STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	**225 WHITE STREET JACKSONVILLE, NC 28546**

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E 000	Initial Comments An unannounced Recertification survey was conducted on 09/16/19 through 09/20/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M1OT11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/16/19 through 09/20/19. Event ID#M1OT11. [X] 1 of the 26 complaint allegations were substantiated resulting in deficiency.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		10/18/19

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

Electronically Signed | 10/13/2019

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F 585	Continued From page 1 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being	F 585		

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F 585	Continued From page 2 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide written responses to grievances for 2 (Resident #402 and Resident #403) of 2 residents reviewed for grievances. Findings included:	F 585	Premier Nursing and Rehabilitation Center Acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable	

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F 585	Continued From page 3 1. Record review revealed Resident #402 was admitted 01/15/2019 with diagnoses which included adult failure to thrive, Parkinson's Disease, and dementia. Resident #402 was no longer residing in the facility at the time of the survey. Review of the quarterly Minimum Data Set (MDS) dated 04/27/19 indicated Resident #402 was rarely/never understood and required total care for all her activities of daily living (ADLs). Record review of grievances indicated Resident #402's family member filed a written grievance on 05/01/19. The grievance was investigated by the Director of Nursing (DON) on 05/01/2019. The grievance form listed the grievance as resolved on 05/07/2019 and indicated the investigation findings were reported to the family member on 05/07/19. The documentation revealed the grievance was completed by the Administrator who was listed as the facility's Grievance Officer. The family concern/grievance form noted the family was given a response in person. The method of "in writing" was not checked on the form. There was no evidence of a written response/summary provided to the family member who filed the grievance. Record review of grievances indicated Resident #402's family member filed a written grievance on 05/14/2019. The grievance was investigated by the Director of Nursing (DON) on 05/14/2019. The grievance form listed the grievance as resolved on 05/15/2019 and indicated the investigation findings were reported to the family member on 05/15/19. The documentation revealed the grievance was completed by the Administrator who was listed as the facility's	F 585	rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Premier Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote Agreement with the Statement of Deficiencies nor does it constitute an Admission that any deficiency is accurate. Further, Premier Nursing and Rehabilitation Center reserves the right to Refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal Procedure and/or any other administrative or legal proceeding. Resident # 402 and resident # 403 no longer at facility. 100% of all alert and oriented residents were interviewed by the Social Workers (SW) utilizing a resident questionnaire regarding: Do you know to whom you should voice concerns? If no, resident educated on grievance process. Do you feel like recent concerns voiced have been address? To be completed by 10/11/19. A resident council meeting will be conducted on 10/15/19 by the Activity Director with all alert residents to include discussion of the grievance process and resident rights. Any alert and oriented resident who does not attend the Social	

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F 585	Continued From page 4 Grievance Officer. The family concern/grievance form noted the family was given a response in person. The method of "in writing" was not checked on the form. There was no evidence of a written response/summary provided to the family member who filed the grievance. An interview was conducted with the Administrator on 9/18/2019 at 5:15 PM. The Administrator revealed the grievances were resolved and indicated the investigation findings were reported to the family member verbally, but no written summary/documentation had been provided. The Administrator stated there was not a copy of a written response attached to the grievance, and there was no written notification of the resolution provided to the person who filed the grievance. The Administrator revealed it had been brought to her attention by her corporate official that there needed to be written documentation to the family member who initiated the grievance. The Administrator stated she had started to in-service her staff on the morning the survey began, and she need to provide a written response to the person who filed the grievance. In an interview on 9/19/2019 at 4:01 PM, the Administrator stated her expectation was a written copy of the grievance summary response upon resolution of the grievance be provided to the person who filed the grievance and that the quality assurance and performance improvement be completed for grievance summaries. 2. Record review revealed Resident #403 was admitted 04/23/2019 with diagnoses which included sepsis, diabetes, hypertension and urinary tract infection. Resident #403 was no	F 585	Worker will do an in room discussion of the grievance process and resident rights. On 9/17/2019 an in-service was completed by the Corporate Clinical Director with the Administrator regarding the grievance process to include investigation process and PROVIDING written responses. On 9/20/2019 an in-service was completed by the Administrator with the Director of Nursing (DON), Social Workers (SW) and Activities Director on the grievance process to include investigation process and interventions. All resident concerns will be brought to the morning cardinal IDT meeting by the Social Worker for review from the Cardinal IDT team utilizing the Concern Audit tool 5x per week x 4 weeks and then weekly x 2 months to ensure that all grievances have been written, followed up timely, investigation completed and a written response has been provided to resident or resident representative. The Administrator will review and initial the Concern audit tool weekly x 3 months to ensure completion and that grievances have been addressed, to include the written responses provided to resident and/ or resident representative. The Administrator will forward the results of the Concern Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the Concern	

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F 585	Continued From page 5 longer residing in the facility at the time of the survey. Review of the admission Minimum Data Set (MDS) dated 04/30/19 indicated Resident #403 was severely cognitively impaired and required limited assistance for bed mobility and locomotion. He required extensive assistance for transfers, dressing, toilet use, personal hygiene, and bathing. Record review of grievances indicated Resident #403's family member filed a written grievance on 04/29/19. The grievance was investigated by the Director of Nursing (DON) on 04/29/2019. The grievance form listed no date of resolution for the grievance. The investigation findings were verbally reported to the family member filing the grievance. There was no evidence of a written response/summary provided to the family member who filed the grievance. An interview was conducted with the Administrator on 9/18/2019 at 5:15 PM. The Administrator revealed the grievances were resolved and indicated the investigation findings were reported to the family member verbally, but no written summary/documentation had been provided. The Administrator stated there was not a copy of a written response attached to the grievance, and there was no written notification of the resolution provided to the person who filed the grievance. The Administrator revealed it had been brought to her attention by her corporate official that there needed to be written documentation to the family member who initiated the grievance. The Administrator stated she had started to in-service her staff on the morning the survey began, and she need to provide a written	F 585	Audit Tool 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 585	Continued From page 6 response to the person who filed the grievance. In an interview on 9/19/2019 at 4:01 PM, the Administrator stated her expectation was a written copy of the grievance summary response upon resolution of the grievance be provided to the person who filed the grievance and that the quality assurance and performance improvement be completed for documentation of grievance summaries.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS, a tool used for resident assessment) for 4 of 30 resident assessments reviewed (Resident #117, Resident #154, Resident #48 and Resident #126). Findings included: 1. Resident #117 was admitted to the facility on 11/1/2011 with diagnoses which included depression, hyperlipidemia and Hypertension. A review of Resident #117's MDS dated 8/19/2019 was coded as a quarterly assessment. The MDS assessment was incorrectly coded for the resident taking Antianxiety medication instead of Hypnotic medication. The MDS revealed Resident # 117 had no anxiety diagnosis but was taking Valium medication for sleeplessness.	F 641	The Minimum Data Set (MDS) assessment for resident #117 was modified by the MDS nurse on 9/20/19 for the use of Valium as a hypnotic. The Minimum Data Set (MDS) assessment for resident #48 was modified by the MDS nurse on 9/18/2019 with the correct PASSR the information. The Minimum Data Set (MDS) assessment for resident #154 was modified by the MDS nurse on 9/20/2019 to reflect correct discharge status. The Minimum Data Set (MDS) assessment for resident #126 MDS was modified by the MDS nurse on 10/9/2019 to reflect the resident psychoactive diagnosis of anxiety and depression. 100% audit of all current resident most current MDS assessment was initiated on 9/25/19 by the Director of Nursing (DON)	10/18/19

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F 641	Continued From page 7 A review of Resident #117's MDS dated 8/19/2019 revealed the resident had received Antianxiety 7 out of 7 days of the assessment period. There was no diagnosis of anxiety coded on the MDS. On 9/18/2019 at 1:29 PM, the MDS Nurse was interviewed. She acknowledged that Resident # 117 was on Valium medication for sleeplessness and the hypnotic medication should have been coded on the MDS instead of Antianxiety. She added that the MDS nurse who inaccurately coded the MDS was on leave, but she was going to make the adjustment immediately. During an interview on 9/19/2019 at 1:30pm with the DON (Director of Nursing), she indicated that Hypnotic should have been coded for valium medication instead of Antianxiety. DON reported the MDS should have been coded accurately on Resident # 117's MDS dated 8/19/2019. During Further interview with DON, she stated that it is her expectation that if a resident was receiving Hypnotic medications, the correct diagnosis should have been accurately coded. 2. Resident #154 was admitted to the facility on 6/5/2019 with diagnosis that included acute kidney failure, anemia, diabetes, hyperlipidemia and hemiplegia. Review of the discharge Minimum Data Set (MDS) dated 6/25/2019 indicated Resident #154 was discharged to the acute hospital. Review of the nurse note dated 6/25/2019 indicated Resident #154 was discharged home with home health services not acute hospital.	F 641	utilizing a MDS Accuracy Audit tool to ensure all completed MDS□s were accurately coded to include psychoactive medication and diagnosis, correct PASSAR level information and correct discharge status. Any identified areas of concerns were corrected to include modifications by the MDS Nurses during the audit. Audit completed on 10/8/19. On 10/10/2019 an in-service was completed by the Facility MDS consultant with the MDS Nurses in regards to accurately coding the MDS, to include psychotropic medications, diagnosis for psychotropic medication use, PASSR level II and discharge status. 10% of completed MDS□s, will be reviewed by the Assistant DON and or the Registered Nurse (RN) supervisors to ensure all MDS□s are accurately coded to include psychoactive medication and diagnosis, correct PASSAR level and discharge status utilizing an MDS Accuracy QA Tool weekly for 8 weeks and monthly X 1 month. Any identified areas of concern will be immediately addressed by the ADON and/or the RN Supervisor to include additional training and modifications to assessment as indicated. The DON will review and initial the MDS Accuracy QA Tool weekly for 8 weeks and then monthly for 1 month for accuracy and to ensure all areas of concerns have been addressed. The Administrator will forward the results of the MDS Accuracy QA Tool to the	

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F 641	Continued From page 8 During the interview on 9/18/2019 at 1:29 PM, Minimum Data set (MDS) nurse reviewed the discharge MDS and confirmed it was inaccurate. The MDS nurse explained it was coded in error as Resident # 154 was discharged home not to acute hospital. During an interview on 9/19/2019 at 1:30pm with the DON (Director of Nursing), she indicated that discharge to the community should have been coded on Resident # 154's MDS dated 6/25/2019. During Further interview with DON, she stated that it is her expectation that the MDS should be coded accurately. 3. Resident #48 was admitted to the facility on 10/04/18 and most recently readmitted on 01/12/19 with multiple diagnoses that included major depressive disorder, migraine, post-traumatic stress disorder, obsessive compulsive personality disorder, attention-deficit hyperactivity disorder, bipolar disorder, psychosis, and anxiety disorder. The resident's medical record contained a Preadmission Screening Resident Review (PASARR) Level II Determination Notification that was dated 03/27/19 with no end date. The Significant Change Minimum Data Set dated 01/19/19 indicated a "No" to question A1500 which asked if Resident #48 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or intellectual disability or a related condition.	F 641	Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the MDS Accuracy QA Tool 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 641	Continued From page 9	F 641		

Interview with MDS Nurse #1 on 09/18/19 at 5:05 PM revealed Section A1500 was miscoded on the Significant Change MDS dated 01/19/19. The MDS Nurse #1 revealed the Section A1500 should have been coded as "Yes".

Interview with the Administrator on 09/18/19 at 5:15 PM revealed her expectation is that all MDS documentation be coded correctly.

4. Resident #126 was admitted to the facility on 8/20/19 with diagnoses including Depression and Anxiety.

The admission MDS assessment dated 8/27/19 coded Resident #126 as being cognitively impaired and required extensive assistance for activities of daily living (ADL). The MDS did not specify the resident had diagnoses including Anxiety and Depression on the MDS.

During an interview with the Director of Nursing (DON) on 9/20/19 at 1:42 P.M., the DON stated Resident #126 was diagnosed with Anxiety and Depression and expected the staff to correctly code the MDS to accurately reflect the resident's diagnoses reflect the accurate diagnoses.

During an interview with the MDS Nurse #1 on 9/20/19 at 3:32 P.M., MDS Nurse #1 stated she was responsible for the accurate coding of a resident's diagnoses on the MDS assessments and the MDS assessments will be rechecked to assure the correct coding has been inputted in the system.

During an interview with the Administrator on

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F 641	Continued From page 10 9/20/19 at 3:57 P.M., the Administrator stated there were issues with the coding of the MDS assessments and they should be coded accurately.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to make a referral for re-evaluation after a change in mental health status for 1 of 4 residents (Resident #43) reviewed for Pre-Admission Screening and Resident Review. Findings Included: Resident #43 was admitted to the facility on 12/01/15 with diagnoses which included, in part,	F 644	On 9/20/2019 resident # 43 PASRR information was re-submitted by the Social Work Director due addition of qualifying diagnosis of major depressive disorder, anxiety disorder and psychosis. A 100% audit of all residents diagnosis to include major depressive disorder, anxiety disorder and psychosis was initiated on 9/20/2019 by the Social Work	10/18/19

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F 644	Continued From page 11 hypertension, diabetes mellitus and cerebral infarction without residual deficits. A record review revealed Resident #43 had a negative Level I Pre-Admission Screening and Resident Review (PASRR) completed prior to admission to the facility which indicated a negative PASRR screening. Resident #43's annual Minimum Data Set (MDS) dated 10/12/19 revealed Resident #43 to be severely cognitively impaired. The MDS indicated Resident #43 was not considered to have serious mental illness and/or intellectual disability. The MDS indicated Resident #43 had diagnoses which included non-Alzheimer's dementia, anxiety disorder, depression and psychotic disorder A review of Resident #43's diagnoses revealed the diagnosis of major depressive disorder had been added to her medical record on 12/23/15 and the diagnoses of anxiety disorder and psychosis had been added to her medical record on 03/09/16. During an interview with the Social Worker (SW) on 09/18/19 at 9:18 a.m., the SW stated she had recently taken over the tasks for PASRR in the facility and had been unable to answer why Resident #43 had not been referred for a re-evaluation after she had a change in her mental health status. During an interview with Facility Consultant (FC) on 09/18/19 at 2:40 p.m., the FC stated the people in the facility who were responsible for doing the PASRR's did not realize if a resident came in without mental health diagnoses and later received a mental health diagnosis, they had	F 644	Director utilizing a resident census to determine the need for re-submission of PASRR information. All identified issues were corrected during the audit by the Social Work Director to include re-submission of PASRR information as indicated. Audit was completed by 10/10/19. On 9/20/2019 an in-service was completed by the Administrator with the social work director, facility social worker, admissions coordinator, Accounts Receivable (AR) Bookkeeper and AR Bookkeeper# 2 in regards to the requirements for PASARR screening prior to admission and upon receipt of qualifying diagnosis during resident stay by the Administrator. 10 % of all new physician orders will be reviewed by the Social Work director to ensure new PASRR qualifying diagnosis to include major depressive disorder, anxiety disorder and psychosis are identified for re-submission to PASRR utilizing a PASRR Audit tool 5 X a week X 8 weeks and then monthly X 1 month. Any identified areas of concerns will be completed by the Social work director during the audit to include re-submission to PASRR. The Administrator will review and initial the PASRR Audit Tool weekly for 8 weeks and monthly for 1 month to ensure that all areas of concern have been addressed. The Administrator will forward the results of the PASRR Audit Tool to the Executive QA Committee monthly x 3 months. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 09/20/2019

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PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

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F 644	Continued From page 12 to submit a new application for PASRR Level 2. During an interview with the Administrator on 09/19/19 at 11:39 a.m., the Administrator stated she had not been aware of any issues with the PASRR's until this had been brought to her attention during this survey. The Administrator stated it was her expectation staff will have residents re-screened with receipt of new mental health diagnoses.	F 644	Executive QA Committee will meet monthly x 3 months to review the PASRR Audit Tool 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 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		10/18/19

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	345217	A. BUILDING _____ B. WING _____	C 09/20/2019

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F 645	Continued From page 13	F 645		

the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as

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	345217	A. BUILDING _____ B. WING _____	C 09/20/2019

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F 645	Continued From page 14 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to apply for a level II (Preadmission Screening and Resident Review)PASRR screening for 2 of 5 residents reviewed for PASRR II screenings (Resident# 135 and # 69). Findings included: A review of the medical record revealed Resident # 135 was admitted to the facility on 10/15/2019 with diagnoses including, Bipolar disorder, major depressive disorder, and schizophrenia. The Significant change Minimum Data Set (MDS) dated 8/22/2019 noted Resident # 135 to be cognitively intact and needed extensive assistance with bed mobility and total dependent on staff for transfer with the help of two person. The MDS noted Resident # 135 was taking antipsychotic and antidepressant medication. MDS did not code screening for a PASRR level II. On 9/18/2019 at 10:10 AM the Social Worker (SW)was interviewed and stated she did not have a reason for not completing the PASRR II screening for Resident # 135. SW further indicated moving forward she will make sure all residents during admissions will be screened for a PASRR level II. In an interview on 9/19/2019 at 1:30 PM, the Administrator stated her expectation was any resident who needs to be screened for a PASRR level II will have that application completed appropriately. 2. Resident #69 was admitted to the facility on	F 645	On 9/20/2019 residents #135 and resident #69 information was re-submitted by the Social Work Director for PASARR re-evaluation. A 100% audit of all residents diagnosis was initiated on 9/20/2019 by the Social Work Director utilizing a resident census to determine the need for re-submission of PASRR information. All identified issues were corrected during the audit by the Social Work Director to include re-submission of PASRR information as appropriate. Audit was completed by 10/10/19. On 9/20/2019 an in-service was completed by the Administrator with the Social work director, facility social worker, admissions coordinator, Accounts Receivable (AR) Bookkeeper and AR Bookkeeper # 2 in regards to the requirements for PASRR screening prior to admission and upon admission. All new admissions will be reviewed by facility admissions director prior to and upon admission or re-admission to ensure a PASARR present upon admission, and that the level of PASRR is appropriate for the diagnosis present utilizing a PASRR Audit Tool weekly X 8 weeks and monthly X 1 month. Any identified areas of concerns will be addressed during the audit by the facility social worker to include re-submission of PASRR	

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	345217	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 645	Continued From page 15 11/30/16 with diagnosis of Dementia. Review of Resident #69's Annual Minimum Data Set (MDS) assessment dated 12/09/2018 indicated that the resident cognition was intact. Section A (A1500 - PASRR) was coded no for being evaluated by level II PASRR (Preadmission Screening and Resident Review). Section I, had Resident #69 coded with a diagnosis of a dementia, depression and post traumatic distress disorder. The resident was coded as having had received antidepressant medication for 7 of the 7 days during the assessment period. Review of Resident #69's care plan which was revised on 08/20/19 indicated that the resident was care planned for psychotropic drug use due to diagnoses of PTSD and major depressive disorder. An interview with the Social Worker on 9/18/19 at 10:00 am stated she was not aware when a resident is later diagnosed with additional mental health diagnoses that the resident must be re-evaluated for PASRR level II. The Social Worker further stated moving forward she will make sure all residents that receive a new mental health diagnosis(es) be screened for a PASRR level II. An interview with the facility consultant nurse on 09/18/19 at 2:40 pm stated the facility staff responsible for completing the doing the PASRR did not realize if the resident comes in without mental health diagnoses and later receives a mental health diagnosis(es) they must submit a new application for PASRR level II. The facility consultant nurse further stated that the MDS Nurse responsible for Resident #69 MDS	F 645	information as appropriate. The Administrator will review and initial the PASARR Audit Tool weekly for 8 weeks and monthly for 1 month to ensure that all areas of concern have been addressed. The Administrator will forward the results of the PASRR Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the PASRR Audit Tool 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 645	Continued From page 16 assessments was out on family medical leave. An interview with administrator on 9/19/19 at 11:39 am stated that she had not been aware of any issues with PASRR until this had been brought to her attention this week. The administrator further stated it was her expectation that staff will re-screen residents when they receive new mental health diagnoses.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		10/18/19

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F 656	Continued From page 17 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a plan of care with measurable objectives and timetables to address Psychotropic medications for 2 of 5 sampled residents. (Resident # 117 and Resident #126). Findings included: 1. Resident #117 was admitted to the facility on 11/1/2011 with diagnoses which included depression, hyperlipidemia and Hypertension. A review of Resident #117's MDS dated 8/19/2019 was coded as a quarterly assessment. The MDS assessment was coded for the resident taking antidepressant medication, Hypnotic medication which was coded as Antianxiety medication. The resident's cognition was intact. A review of Resident #117's MDS dated 8/19/2019 revealed the resident had received Antianxiety medication 7 out of 7 days of the assessment period and received antidepressant	F 656	On 9/20/2019 the care plans for residents #117 and #126 were updated by the Minimum Date Set (MDS) to identify measurable objectives to address psychotropic medications. 100% audit of all current residents care plans was initiated on 9/25/19 by the Director of Nursing (DON) to include residents #117 and #126, to ensure the care plan addressed measurable objectives to address psychotropic medication use. Any identified areas of concerns will be corrected by the DON and/or the MDS nurses during the audit. Audit completed on 10/2/19. On 10/10/2019 an in-service was completed by the facility MDS Consultant with the MDS nurses and Social workers in regards to Developing and Implementing a Comprehensive care plan to include addressing measureable	

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	345217	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 18 medication 7 out of 7 days of the assessment period. A record review of Resident # 117's care plan revealed there was no plan of care in place for the psychotropic medications. An interview was conducted with the MDS/Care Plan Nurse on 9/19/2019 at 2:30 pm. The MDS nurse stated the facility developed a care plan for every Psychotropic medication. The MDS nurse confirmed there was no care plan in place for psychotropic medication for Resident # 117 and there should be one. The MDS nurse stated it was an over sight that a care plan was not implemented for the Psychotropic medications for Resident # 117. An interview with the Director of Nursing (DON) on 9/19/2019 at 4:05 pm revealed her expectation was that the care plans should reflect the care that was being provided for the resident. 2. Resident #126 was admitted to the facility on 8/20/19 with diagnoses including Depression and Anxiety. The care plan dated 8/21/19 had a focus on the use of psychotropic drugs with the potential for or characterized by side effects of cardiac, neuromuscular, gastrointestinal systems as evidenced by (AEB): anti-depressant. There was not a plan of care for the diagnosis of Anxiety and the use of the Antipsychotic medication Risperdal (an antipsychotic medication used to treat anxiety).	F 656	objectives for psychotropic medications use. 10% of residents care plans, to include residents #117 and #126 will be reviewed to ensure the care plan addressed measureable objectives foe psychotropic medication use utilizing a Care plan audit tool by the Registered Nurse (RN) Supervisor, Staff Facilitator and/or Quality Assurance nurses weekly X 8 weeks then monthly X 1 month. Any identified areas of concerns will be corrected during the audit by the Registered Nurse (RN) Supervisor, Staff Facilitator and/or Quality Assurance nurses to include updating the care plan and re-education as appropriate. The DON will review and initial the Care Plan audit tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the Care Plan Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the Care Plan Audit Tool 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 19 The admission Minimum Data Set (MDS) assessment dated 8/27/19 coded Resident #126 as being cognitively impaired and required extensive assistance for activities of daily living (ADL). The MDS coded a diagnosis of Anxiety and a use of an antipsychotic during the 7-day look back period. The Medication Administration Record (MAR) dated August 2019 indicated Risperdal 1 milligram (mg) tablet to take by mouth twice daily for anxiety. It had been noted as administered daily from 8/21 to 8/31/19. During an interview with the Director of Nursing (DON) on 9/20/19/ at 1:42 P.M., the DON stated Resident #126 was diagnosed with Anxiety and the MDS Nurses are responsible for developing and completing the care plans and all care areas should be included. During an interview with MDS Nurse #2 on 9/20/19 at 3:40 P.M., MDS Nurse #2 stated he is responsible for the development of the care plan and it was an oversight. During an interview with the Administrator on 9/20/19 at P.M., the Administrator stated the MDS Nurses are responsible for the completion of the care plans and the care plans should include all care areas.	F 656		
F 657 SS=D	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	F 657		10/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 20 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 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 and staff interview the facility failed to revise a comprehensive care plan for a resident who attempted to elope for 1 of 1 sampled residents reviewed for wandering (Resident #39). Findings included: Resident # 39 was admitted on 5/26/2019 with diagnoses of dementia, bradycardia, chronic congestive heart failure, repeated falls, major depressive disorder, mental, Anemia, heart failure, hypertension, neurogenic bladder, non-Alzheimer's dementia, seizure disorder, anxiety	F 657	On 10/7/2019 resident # 39□s care plan was revised by the Director of Nursing (DON) to include the attempted unsupervised exit. On 9/25/2019 a 100% audit was initiated of all current residents, to include #39 by the DON for residents with care plans for wandering to ensure the care plan addressed at risk for unsupervised exits. Any identified areas of concerns will be corrected by the Minimum Data Set (MDS) nurses during the audit. The audit was completed on 10/2/19.	

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	345217	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 21 disorder and depression. Minimum Data Set (MDS)dated 7/12/2019 indicated the resident's cognition as severely impaired, required extensive assistance with bed mobility, transfer, toileting, dressing and independent with eating. Resident # 39 was care planned for the following: Problematic way resident acts characterized by ineffective coping wandering and /or at risk for unsupervised exits from facility related to: cognitive impairment, physical actions. Interventions included: Allow resident to wander on unit, approach wandering resident in non- threatening manner Review of Resident # 39's care plan dated 3/14/2019 revealed no update of the wander guard placed on the resident after the attempted elopement on 3/14/2019. Further review of the care plan revealed no update with new interventions after Resident # 24's second attempted elopement on 6/22/2019. Review of Resident # 39 Unsupervised Exits dated 3/14/2019 documented the following: At approximately 1:40pm- The receptionist was up at the front door of facility. The receptionist observed a family member leaving the facility and holding the door open for resident. The receptionist noted resident going out the front door. The receptionist went outside with the resident due to resident appeared agitated and the receptionist did not want to increase resident's agitation. The receptionist accompanied the resident to the handicap parking spaces. When the resident calmed down, the resident and receptionist came back in facility. At approximately 1:48 pm- The resident was wheeled to the assigned hall nurse and made	F 657	On 10/10/2019 an in-service was completed by the Facility MDS consultant with the MDS nurses in regards to developing, implementing and revising a comprehensive care plan for residents at risk for an unsupervised exits. 10% of residents care plans, to include resident #39, will be audited to ensure the care plan addressed at risk for unsupervised exits utilizing a Care plan audit tool by the Registered Nurse (RN) Supervisor, the Staff Facilitator and/or Quality Assurance (QA) nurses weekly X 8 weeks then monthly X 1 month. Any identified areas of concerns will be corrected by the MDS nurses during the audit. The DON will review and initial the Care plan audit tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the Care Plan Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the Care Plan Audit Tool 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 09/20/2019

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PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

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F 657	Continued From page 22	F 657		

aware of resident's attempted unsupervised exit. The hall nurse made the attending physician and the resident representative aware of resident's attempted unsupervised exit. The assigned hall Nurse applied a wander guard to the residents left wrist. The resident was re-assessed for being at risk for wandering and the care plan/ care guide was updated. On 3/15/2019- the cardinal interdisciplinary team reviewed the resident's attempted unsupervised exit and agreed with the current intervention.

Review of the unsupervised exits dated 6/22/2019 documented the following approximately 7:30pm- The front door alarm was heard sounding by the Quality Improvement (QI) Nurse. The QI nurse observed the resident with the front wheels of the wheelchair over the threshold and the back wheels in the doorway of the facility. The QI nurse then turned the resident's wheelchair around and brought the resident back from the front door. The resident stated that he was just wanting to get some air. The QI nurse asked the nursing assistant to bring the resident to a hall nurse and make the hall nurse aware that the resident was attempting to get out of the front door. The nurse assessed the resident and kept the resident with her for the rest of the 3-11 shift. At approximately 7:55pm- The resident representative was made aware by the hall nurse of the resident attempting to go out of facility. On 6/24/2019- The cardinal interdisciplinary team reviewed the resident's attempted unsupervised exit. On 6/24/2019- The Quality Improvement nurse initiated an investigation of the resident's unsupervised exit. During the investigation it was found that the resident became agitated after the residents sister left the facility from visiting and the resident

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F 657	Continued From page 23 wanted some air. On 6/24/2019- At approximately 2:58pm- a second wander guard was placed on the resident's wheelchair by the Quality Improvement nurse as well as the wander guard on the resident's left wrist. On 6/24/2019- An in-service was initiated by the Assistant Director of Nursing in regards to notification to the Director of Nursing and Administrator of resident elopements. On 6/30/2019- An in-service was initiated with all staff by the Staff Facilitator in regards to wander guard placement, not escorting residents out of the facility unless approved by hall nurse and checking door alarms. An interview was conducted with the MDS nurse on 9/18/2019 at 3:00 pm. During this interview she stated it was an oversight that the wander guard was not included in the care plan and she was not aware of the resident's second attempted elopement and that was the reason the care plan was not updated. An interview with the Director of Nursing (DON) was conducted on 9/19/2019 at 3:09 pm. The DON stated she expected care plans to be updated for any attempted elopement at the facility.	F 657		
F 689 SS=D	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.	F 689		10/18/19

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F 689	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide supervision to prevent accidents and failed to implement appropriate interventions to prevent further accidents which resulted in multiple falls for 1 of 1 resident (Resident # 39). Findings included: Resident # 39 was admitted on 5/26/2019 with diagnoses of dementia, bradycardia, chronic congestive heart failure, repeated falls, major depressive disorder, mental, Anemia, heart failure, hypertension, neurogenic bladder, non-Alzheimer's dementia, seizure disorder, anxiety disorder and depression. Minimum Data Set (MDS)dated 7/12/2019 indicated the resident's cognition as severely impaired, required extensive assistance with bed mobility, transfer, toileting, dressing and independent with eating. The resident was care planned on 7/12/2019 for actual fall. It indicated "Due to history multiple falls, impulsive behaviors causing falls; risk factors due psychotropic drug use, aging process, moderate cognitive impairment, presence of a Foley catheter, physical limitations/non-ambulatory, weakness, unsteady balance/coordination, limited endurance. Generalized Muscle Weakness, Morbid Obesity, Glaucoma, Debility, Repeated falls, abnormal posture, Unsteadiness on feet, Lack of coordination, Cognitive Communication Deficit, Mixed receptive-expressive language due to Mental Disorder/Intellectual Disabilities/level II PASRR. Mentally is that of a 5-8 year old child per history. Diagnosis of Dementia, Anxiety." The	F 689	On 9/19/2019 the last 30 days of falls were reviewed for resident #39 by the Assistant Director of Nursing (ADON) to ensure that a proper investigation was completed for each incident to include collecting witness statements, physician and resident representative notification, determining a root cause, documentation in the medical records, implementation of appropriate interventions, and care plan updates and was completed on 9/23/19. On 9/19/2019 a 100% audit was initiated by the Director of Nursing (DON), Quality Assurance (QA) Nurses, Unit Managers and Assistant Director of Nursing (ADON) of all incidents reports, to include resident #39, for the last 30 days to ensure that a proper investigation was completed for each incident to include collecting witness statements, physician and resident representative notification, determining a root cause, documentation in the medical records, implementation of appropriate interventions, and care plan updates as appropriate. Any identified areas of concerns were addressed by the QA nurses, the unit manager and the ADON during the audit to include a proper investigation; collecting witness statements, physician and resident representative notification, determining a root cause, documentation in the medical records, implementation of appropriate interventions, and care plan updated as appropriate. This audit was completed on 9/23/19.	

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F 689	Continued From page 25 interventions included "Assist resident to negotiate barriers as necessary. Evaluate effectiveness & side effects of psychotropic drugs with physician for possible decrease/elimination of medication as appropriate. Mattress beside bed when resident is in bed. Non-skid strips beside bed. Provide adequate environmental lighting in resident's surroundings. Explain locations of items in reach as appropriate, has right eye blindness. Wheelchair with Dyce & anti-roll backs when out of bed." Review of the incident report revealed the resident was observed with the following falls without appropriate interventions: 1/4/2019- Resident stood up from wheel chair and fell on the floor- No interventions 1/5/2019- fell out of chair while bending over trying to pick up envelope off the floor. Resident had UTI and was on antibiotics. MD examination and MD medication review completed- No interventions 2/14/2019- fall from the wheelchair. Reinforce to use light- Inappropriate interventions due to resident's cognition 3/18/2019- fall from the wheelchair. Reinforce to lock brakes on when not propelling- inappropriate intervention due to the resident's cognition 5/22/2019- fall from the wheelchair. ER visit and facility MD examination. Heart rate issue. Care plan on 5/26/2019 to offer assistance before meals, before bed, and as needed- Inappropriate intervention due to the resident falling out of the chair.	F 689	On 9/19/2019 a 100% audit was initiated of all resident□s progress notes for the last 30 days, to include resident #39, by the DON to ensure that a proper investigation was completed for each incident to include completion of an incident report, collecting witness statements, physician and resident representative notification, determining a root cause, documentation in the medical records, implementation of appropriate interventions, and care plan updates as appropriate. Any identified areas of concerns were addressed by the DON during the audit. A proper investigation will be initiated by the DON to include completion of an incident report, collecting witness statements, physician and resident representative notification, determining a root cause, documentation in the medical records, implementation of appropriate interventions, and care plan updates as appropriate. The audit was completed on 9/23/19. On 9/18/2019 an in-service was initiated by the Staff Facilitator with all licensed nurses in regards to the completion of an incident report, to include falls. In-service was completed on 9/20/19. On 9/19/2019 an in-service was completed by the Facility consultant with the Administrator, DON, ADON and QA nurses on conducting investigations to include obtaining witness statements, return demonstrations if applicable, timeline of events and determining the root cause for implementation of proper	

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F 689	Continued From page 26 6/11/2019- fall from the wheelchair- No interventions 6/28/2019- fall from chair while trying transfer to bed. Reinforce with nursing assistants to lock the bed 7/11/2019- unobserved from bed. Resident trying to get newspaper off table. Paper provided to resident- Inappropriate intervention. 7/22/2019- assisted fall. Bed brakes not locked, bed moved. Assessed that bed brakes were working when applied. Verbally told CNA to always check breaks. - Inappropriate intervention as NA's failed to lock the bed during another fall. 7/28/2019- unobserved fall from chair. Sent to acute care hospital for evaluation. Recent kappa adjustment. - No intervention. An observation of Resident #39 was conducted on 9/19/2019 at 3:07 PM. The resident was up in the wheelchair next to the nurse's station. No behavioral problems were noted. An interview was conducted on 9/19/2019 at 3:30 PM with the unit Nurse (UN) assigned to the resident. The UN reported she was aware of Resident #39's repeated falls. The UN indicated the falls were reviewed daily by the clinical team and interventions were put into place which were appropriate. The UN further indicated interventions for the resident were not easy due to the fact the resident had decreased safety awareness and attempted to get up independently. An interview was conducted on 9/19/2019 at 3:40	F 689	interventions. 10 % of all incident reports and resident progress notes, to include resident # 39 will be reviewed by the Registered Nurse (RN) supervisor, QA nurses 5x per week x 8 weeks and then weekly x 1 month to ensure all incidents have an incident report completed, investigation, physician and resident representative notification, documentation in the clinical record, and appropriate interventions initiated. This will be documented on the Falls audit tool. The DON will review and initial the Falls audit tool weekly x 3 months. The DON will forward the results of the Falls Audit Tools to the Executive QA Committee monthly x 3 weeks. The Executive QA Committee will meet monthly x 3 months to review the Falls Audit tool 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 689	Continued From page 27 PM with Nursing Assistant (NA) # 2. NA #2 confirmed she was familiar with Resident #39 and worked with her regularly. NA #39 reported the resident tried to get up and would fall often. NA #2 said she checks on the resident at least every hour when she works. An interview was conducted with the Director of Nursing (DON) on 9/19/2019 at 3:50 PM. The DON revealed the clinical team met every day and discussed each fall. The DON indicated the clinical team tried to find appropriate interventions for all falls. The DON reported she was aware of Resident #39's numerous and repeated falls and since the resident was not cognitively able to follow directions the clinical team continues to try different interventions. The DON stated the staff was encouraged to check the resident often. The DON stated the expectation was for fall interventions to be appropriate and individual and for supervision to be provided to prevent accidents.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review of the Facility's Quality Assessment and Assurance Committee (QAA) the facility failed to maintain implemented procedures and monitor interventions that the committee put into place	F 867	The Administrator, DON and QI Nurse were educated by the Facility Consultant on the QA process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA	10/18/19

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F 867	Continued From page 28 following the 08/03/2018 annual recertification survey. This was for one recited deficiency in the areas of Free of accidents Hazards (F 689). This deficiency was cited again on the annual recertification survey on 09/20/2019. This continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA programs. Findings included: This tag is cross referenced to: F- 689-Based on record reviews, observations, family interview, physician interview and staff interviews, the facility failed to attach and tighten the mechanical lift's leg straps around the lower legs per manufacturer's guidelines and failed to implement care plan and care guide interventions indicating use of 2 person assistance while transferring with the use of mechanical lift (sit to stand) and failed to ensure the resident had on non-skid footwear for 1 of 5 sampled residents reviewed for accidents. Resident #37 slipped during a transfer from the mechanical lift which allowed the lift's straps to slip around the resident's neck which caused the resident's face to turn purplish blue in color. Resident #37 was assessed at the facility and found to have no physical injuries. During the recertification survey, the facility was cited for F 689 the facility failed to provide supervision to prevent accidents and failed to implement appropriate interventions to prevent further accidents which resulted in multiple falls for 1 of 1 sampled resident.	F 867	process, modification and correction if needed to prevent the reoccurrence of deficient practice identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program on 10/11/2019. The Director of Nursing completed 100% audit of previous citations and action plans within the past year to include to prevent accidents and to implement appropriate interventions to prevent further accidents to ensure that the QA committee has maintained and monitored interventions that were put into place. Action plans will be revised and updated and presented to the QA Committee by the DON on 10/16/2019 for any concerns identified. All data collected for identified areas of concerns to include implementing appropriate interventions to prevent further accidents will be taken to the Quality Assurance committee for review monthly x 6 months by the Quality Assurance Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the Quality Assurance Nurse. The Facility Consultant will ensure the	

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F 867	Continued From page 29 During an interview with the Administrator on 9/20/2019 at 3:32 PM, the Administrator indicated her expectation for repeat tags was they will re-examine the system to find the root cause of the issue and address it in daily Quality assurance committee meetings.	F 867	facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include implementing appropriate interventions to prevent further accidents, and all current citations and QA plans are followed and maintained Quarterly x 2. The Facility Consultant will immediately retrain the Administrator, DON and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	