STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345072	A. BUILDING ______ B. WING ______	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RIVERS NURSING AND REHABILITATION CENTER	1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 09/23/19 through 09/27/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #MH2E11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/23/19 through 09/27/19. Event ID#MH2E11. [X] 9 of 9 complaint allegations were unsubstantiated .	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their	F 565		10/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/18/2019

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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F 565	Continued From page 1 response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident council group interviews, the facility failed to resolve grievances that were reported in the monthly resident council meetings for 6 of 13 months reviewed (October 2018, November 2018, December 2018, March 2019, August 2019 and September 2019). Findings included: During residents' council meeting on 9/25/2019 at 2:00 PM, it was reported by the residents in the meeting that the grievances were not acted on promptly by the facility and there were no explanations given as to the reason the grievances were not resolved. The assistant resident council president explained that during each meeting the issues from the prior month were discussed by the council members to see if the issues were still a concern. The assistant resident council president reported the Activities Director (AD) documented the issues and discussed the ongoing concerns during each meeting. Several of the members indicated the	F 565	On 10/17/2019 a Resident Council meeting was held by the Administrator to address actions initiated in response to unresolved resident council grievances. On 9/24/2019, 100% of alert and oriented resident interviews were initiated by Social Worker with all alert and oriented residents in regards to are you being offered snacks at night. Any identified areas of concerns were addressed by the Social Worker during the interviews. Interviews were completed on 9/25/2019. On 9/26/2019, 100% of alert and oriented residents were interviewed by the Social Worker utilizing a Resident Questionnaire in regards to call lights to identify any concerns related to timelines of staff response to call lights. All areas of concern were addressed during the audit by the Social Worker and Nurse Supervisor. Questionnaires completed on 9/26/2019. On 9/24/2019 an in-service was initiated	

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F 565	Continued From page 2 AD explained during the meetings that the issues were passed along to the appropriate staff to ensure resolution of the issues. The members stated the issues that were not being resolved and on ongoing were the following: Call lights were not being answered timely sometimes when they need to be changed after they were incontinent. Night time snacks were still not being provided and their bed linens were not being changed regularly. Review of the monthly resident council meeting minutes from September 2018 until September 2019 were reviewed. The minutes revealed no response for the following grievances: Review of the resident council minutes dated October 23, 2018 indicated the residents reported night snacks were not being passed by staff and the residents asked when a task requires 2 Nurse Assistants (NA) that if one of the Nurse Assistant (NA) is new, that the other Nurse Assistant (NA)be experienced. Further review of the council minutes revealed no response for the residents' concerns. Review of the resident council minutes dated November 13, 2018 revealed that the residents were not getting their linens changed on their shower days or when they are soiled. Further review of the council minutes revealed no response for the residents' concerns. Review of the resident council minutes dated December 13, 2018 indicated the residents voiced concerns of staff coming in late for their shift, therefore residents were waiting long periods of time before getting assistance. Further	F 565	by Staff Facilitator with all nurses and nursing assistants in regards to offering and providing assistance with nourishing snacks to all residents who are not NPO specifically at bedtime. In-service completed on 10/14/2019. On 9/25/2019 an in-service was initiated by Staff Facilitator with all nurses and nursing assistants on changing bed linens on shower days and when soiled. In-service completed on 10/14/2019. On 9/26/2019 Staff Facilitator initiated in-service for all staff (Nursing, Dietary, Maintenance, Activities, Business Office, Reception, Social Work, Medical Records, Housekeeping, and Laundry) is on answering call lights and call light response. In-service completed on 10/14/2019. On 10/18/2019 Administrator completed in-service with Department Heads (Director of Nursing, Staff Facilitator, Social Worker, Maintenance Director, Dietary Manager, Accounts Receivable, Unit Managers, MDS Coordinators, Activity Director, and Rehab Manager) in regards to the Resident Council Grievance Process. 10% of all alert and oriented residents will be interviewed by Social Worker or designee utilizing Call Bell, Snack, and Linen Audit weekly x 8 weeks then monthly 1 month to ensure call bells are answered timely, snacks offered at bedtime, and linens changed on shower days and prn. All concerns will be addressed by Unit Manager, Quality Assurance Nurse and Staff Facilitator	

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F 565	Continued From page 3 review of the council minutes revealed no response for the residents' concerns. Review of the resident council minutes dated March 29, 2019 indicated the residents reported continued issues from the last council meetings. The residents were not getting changed timely and call lights were not getting answered timely. Further review of the council minutes revealed no response for the residents' concerns. Review of the resident council minutes dated August 29, 2019 indicated the bed linens were not being changed and nourishments were not getting passed out. Further review of the council minutes revealed no response for the residents' concerns. Review of the resident council minutes dated September 10, 2019 indicated the residents reported nourishments were not getting passed. Linens on the 100, 200 and 300 halls were not getting changed at least twice a week and call lights on all halls were not getting answered timely. Further review of the council minutes revealed no response for the residents' concerns. An interview was conducted with the Activity Director (AD) on 9/26/2019 at 11:44 AM. The AD indicated the grievances from the Resident Council meetings for the last year were forwarded to the specific departments for resolution. The AD reported she was aware that the department heads were not responding back to the resident council grievances. AD reported she always made the Administrator aware of the department heads not responding back to resident council minutes.	F 565	during the audit. The Administrator will review and initial the Call Bell, Snack, and Linen Audit tool weekly x 8 weeks then monthly x 1 month to ensure completion and that all areas of concerns have been addressed. The Administrator will forward the results of the Call Bell, Snack, and Linen Audit Tool to the Executive QA Committee monthly x 3 month. The Executive QA Committee will meet monthly x 3 months to review the Call Bell, Snack, and Linen Audit Tool to determine trends and/or issues	

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F 565	Continued From page 4 An interview was conducted with the Administrator on 9/27/2017 at 9:59 AM. The Administrator revealed the Resident Council grievances were not addressed under another Administrator who no longer was employed at the facility. She reported they were unable to locate the Resident council grievance responses from the last year. The Administrator stated the facility grievance resolution system was under review. She stated the expectation was all grievances would be investigated when reported and the actions of the investigations be documented and reported to ensure resolution.	F 565		
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) assessments for 7 of 29 resident assessments reviewed (Residents #64, #97, #89, #91, #92, #36 and #71). Findings included: 1. Resident # 64 was admitted to the facility on 8/14/2019 with multiple diagnoses that included manic depressive disorder, hyperlipidemia, hypokalemia and diabetes. The resident's medical record contained a Preadmission Screening Resident Review (which is an evaluation for mental illness or intellectual	F 641	The Minimum Data Set (MDS) assessment for resident #64 was modified by the MDS nurse on 9/25/19 with the correct PASSR the information. The Minimum Data Set (MDS) assessment for resident #97 was modified by the MDS nurse on 10/18/2019 to reflect correct discharge status. The Minimum Data Set (MDS) assessment for resident #91, #92, and #71 was modified by the MDS nurse on 9/25/2019 to delete anticoagulant medication. The Minimum Data Set (MDS) assessment for resident #89 was modified by the MDS nurse on 10/8/2019 to delete anticoagulant medication. The Minimum Data Set (MDS) assessment for resident #36 was modified by the MDS	10/18/19

F 641 Continued From page 5

disability for all persons who live in or seek entry to a Medicaid-certified nursing facility) Level II Determination Notification that was dated 6/25/2019 with the end date of 9/23/2019.

The Admission Minimum Data Set dated 8/20/2019 indicated a "No" to question A1500 which asked if Resident # 64 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or intellectual disability or a related condition.

During the interview on 9/26/2019 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 # 64 had been approved for a level II PASRR on 6/25/2019 and determined to have a serious mental illness.

During an interview on 9/26/2019 at 1:35 pm with the Director of Nursing (DON) she acknowledged Resident # 64's Admission MDS was inaccurately coded. She stated that it is her expectation that the MDS should be coded accurately.

Interview with the Administrator on 09/26/19 at 4 :15 PM revealed her expectation is that all MDS documentation be coded correctly.

2. Resident #97 was admitted to the facility on 4/25/2019 with diagnosis that included heart failure and anemia.

Resident #97's discharge Minimum Data Set (MDS) dated 6/28/2019 indicated Resident #97 was discharged to an acute hospital.

Review of the nurse note dated 6/28/2019

F 641

nurse on 9/24/2019 to delete anticoagulant medication and insulin injections.

100% audit of all current resident most current MDS assessment was initiated on 9/25/19 by the MDS Consultant and MDS Coordinator utilizing a MDS Accuracy Audit tool to ensure all completed MDS's were accurately coded to include anticoagulant medication, insulin injections, 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 10/18/19.

On 10/3/2019 an in-service was completed by the Regional MDS consultant with the MDS Nurses in regards to accurately coding the MDS, to include anticoagulant medications, coding insulin injections, 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 anticoagulant medication, insulin injections, 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 Staff Facilitator and/or the RN Supervisor to include additional training and modifications to assessment as

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F 641	Continued From page 6 indicated Resident # 97 was discharged home with home health services not to an acute hospital. During the interview on 9/26/2019 at 1:29 PM, Minimum Data Set (MDS) nurse reviewed Resident #97's discharge MDS and confirmed it was inaccurately coded that the resident was discharged to acute hospital. The MDS nurse explained it was coded in error as Resident # 97 was discharged home not to acute hospital. During an interview on 9/26/2019 at 1:35 pm with the Director of Nursing (DON) she acknowledged Resident #97 discharge MDS was inaccurately coded. She indicated that discharge to the community should have been coded on Resident #97's MDS dated 6/28/2019 not acute hospital. During further interview with DON, she stated that it is her expectation that the MDS should be coded accurately. Interview with the Administrator on 09/26/19 at 4 :15 PM revealed her expectation is that all MDS documentation be coded correctly. 3. Resident #89 was admitted to the facility on 08/27/18 with diagnoses of atherosclerotic heart disease of native coronary artery without angina	F 641	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 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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pectoris and cerebral infarction due to embolism of left middle cerebral artery.

The annual Minimum Data Set (MDS) assessment dated on 09/03/19 revealed that the resident was coded as receiving an anticoagulant medication for 7 of 7 days during the assessment period.

Review of Medication Administration for September 2019 indicated that the resident was prescribed Aspirin 325 mg daily and Plavix 75 mg daily and the Resident Assessment Instrument (RAI) indicated "do not code" this medication in section N under anticoagulant.

An interview was conducted with the MDS Coordinator on 09/27/19 at 12:20 PM. She stated that she thought all anticoagulants had to be coded in Section N on the MDS to include Aspirin and Plavix. The MDS Coordinator further stated that it is her expectation all residents MDS assessments be coded correctly.

An interview was conducted with Administrator on 09/27/19 at 3:30 PM. She stated that it is her expectation that all MDS documentation be coded correctly.

4. Resident #91 was admitted to the facility on 09/28/18 with diagnosis of congestive heart failure.

The annual Minimum Data Set (MDS) assessment dated on 09/04/19 revealed that the resident was coded as receiving an anticoagulant for 7 of 7 days during the assessment period.

Review of Medication Administration Record for

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F 641	Continued From page 8 September 2019 indicated the resident was prescribed Clopidogrel Bisulfate 75 mg daily and the Resident Assessment Instrument (RAI) indicated "do not code" this medication in section N under anticoagulant. An interview was conducted with the MDS Coordinator on 09/27/19 at 12:20 PM. She stated that she thought all anticoagulants had to be coded in Section N on the MDS to include Clopidogrel Bisulfate. The MDS Coordinator further stated that it is her expectation all residents MDS assessments be coded correctly. An interview was conducted with Administrator on 09/27/19 at 3:30 PM. She stated that it is her expectation that all MDS documentation be coded correctly. 5. Resident #92 was admitted to the facility on 08/28/19 with a diagnosis of cerebrovascular disease. The admission MDS dated on 09/14/19 revealed the resident was coded as receiving an anticoagulant for 7 of 7 days during the assessment period. Review of the Medication Administration for September 2019 indicated that the resident was prescribed Aspirin 325 mg daily and the Resident Assessment Instrument (RAI) indicated "do not code" this medication in section N under anticoagulant. An interview was conducted with the MDS Coordinator on 09/27/19 at 12:20 PM. She stated that she thought all anticoagulants had to be coded in Section N on the MDS to include Aspirin.	F 641		

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The MDS Coordinator further stated that it is her expectation all residents MDS assessments be coded correctly.

An interview was conducted with the Administrator on 09/27/19 at 3:30 PM. She stated that it is her expectation that all MDS documentation be coded correctly.

6. Resident #36 was admitted to the facility on 06/13/13 with diagnoses which included, in part, type 2 diabetes mellitus and hypertension.

A review of Resident #36's quarterly Minimum Data Set (MDS), dated 07/25/19, indicated Resident #36 was cognitively intact had received injections, insulin and anticoagulant medications for 7 days of the assessment period.

A review of Resident #36's Care Plan, last updated 07/25/19, revealed insulin injections and anticoagulant medications had not been planned.

A review of Resident #36's physician orders revealed no orders for insulin injections or anticoagulant medications.

During an interview with the MDS Nurse on 09/27/19 at 11:50 a.m., the MDS Nurse stated he must have been looking at another resident's medication list and had accidently transcribed insulin injections and anticoagulant medications into Resident #36's MDS assessment.

During an interview with the Director of Nursing (DON) on 09/26/19 at 1:35 p.m., the DON stated it was her expectation the MDS assessments be correctly coded.

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F 641	Continued From page 10 During an interview with the Administrator on 09/26/19 at 4:15 p.m., the Administrator stated it was her expectation the MDS assessments be correctly coded. 7. Resident #71 had been admitted to the facility on 03/09/10 with diagnoses which included, in part, chronic kidney disease, arteriorsclerotic heart disease and heart failure. A review of Resident #71's quarterly Minimum Data Set (MDS), dated 08/30/19, indicated Resident #71 was severely cognitively impaired and had received anticoagulant medication for 7 days of the assessment period. A review of Resident #71's Care Plan, last updated 09/09/19, revealed anticoagulant medications had not been planned. A review of Resident #71's Physician Orders revealed Resident #71 had orders for Aspirin 81 milligrams (mg) daily for anticoagulant. The Resident Assessment Instructions (RAI) indicated not to code the medication aspirin in section N of the MDS assessment. During an interview with the MDS Nurse on 09/27/19 at 11:50 a.m., the MDS Nurse stated he had been in training as a new MDS nurse at the facility and had misunderstood his corporate trainer. The MDS Nurse stated he had thought if the physician's order for aspirin indicated it was to be used as an anticoagulant he should code aspirin as an anticoagulant in section N of the MDS assessment. During an interview with the Director of Nursing (DON) on 09/26/19 at 1:35 p.m., the DON stated	F 641		

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F 641	Continued From page 11 it was her expectation the MDS assessments be correctly coded. During an interview with the Administrator on 09/26/19 at 4:15 p.m., the Administrator stated it was her expectation the MDS assessments be correctly coded.	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 interviews, the facility failed to implement a care plan for a resident with a Level II Preadmission Screening and Resident Review (PASRR), failed to incorporate PASRR recommendations into a care plan for 1 of 1(Resident # 64)residents reviewed for PASRR care plan. Facility also failed to make	F 644	Level II Preadmission Screening and Resident Review (PASRR) recommendations were incorporated into the care plan for resident # 64 by the Social Worker. On 10/16/2019 the PASRR Level II application was re-submitted by the Social Worker for Resident # 2, # 23,	10/25/19

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a referral for re-evaluation after a change in mental health status for 4 of 4 residents (Resident #64, #2, #74, #91 and #23) reviewed for Pre-Admission Screening and Resident Review.

Findings included:

1. Resident # 64 was admitted to the facility on 8/14/2019 with multiple diagnoses that included manic depressive disorder, hyperlipidemia, hypokalemia and diabetes. The resident's Minimum Data Set (MDS) dated 8/20/2019 indicated the resident's cognition was intact and he had no behavioral symptoms indicated. MDS also indicated the resident was taking antipsychotic medication.

The resident's medical record contained a Preadmission Screening Resident Review (PASARR) Level II Determination Notification that was dated 6/25/2019 with the end date of 9/23/2019. The notification indicated the resident placement was appropriate for 90 days. Under specialized services determination the notification indicated the following: - Follow- up psychiatrist services by a psychiatrist and continue substance use treatment.

Review of Resident # 64 care plan dated 8/14/2019 and medical record revealed no care plan was in place for follow-up with psychiatrist services and the resident had not received psychiatrist services as recommended by PASRR level II determination. The Minimum Data Set (MDS) nurse was responsible for updating the care plan and Director of Nursing (DON) was responsible for monitoring the care plan.

F 644

91, # 64 and # 74.

A 100% review of all current residents' diagnosis was initiated by the Social Worker on 10/14/2019 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 to include re-submission of PASRR information as indicated. Audit to be completed by 10/25/2019.

On 10/16/2019 the Social worker, Accounts Receivable (AR) Bookkeeper, backup AR Bookkeeper and Admissions Director were in-serviced by the Administrator on requirements for PASSR screening prior to admission. On 10/3/2019 Minimum Data Set Coordinator (MDS) and MS Nurse in-serviced by Regional Consultant on coding PASRR information in section A of MDS assessment. On 10/16/2019 the Social Worker was in-serviced by the Administrator on the requirements for PASSR resubmission upon receipt of qualifying diagnosis during resident stay. 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. Social Worker or designee will review PASRR information of potential residents with Level II PASRR prior to admission to ensure PASRR recommendations can be initiated upon admission. Results of review will be documented on PASRR Audit Tool weekly for 8 weeks then

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F 644	Continued From page 13 An observation of the resident on 9/25/2019 at 10:00 AM revealed the resident sleeping in his bed with his eyes closed. No concerns or behavioral problems were noted. An interview was conducted with the Minimum Data Set (MDS) Nurse #1 on 9/26/2019 at 10:15 AM and she reported she did not complete the Admission MDS assessment dated 8/20/2018 for Resident # 64. MDS Nurse #1 added the nurse who was responsible for completing the MDS was on sick leave. MDS Nurse # 1 added that in the future they will be more specific in documenting the specialized recommendations from a PASSR level II determination. An interview was conducted with Nurse # 4 on 9/26/2019 at 10:20 AM. She reported the resident had no behavioral problems since his admission to the facility. She reported the resident continues to take his antipsychotic medications with no problems. The Social Worker (SW) was interviewed on 9/26/2019 at 10:28 AM. The SW reported Resident # 64 was a Level II PASRR and she did not refer the resident for psychiatrist services sooner because she was out on sick leave. SW reported she was on leave for about a month and the Admissions coordinator was responsible for setting up an appointment for the resident with the psychiatrist. SW added she was going to set up an appointment immediately. She also stated that the resident was stable and had not experienced any behavioral symptoms or any decline due to not receiving psychiatrist services and substance use treatment for the last 1 month. The Administrator (AD) was interviewed on	F 644	monthly. Administrator will review and initial PASSR Audit Tool for 8 weeks. 10 % of all new physician orders to include residents #2, #23, # 91, # 64 and # 74 will be reviewed by the Social Worker to ensure new PASRR qualifying diagnosis 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 worker or designee during the audit to include re-submission of information to PASRR and care plan update as required. 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 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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9/26/2019 at 4:44 PM. The AD explained she was not aware that Resident #64 had not been seen by a psychiatrist as determined by PASRRR level II since his admission. AD reported the Admissions coordinator was responsible for fulfilling the SW responsibilities while the SW was on leave but it looks like she missed setting up an appointment for the resident with the psychiatrist. The AD further reported a new process will be initiated to track all residents with Level II PASRR and had specialized services. She added her expectation will be to have the SW set up psychiatrist appointments with PASRR level II residents as soon as they get admitted to the facility.

2. Resident #2 was admitted to the facility on 03/03/17 with diagnosis of Dementia.

Review of face sheet list with diagnoses revealed the resident had additional mental health diagnoses since the PASARR Level I screen was completed on 03/10/16. The additional mental health diagnoses included paranoid schizophrenia, major depressive disorder and anxiety disorder.

The significant change Minimum Data Set (MDS) assessment dated 08/02/19 revealed that the resident's cognition is severely impaired. The staff assessment noted her feeling tired or having little and poor appetite or overeating on 2 to 6 days. She had delusions and on 1 to 3 days verbal behavior. The Resident was administered antipsychotic and antidepressant medication on 7 of 7 days. Her active diagnoses included anxiety disorder, major depressive and paranoid schizophrenia.

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Review of the care plan dated on 08/21/19 revealed that the resident was care planned for psychotropic drug use.

Review of the PASARR Level I Determination Notification dated on 03/10/16 revealed that the resident did not have any mental health diagnoses and had a cognitive diagnosis of dementia.

An interview was conducted with the Social Worker on 09/27/19 at 3:00 PM. She stated that she was not aware that the resident was diagnosed with any additional mental health diagnoses. She further stated that she was not aware that another PASARR screening needed to be completed.

An interview was conducted with the Administrator on 09/27/19 at 3:43 PM. She stated that there had been a lot of turnover and transition in the staff at the facility. She further stated that it was her expectation that when a resident is diagnosed with additional mental health diagnoses that the resident would be referred for a PASARR re-evaluation.

3. Resident #74 was admitted to the facility on 03/07/13 with a diagnosis of schizophrenia.

Review of face sheet list with diagnoses revealed the resident had additional mental health diagnoses since the PASARR Level I screen completed on 12/03/09. The additional mental health diagnoses included paranoid schizophrenia, major depressive disorder, anxiety disorder, brief psychotic disorder and schizoaffective disorder.

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F 644	Continued From page 16 Review of the PASARR Level II Determination Notification letter was dated 12/07/09 revealed that the PASARR expiration date was 12/07/10. The quarterly Minimum Data Set (MDS) dated 08/24/19 revealed that the resident's cognition was moderately impaired. No mood or behaviors were documented on the MDS. The Resident was administered antipsychotic and antidepressant medication on 7 of 7 days. Her active diagnoses included anxiety disorder, depression, psychotic disorder and schizophrenia. Review of the care plan dated on 09/01/19 revealed that the resident was care planned for psychotropic drug use with diagnoses of anxiety, depression, schizophrenia and psychosis. An interview was conducted with the Social Worker on 09/27/19 at 3:00 PM. She stated that she was not aware that the resident was diagnosed with any additional mental health diagnoses. She further stated that she was not aware that another PASARR screening needed to be completed. An interview was conducted with the Administrator on 09/27/19 at 3:43 PM. She stated that there had been a lot of turnover and transition in the staff at the facility. She further stated that it was her expectation that when a resident is diagnosed with additional mental health diagnoses that the resident would be referred for a PASARR re-evaluation. 4. Resident #91 was admitted to the facility on 09/28/18 with no mental health diagnoses.	F 644		

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F 644	Continued From page 17 Review of face sheet list with diagnoses revealed the resident has additional mental health diagnoses since the PASARR Level I screen completed on 09/28/18. The additional mental health diagnoses as of 12/11/18 which included bipolar disorder and major depressive disorder. Review of the PASARR Level I Determination Notification dated on 09/28/18 revealed that the resident did not have any mental health diagnoses. The annual Minimum Data Set (MDS) dated on 09/04/19 revealed that the resident's cognition was intact. No mood or behaviors were documented on the MDS. The Resident was administered antipsychotic and antidepressant medication on 7 of 7 days. Her active diagnoses included depression and bipolar order. Review of the care plan dated on 09/20/19 revealed that the resident was care planned for psychotropic drug use with diagnoses of depression and bipolar disorder. An interview was conducted with the Social Worker on 09/27/19 at 3:00 PM. She stated that she was not aware that the resident was diagnosed with any additional mental health diagnoses. She further stated that she was not aware that another PASARR screening needed to be completed. An interview was conducted with the Administrator on 09/27/19 at 3:43 PM. She stated that there had been a lot of turnover and transition in the staff at the facility. She further stated that it was her expectation that when a	F 644		

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resident is diagnosed with additional mental health diagnoses that the resident would be referred for a PASARR re-evaluation.

5. Resident #23 was admitted to the facility on 02/27/13 with diagnoses which included anxiety disorder, major depressive disorder, unspecified dementia without behavioral disturbance and unspecified psychosis not due to a substance or known physiological condition.

A review of the North Carolina Department of Health and Human Services, Division of Medical Assistance, Preadmission Screening and Annual Resident Review (PASRR) application, dated 02/22/13, revealed Resident #23's mental health diagnoses had not been included on the application. Resident #23 had been given the determination of a PASRR Level 1 with no expiration date.

A review of Resident #5's annual Minimum Data Set (MDS), dated 02/01/19, revealed Resident #5 was severely cognitively impaired and had not been considered by the State Level II PASRR process to have a serious mental illness. The MDS indicated Resident #5 had diagnoses which included, in part, non-Alzheimer's dementia, anxiety, depression and psychotic disorder.

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F 644	Continued From page 19 A review of Resident #5's Care Plan, last revised 08/13/19, revealed Resident #5 had been planned for the use of psychotropic medications. During an interview with the Social Worker (SW) on 09/27/19 at 9:44 a.m., the SW stated she had been doing the PASRR tasks for the past 3 to 4 years and had just found out she had been doing it incorrectly secondary to a misunderstanding of the PASRR process. During an interview with the Administrator on 09/27/19 at 4:15 p.m., the Administrator stated it was her expectation PASRRs are completed as per the federal regulations.	F 644		