cart was responsible for the cart and ensuring it was secured.

An interview with the Administrator on 7/26/24 at 10:02 AM revealed medication carts should not be unlocked unless the Medication Aide or Nurse was using it. The Administrator stated the Medication Aide or Nurse assigned to that medication cart was responsible for it for their entire shift.

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medication/securing medication cart when not directly supervised by assigned nurse or medication aide. In-service will be completed by 8/12/24. After 8/12/24, any nurse or medication aide who has not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses and medication aides will be in-service by the Staff Development Coordinator during orientation regarding Medication Storage.

The Unit Managers, Staff Development Coordinator and/or Assistant Director of Nursing will audit all medication carts 3 times a week x 4 weeks then monthly x 1 month utilizing the Medication Cart Audit Tool. This audit is to ensure that all carts were locked when not directly supervised by the assigned nurse or medication aide. The medication cart will be immediately secured and the nurse and/or medication aides will be re-trained by the Unit Managers, Staff Development Coordinator and/or Assistant Director of Nursing for any identified areas of concern. The DON will review the Medication Cart Audit Tool for completion and to ensure all areas of concerns are addressed 3 times a week x 4 weeks then then monthly X 1 month.

The Director of Nursing will forward the results of the Medication Cart Audit Tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or

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F 761	Continued From page 10	F 761	frequency of monitoring.	
F 812 SS=E	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 and staff interviews the facility failed to discard thickened beverages by the manufacturer's use by date and failed to prevent the potential for cross-contamination by storing a plastic scoop inside the dry ingredient bin allowing the handle to touch the dry ingredient for 1 of 1 kitchen observation. Findings included: 1. During observation on 7/23/24 at 10:14 AM 43 cartons of thickened orange juice with a use by date of 6/12/24 were observed in the kitchen's dry	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary On 7/23/2024, the Dietary Manager removed all expired thicken liquids. On 7/23/2024, the sugar scoop was removed from the container of sugar, cleaned, and stored appropriately per facility protocol. On 7/23/2024, the Assistant Dietary Manager educated all dietary staff	8/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING ______ B. WING ______	C 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	**250 LOVERS LANE WASHINGTON, NC 27889**

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F 812	Continued From page 11 storage available for resident use. During an interview on 7/23/24 at 10:15 AM the Assistant Dietary Manager stated the 43 thickened orange juice cartons were expired. She stated they were stored in the dry storage and were available for use and there were residents on thickened liquid diets currently in the facility. She concluded the thickened orange juice should have been discarded before now as they were expired and should not have been on the shelf available for residents. During an interview on 7/25/24 at 8:05 AM the Administrator stated food item stock should be rotated and outdated foods should be discarded. 2. During observation on 7/23/24 at 10:20 AM the scoop for the dry sugar ingredient bin was observed stored in the in the dry sugar ingredient bin and the handle was in contact with the sugar. During an interview on 7/23/24 at 10:22 AM the Assistant Dietary Manager stated for cross contamination reasons with the scoop's handle, the scoop should not be stored in the dry sugar ingredient bin. It should be stored outside the dry sugar ingredient bin on the dry rack so the handle could not come in contact with the sugar. During an interview on 7/25/24 at 8:05 AM the Administrator stated the scoop for the dry sugar ingredient bin should not have been stored inside the dry sugar ingredient bin.	F 812	currently working regarding (1) storage of scoops with emphasis on not placing scoops in containers and (2) rotating stock to ensure items are used prior to expiration dates and process for checking/removing items when outdated. On 7/23/2024, an audit of all thicken liquids was completed by the Dietary Manager under the oversight of the Dietary Consultant to ensure all no expired thicken liquids. There were no additional identified concerns during the audit. On 7/23/2024, the Assistant Dietary Manager under the supervision of the Dietary Consultant completed an audit of all scoops to ensure scoops were stored appropriately and not left inside containers. There were no additional concerns identified during the audit. On 7/23/2024 an in-service was initiated by the Dietary Consultant with all dietary staff regarding (1) Label/Dating and Expired Foods with emphasis on removing and discarding items per facility protocol when out of date/expired and (2) Storage of Scoops with emphasis on not storing scoops inside containers. The in-services will be completed by 8/12/24. After 8/12/24, any dietary staff who have not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired dietary staff will be in-service during orientation by the Dietary Manager.	

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F 812	Continued From page 12	F 812	The Dietary Manager and/or Assistant Dietary Manager will complete kitchen observations of thicken liquids and storage of scoops 2 times a week x 4 weeks then monthly x 1 month utilizing the Kitchen Audit Tool. This audit is to ensure all thicken liquids were used by the expiration date and/or discarded per facility protocol and that no scoops were stored inside containers. The Dietary Manager and/or Assistant Dietary Manager will address all concerns identified during the audit to include removing and discarding out-of-date items, proper storage of scoops when indicated and re-training of staff. The Administrator will review the Kitchen Audit Tool twice weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Dietary Manager will present the findings of the Kitchen Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	