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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 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 [DATE] 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) 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. 37468 2. Resident #24 was admitted to the facility on [DATE]. Review of Resident #24's Minimum Data Set assessment dated [DATE] revealed he was assessed as moderately cognitively impaired (Brief Interview for Mental Status score of 11). (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 schedule. She concluded care plans should be reviewed and updated quarterly.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 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 [DATE] 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 [DATE] 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 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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 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 [ROOM NUMBER], 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 [ROOM NUMBER] 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 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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 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 [DATE] at 10:14 AM 43 cartons of thickened orange juice with a use by date of [DATE] were observed in the kitchen's dry storage available for resident use. During an interview on [DATE] 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 [DATE] at 8:05 AM the Administrator stated food item stock should be rotated and outdated foods should be discarded. 2. During observation on [DATE] 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 [DATE] 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 [DATE] 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.