| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| THREE RIVERS HEALTH AND REHAB | 1403 CONNER DRIVE WINDSOR, NC 27983 |

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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 12/9/19 through 12/12/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #0RLS11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 12/9/19 through 12/12/19. Event ID# 0RLS11.<br><br>0 of the 5 complaint allegatios were substantiated. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all | F 550 | | 1/10/20 |

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

Electronically Signed | 01/09/2020

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| F 550 | Continued From page 1<br>residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews the facility failed to provide a dignified dining experience for one of one residents (Resident #27) reviewed for dignity by standing over him while assisting with his meal.<br><br>Findings included:<br>Resident #27 was admitted to the facility on 2/13/15 with diagnoses including Alzheimer's dementia.<br><br>A review of the most recent Minimum Data Set assessment (MDS) for Resident #27 dated 10/22/19 indicated he was severely impaired for daily decision making, had an altered level of consciousness that fluctuated and was rarely if ever understood. It further indicted Resident #27 needed the total assistance of one person for eating. | F 550 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.<br><br>Plan for correcting specific deficiency.<br>The process that led to deficiency cited.<br><br>On 12/09/2019, Resident #27 was | |

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| F 550 | Continued From page 2<br><br>A review of the most current care plan for Resident #27 revealed a focus area of requires assistance with activities of daily living and at risk for complications related to dependence with a goal of will maintain or improve current level of function through next review and interventions including requires total assistance to eat and encourage me to participate to my fullest extent with every interaction.<br><br>On 12/9/19 at 12:25 PM Nurse #1 was observed in the dining room assisting Resident #27 with his lunch meal. Resident #27 was seated in a recliner chair and Nurse #1 was standing to his side, feeding him. Resident #27 was wearing a baseball hat with a brim and could not make eye contact with Nurse #1 during the activity.<br><br>On 12/9/19 at 12:30 PM Nurse Aide #1 was observed to walk into the dining room and say to Nurse #1, "You need to sit down". Nurse #1 was heard to reply, "Why?' and then observed to sit in a chair beside Resident #27.<br><br>On 12/9/19 at 12:59 PM an interview with Nurse #1 indicated she was familiar with Resident #27 and had assisted him with meals before. She stated she heard Nurse Aide #1 tell her to sit down while she was assisting Resident #27 with his meal, but she did not know why Nurse Aide #1 said this. Nurse #1 went on to say sometimes she sat down while assisting residents with meals but other times she stood up when feeding them. She stated sitting down or standing up while feeding residents was not something she ever really thought about. Nurse #1 indicated that she thought it was easier for her to reach Resident #27's food while she was standing up. | F 550 | assisted by LPN Support Nurse during meal time by standing while setting up and assisting with his meal.<br><br>On 12/9/2019, the LPN Support Nurse was re-educated by the Director of Nursing on the dining experience which states staff should be seated at eye level.<br>2. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: -<br><br>On 12-10-17, The Administrator and Director of Nursing began in servicing all FT, PT, and PRN RN's and LPN's, and CNA's on the following procedures:<br><br>Resident Dignity - Sitting beside a resident while feeding them instead of standing up to feed.<br><br>Any in-house staff member who did not receive in-service training by 01/09/2020, will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br><br>The Administrator, Director of Nursing or | |

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| F 550 | Continued From page 3<br><br>On 12/9/19 at 1:09 PM an interview with Nurse Aide #1 indicated the facility provided staff with annual in-services regarding treating residents with dignity. She stated this included sitting at eye level with residents when assisting them with meals.<br><br>On 12/9/19 at 1:12 PM an interview with the Director of Nursing (DON) indicated Nurse #1 received training in treating residents with dignity within the last year which included sitting at eye level with residents while assisting them with meals. She stated Nurse #1 should have been seated next to Resident #27 while feeding him and Nurse #27 knew that. The DON added staff standing over a seated resident while assisting with meals would not be appropriate.<br><br>On 12/9/19 at 1:17 PM an attempt to interview Resident #27 was unsuccessful.<br><br>On 12/9/19 at 3:11 PM an interview with the Administrator indicated Nurse #1 should have been aware of the need to be at eye level with residents when assisting them with meals as she had received training on treating residents with dignity which included sitting at eye level with residents when assisting them with meals within the last year. She stated she thought Nurse #1 was just having a bad day. | F 550 | Support Nurse will conduct audits to ensure the staff are providing a dignified dining experience and staff are seated at eye level. These audits will be conducted weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.<br>The title of the person responsible for implementing the plan of correction.<br>The Administrator is responsible for implementation and completion of the acceptable plan of correction.<br><br>Date of Compliance:<br><br>01/09/2020 | |
| F 641 SS=E | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced | F 641 | | 1/9/20 |

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| F 641 | Continued From page 4<br>by:<br>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 5 or 19 resident records reviewed for MDS accuracy (Residents #49, #28, #15, #11, and #39).<br><br>Findings included:<br><br>1. Resident #49 was admitted to the facility on 08/07/18 with diagnoses that included: hypertension and non-Alzheimer's dementia.<br><br>A review of the quarterly MDS assessment dated 11/15/19 indicated that Resident #49 was not coded for a wanderguard and did not exhibit wandering behaviors.<br><br>A review of the annual MDS assessment dated 8/15/19 indicated that Resident #49 was coded for a wanderguard and did not exhibit wandering behaviors.<br><br>A review of the physician's orders revealed an order for wanderguard dated 8/09/19 for Resident #49.<br><br>A review of the November Medication Administration Record (MAR) revealed there was a scheduled task to check that Resident #49's wanderguard bracelet was on every shift.<br><br>During an interview with the MDS Coordinator on 12/10/19 at 12:57 PM, she revealed that the MDS assessment for Resident #49 dated 11/15/19 was incorrect and should have reflected her wanderguard alarm as being used daily. She stated she must have made a mistake and had not coded it correctly on the quarterly MDS. | F 641 | F641<br>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.<br><br>Plan for correcting specific deficiency. The process that led to deficiency cited.<br><br>The facility failed to accurately code the Minimum Data Set (MDS) for 5 Residents. Residents #49, #28, #15, #11, and #39.<br><br>1. On 12/10/19, it was identified that the MDS Assessment for Resident #49 dated 11/15/2019 was incorrect and assessment should have reflected Resident wanderguard alarm as being used daily.<br>2. On 12/11/2019, it was identified that the MDS Assessment for Resident #28 dated 10/28/2019 was incorrect and should have accurately reflected exhibited behaviors.<br>3. On 12/11/2019, it was identified that the MDS Assessment for Resident #15 dated 09/27/2019 was incorrect and should have accurately reflected hospice | |

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| F 641 | Continued From page 5<br><br>During an interview with the Administrator on 12/11/19 at 3:08 PM, she stated the MDS for Resident #49 should have been coded correctly and she did not know why it had not been done.<br><br>2. Resident #28 was admitted to the facility on 10/21/19 with diagnoses that included heart failure and diabetes.<br><br>A nurse ' s note dated 10/24/19 revealed Resident #28 displayed behaviors such as yelling, screaming and cursing.<br><br>Resident #28 ' s minimum data set (MDS) assessment dated 10/28/19, an admission assessment revealed in Section E no behaviors.<br><br>During an interview on 12/11/19 at 2:32 PM the MDS Coordinator reported Resident #28 ' s MDS assessment should have accurately reflected behaviors. She stated Section E of the MDS assessment was completed by social work.<br><br>An interview was conducted on 12/12/19 at 9:00 AM with the Social Serviced Assistant who stated she did not review Resident #28 ' s progress notes to complete Section E of the MDS assessment dated 10/28/19.<br><br>During an interview on 12/12/19 at 11:00 AM the administrator indicated Resident #28 ' s MDS assessment should have accurately reflected exhibited behaviors.<br><br>3. Resident #15 was admitted to the facility 6/16/17 with diagnoses that included | F 641 | services.<br>4. On 12/12/2019, it was identified that the MDS Assessment for Resident #39 dated 11/11/2019 was incorrect and should have accurately reflected exhibited behaviors.<br>5. On 12/11/2019, it was identified that the MDS Assessment for Resident #11 dated 06/28/2019 was incorrect and should have reflected a stage 2 pressure ulcer.<br><br>2. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: -<br>1. On 12/30/19 and 12/31/19, the MDS Assessment for Resident #49 dated 11/15/2019 was corrected and modified to accurately reflect Resident wanderguard alarm as being used daily.<br>2. On 12/30/19 and 12/31/19, the MDS Assessment for Resident #28 dated 10/28/2019 was corrected and modified to accurately reflect exhibited behaviors.<br>3. On 12/30/19 and 12/31/19, the MDS Assessment for Resident #15 dated 09/27/2019 was corrected and modified to accurately reflect hospice services.<br>4. On 12/30/19 and 12/31/19, the MDS Assessment for Resident #39 dated 11/11/2019 was corrected and modified to accurately reflect exhibited behaviors.<br>5. On 12/30/19 and 12/31/19, the MDS Assessment for Resident #11 dated 06/28/2019 was corrected and modified to reflect a stage 2 pressure ulcer.<br><br>All residents have the potential for being affected by the alleged deficient practice. | |

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| F 641 | Continued From page 6<br>hypertension and diabetes mellitus.<br><br>A doctor ' s order dated 7/7/19 revealed an order to admit Resident #15 to hospice.<br><br>Resident #15 ' s minimum data set (MDS) assessment dated 9/27/19 revealed Resident #15 was not coded in Section J as receiving hospice services.<br><br>During an interview on 12/11/19 at 2:32 PM the MDS Coordinator reported Resident #15 ' s MDS assessment should have accurately reflected hospice services. She indicated this was an error.<br><br>During an interview on 12/12/19 at 11:00 AM the administrator indicated Resident #15 ' s MDS assessment should have accurately reflected hospice services.<br><br>4. Resident #39 was admitted to the facility on 11/4/19 with diagnoses that included heart failure and diabetes.<br><br>A nurse ' s note dated 11/10/19 revealed Resident #39 displayed behaviors such as agitation and wandering.<br><br>Resident #39 ' s minimum data set (MDS) assessment dated 11/11/19, an admission assessment revealed in Section E no behaviors.<br><br>During an interview on 12/11/19 at 2:32 PM the MDS Coordinator reported Resident #39 ' s MDS assessment should have accurately reflected behaviors. She stated Section E of the MDS assessment was completed by social work. | F 641 | A 100% audit was completed for all residents in order to identify any others who were affected. The audit results are below:<br><br>0 of 2 residents who wear Wanderguard bracelets were identified with inaccurate coding of Alarms in Section P of their most recent MDS assessment.<br>0 of 0 residents who are receiving Hospice services were identified with inaccurate coding of Prognosis in Section J1400 of their most recent MDS assessment.<br>2 of 21 residents who have had a Pressure Ulcer during the past 30 days were identified with inaccurate coding of Pressure Ulcers in Section M of their MDS assessment.<br>1 of 52 residents who have documented Behaviors during the past 30 days were identified with inaccurate coding of Section E of their MDS assessment.<br><br>These audits were completed by the MDS Coordinator, Social Services Assistant and the Administrator on 01/08/20.<br>All MDSs identified with inaccurate coding of audited areas were modified and corrected by the MDS Coordinator on 01/03/20 and 01/07/2020. The corrected assessments for pressure ulcers were re-submitted to the state database on 01/07/20. The Batch #1392. The corrected assessments for behaviors will completed and submitted to the state by its due date 01/17/2020.<br><br>The above-mentioned MDS assessments | |

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| F 641 | Continued From page 7<br>An interview was conducted on 12/12/19 at 9:00 AM with the Social Serviced Assistant who stated she did not review Resident #39 ' s progress notes to complete Section E of the MDS assessment dated 10/28/19.<br><br>During an interview on 12/12/19 at 11:00 AM the administrator indicated Resident #39 ' s MDS assessment should have accurately reflected exhibited behaviors.<br>6.Resident #11 was admitted to the facility on 8/9/18 with diagnoses including dementia without behavioral disturbance.<br><br>A review of a Minimum Data Set assessment (MDS) for Resident #11 dated 6/28/19 indicated she had no unhealed pressure ulcers or injuries.<br><br>A review of a nursing progress note dated 6/21/19 at 4:07 PM indicated Resident #11 had a sacral (base of spine) wound and the wound care physician had examined her.<br><br>A review of a nursing progress note for Resident #11 dated 6/24/19 at 10:26 AM indicated Resident #11 had a stage two (shallow open area) pressure ulcer to her sacrum.<br><br>A review of a nursing progress note dated 6/25/19 at 9:41 PM indicated Resident #11 had a stage two pressure ulcer to her sacrum.<br><br>On 12/11/19 at 8:27 AM interview with the MDS Coordinator indicated she completed the 6/28/19 MDS section for Resident #11 regarding pressure ulcers. She indicated the assessment period for this MDS was from 6/21/19 through 6/28/19. The MDS Coordinator went on to say she obtained her information by reviewing progress notes, skin | F 641 | were corrected by the facility MDS nurse on 12/30/19 and 12/31/19 and were re-submitted to the state database.<br><br>On 12/31/19, The MDS Consultant in-serviced the MDS Coordinator, Admissions Coordinator and Social Services Assistant on how to accurately code behaviors, alarms, antipsychotic medications, hospice and wounds(completed 01/02/2020) on the MDS assessment. The education emphasized the importance of thoroughly reviewing a resident's complete medical record including: progress notes, orders, medication and treatment administration records, nursing assistant documentation, etc. prior to coding answers on the MDS assessment. The education also included the importance of interviewing staff members as well as assessing the resident prior to coding the MDS assessment.<br><br>This information has been integrated into the standard orientation training for new MDS Coordinators, Admissions Coordinators and Social Services staff and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected | |

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| F 641 | Continued From page 8<br>assessments and wound care notes for the assessment period when completing this section of the MDS for residents. She indicated based on the progress notes for Resident #11, her stage 2 pressure ulcer should have been reflected on her MDS assessment but was not.<br><br>On 12/12/19 at 12:44 PM an interview with the Administrator and Director of Nursing indicated Resident #11's stage two pressure ulcer documented in her progress notes should have been reflected on her MDS dated 6/28/19 but was not. | F 641 | and/or in compliance with the regulatory requirements:<br><br>The Administrator, Director of Nursing or MDS Consultant will conduct audits to ensure the MDS are coded accurately using the QA audit tool entitled “MDS Coding Accuracy QA Tool.” These audits will be conducted weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate.<br>Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.<br>The title of the person responsible for implementing the plan of correction.<br>The Administrator is responsible for implementation and completion of the acceptable plan of correction.<br><br>Date of Compliance:<br><br>01/09/2020 | |
| F 655 SS=E | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident | F 655 | | 1/9/20 |

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| F 655 | Continued From page 9 | F 655 | | |

that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:

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| F 655 | Continued From page 10<br>Based on record review, resident and staff interviews the facility failed to provide a summary of the baseline care plan to residents or their representatives for 5 of 6 residents reviewed for baseline care plans (Resident #28, Resident #55, Resident #39, Resident #8 and Resident #34).<br><br>The findings included:<br><br>1. Resident #28 was admitted to the facility on 10/21/19 with diagnoses that included heart failure and diabetes.<br><br>A review of the most current Minimum Data Set (MDS) assessment dated 10/28/19 indicated he was cognitively intact.<br><br>A review of the most current care plan for Resident #28 dated 10/22/19 indicated focus areas including medication risks, activities of daily living needs such as dressing, bathing and grooming, and fall risk with goals that were measurable and interventions which were individualized.<br><br>On 12/10/19 at 11:30 AM an interview with Resident #28 indicated he did not recall receiving a written summary of his baseline care plan. He denied having any concerns related to his care.<br><br>On 12/11/19 at 2:34 PM the MDS Coordinator indicated neither Resident #28 or his representative had received a written summary of his baseline care plan. She stated she normally gave residents or their representatives a written copy of the order summary report which they signed in order to acknowledge receipt, but it was not provided to Resident #28. | F 655 | F655<br>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.<br><br>Plan for correcting specific deficiency. The process that led to deficiency cited.<br><br>The facility failed to provide a summary of the baseline care plan to residents or their representatives for 5 of 6 residents reviewed for baseline care plans. Residents #28, #55, #39, #8, and #34.<br><br>1. On 12/11/19, it was identified that Resident #28 nor his representative had received a written summary of his baseline care plan.<br>2. On 12/11/19, it was identified that Resident #55 nor his representative had received a written summary of his baseline care plan.<br>3. On 12/11/19, it was identified that Resident #39 nor his representative had received a written summary of his baseline care plan.<br>4. On 12/12/19, it was identified that Resident #8 nor his representative had received a written summary of his baseline care plan. | |

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| F 655 | Continued From page 11<br>During an interview with the Administrator on 12/12/19 at 9:13 AM with the Administrator she indicated it was the facility ' s practice to provide residents or their representatives with an order summary report which would include initial goals, physician orders, dietary orders, and therapy services which served as the written summary of the baseline care plan. She continued to state Resident #28 should have received this information.<br><br>2. Resident #55 was admitted to the facility on 11/20/19 with diagnoses that included hypertension.<br><br>A review of Resident #55 ' s most current Minimum Data Set (MDS) assessment dated 10/28/19 indicated she was cognitively intact.<br><br>A review of the most current care plan for Resident #55 dated 12/10/19 indicated focus areas including medication risks, activities of daily living needs such as dressing, bathing and grooming, and fall risk with goals that were measurable and interventions which were individualized.<br><br>On 12/10/19 at 11:45 AM an interview with Resident #55 indicated she did not recall receiving a written summary of her baseline care plan. She denied having any concerns related to her care.<br><br>On 12/11/19 at 2:34 PM the MDS Coordinator indicated neither Resident #55 or her representative had received a written summary of his baseline care plan. She stated she normally gave residents or their representatives a written copy of the order summary report which they | F 655 | 5. On 12/12/19, it was identified that Resident #34 nor his representative had received a written summary of his baseline care plan.<br><br>2. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: -<br><br>1. On 01/03/2019, Resident #28 was provided a written summary of his baseline care plan.<br>2. On 01/03/2019, Resident #55was provided a written summary of his baseline care plan.<br>3. On 01/03/2019, Resident #39's representative was provided a written summary of his baseline care plan.<br>4. Resident #8 was discharged from the facility on 12/26/2019.<br>5. Resident #34 was discharged from the facility on 12/11/2019.<br><br>All residents have the potential for being affected by the above alleged deficient practice. On 01/03/2020, a 100% audit of all residents who have been admitted to the facility during the past 30 days was completed to validate whether or not a Baseline Care Plan had been completed and reviewed with the resident or not. The audit results are as follows:<br>3 of 11 residents reviewed were identified as not having had a Baseline Care Plan completed as required.<br><br>All residents who were identified as not having the Baseline Care Plan requirement met were provided a written | |

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| F 655 | Continued From page 12<br>signed in order to acknowledge receipt, but it was not provided to Resident #55.<br><br>During an interview with the Administrator on 12/12/19 at 9:13 AM with the Administrator she indicated it was the facility ' s practice to provide residents or their representatives with an order summary report which would include initial goals, physician orders, dietary orders, and therapy services which served as the written summary of the baseline care plan. She continued to state Resident #55 should have received this information.<br><br>3. Resident #39 was admitted to the facility on 11/4/19 with diagnoses that included heart failure and diabetes.<br><br>A review of the most current Minimum Data Set (MDS) assessment dated 11/11/19 indicated she was cognitively impaired.<br><br>A review of the most current care plan for Resident #39 dated 11/4/19 indicated focus areas including medication risks, activities of daily living needs such as dressing, bathing and grooming, and fall risk with goals that were measurable and interventions which were individualized.<br><br>On 12/11/19 at 2:34 PM the MDS Coordinator indicated neither Resident #39 or her representative had received a written summary of his baseline care plan. She stated she normally gave residents or their representatives a written copy of the order summary report which they signed in order to acknowledge receipt, but it was not provided to Resident #39.<br><br>During an interview with the Administrator on | F 655 | summary of his/her Baseline Care Plan if they were still a current, active Resident residing in the facility.<br><br>On 12-31-19, The MDS Consultant in-serviced the MDS Coordinator, Admissions Coordinator and Social Services Assistant on the requirements of completing a Baseline Care Plan for all admitted residents within 48 hours of their admission to facility. This requirement also includes providing all residents and/or their representative with a written and signed summary of their care (Baseline Care Plan). This process is completed by ensuring that all orders for: medications, mental health/social service needs, therapy services, PASRR follow-up/review needs, resident's initial goals and dietary needs are included in their order summary. At the time of the resident's 72 hour care plan meeting, the Order Summary Report, which serves as the Baseline Care Plan is printed and reviewed with the resident and/or resident representative. The Order Summary Report/Baseline Care Plan is then signed by a nurse and the resident and/or representative. The resident and/or representative is given a signed copy and the facility maintains a signed copy of the Baseline Care Plan. The facility copy should be uploaded into the resident's electronic health record in Point Click Care.<br><br>This information has been integrated into the standard orientation training for new MDS Coordinators, Social Services | |

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| F 655 | Continued From page 13<br>12/12/19 at 9:13 AM with the Administrator she indicated it was the facility ' s practice to provide residents or their representatives with an order summary report which would include initial goals, physician orders, dietary orders, and therapy services which served as the written summary of the baseline care plan. She continued to state Resident #39 should have received this information.<br><br>4.Resident #8 was admitted to the facility on 8/22/19 with diagnoses including dementia.<br><br>A review of the most current Minimum Data Set (MDS) assessment dated 8/29/19 indicated Resident #8 was independent with daily decision making.<br><br>A review of the most current care plan for Resident #8 dated 8/23/19 indicated focus areas including medication risks, activities of daily living needs such as dressing, bathing and grooming, and fall risk with goals that were measurable and interventions which were individualized.<br><br>On 12/12/19 at 9:00 AM an interview with Resident #8 indicated he did not recall receiving a written summary of his baseline care plan. He further indicated he did not have any concerns or questions regarding his care and was being taken of.<br><br>On 12/12/19 at 10:34 AM interview with the MDS Coordinator indicated neither Resident #8 or his representative had received a written copy of his baseline care plan. She went on to say she usually gave residents or their representatives a copy of the order summary report which they | F 655 | Assistants and Admissions Directors and in the required in-service refresher courses for these employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br><br>The Administrator, Director of Nursing or MDS Consultant will conduct audits to ensure the baseline care process is provided to Residents and or Resident Representative. These audits will be conducted weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate.<br>Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.<br>The title of the person responsible for implementing the plan of correction.<br>The Administrator is responsible for implementation and completion of the acceptable plan of correction.<br><br>Date of Compliance: | |

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| F 655 | Continued From page 14 | F 655 | 01/09/2019 | |

signed to acknowledge receiving but did not know why she had not provided this information to Resident #8 or his representative.

On 12/12/19 at 9:13 AM an interview with the Administrator indicated it was the facility's practice to provide residents or their representatives with an order summary report which would include initial goals, physician orders, dietary orders and therapy services which served as the baseline care plan written summary. The Administrator went on to say this information had not been provided to Resident #8 or his representative. She stated it just got missed.

5.Resident #34 was admitted to the facility on 10/30/19 with diagnoses including heart failure. She was discharged from the facility to home on 12/11/19.

A review of the most current Minimum Data Set (MDS) assessment for Resident #34 dated 11/6/19 indicated Resident #34 was independent with daily decision making.

A review of the most current care plan for Resident #34 dated 10/31/19 indicated focus areas including medication risks, activities of daily living needs such as dressing, bathing and grooming, and fall risk with goals that were measurable and interventions which were individualized.

On 12/10/19 at 10:32 AM an interview with Resident #34 indicated she did not recall receiving a written copy of her baseline care plan but had been in the facility before, understood her condition, was going home on 11/11/19 and did

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| F 655 | Continued From page 15<br>not have any questions regarding her care.<br><br>On 12/12/19 at 10:34 AM interview with the MDS Coordinator indicated neither Resident #34 or her representative had received a written copy of her baseline care plan before her discharge. She went on to say she usually gave residents or their representatives a copy of the order summary report which they signed to acknowledge receiving but did not know why she had not provided this information to Resident #34 or her representative.<br><br>On 12/12/19 at 9:13 AM an interview with the Administrator indicated it was the facility's practice to provide residents or their representatives with an order summary report which would include initial goals, physician orders, dietary orders and therapy services which served as the baseline care plan written summary. The Administrator went on to say this information had not been provided to Resident #34 or her representative before her discharge. She stated it just got missed | F 655 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic | F 758 | | 1/9/20 |

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| F 758 | Continued From page 16<br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, staff interviews, consultant pharmacist interviews, and physician | F 758 | F758<br>The statements made on this plan of | |

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| F 758 | Continued From page 17<br>interviews, the facility failed to ensure a physician's order for as needed (PRN) psychotropic (drug that affects mental state) medication was time limited in duration for 2 of 6 residents reviewed for unnecessary medication (Resident #41 and #39).<br><br>Findings included:<br><br>1. Resident #41 was admitted to the facility on 9/30/19 with diagnoses that included congestive heart failure and anxiety disorder.<br>The admission Minimum Data Set (MDS) assessment dated 10/07/19 indicated Resident #41 was cognitively intact and received an antianxiety medication 5 days during the look back period.<br><br>A physician's order dated 10/04/19 indicated Xanax (antianxiety medication) 0.5 milligrams (mg) by mouth every 12 hours as needed for anxiety. There was no stop date written for the PRN Xanax order.<br><br>A review of Resident #41's Medication Administration Record (MAR) from October 4, 2019 to December 10, 2019 revealed per staff documentation on the MARs that Resident #41 had received 9 doses of PRN Xanax in October, 3 doses in November, and 4 doses in December of 2019.<br><br>The Consultant Pharmacist (CP) #1 monthly drug regimen review for Resident #41 indicated the CP had recommended the physician clarify the time limit on 10/23/19 and 11/22/19. The physician response for the 10/23/19 monthly drug regimen review recommendation was a handwritten note dated 10/28/19 which stated the patient had | F 758 | correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.<br><br>Plan for correcting specific deficiency. The process that led to deficiency cited.<br><br>1. A physician order dated 10/04/2019 indicated that Xanax (antianxiety medication) 0.5 milligrams (mg) by mouth every 12 hours as needed for anxiety. On 01-03-2019, a physician order with a stop date was obtained for Resident #41.<br>2 A physician order dated 11/10/2019 indicated that Xanax (an antianxiety medication) 0.5 milligrams (mg) by mouth every 6 hours as needed for anxiety. On 01-03-2019, a physician order with a stop date was obtained for Resident #39.<br><br>A 100% audit on all current residents receiving PRN psychotropic medications to ensure stop dates were in place. This audit was completed on 1-6-2019. Any concerns identified were corrected immediately.<br><br>The Director of Nursing inserviced all FT, | |

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| F 758 | Continued From page 18<br>ongoing anxiety issues and did not include a stop date. The physician response for the 11/22/19 monthly drug regimen review recommendation for a duration of therapy was a handwritten note dated 12/01/19 which stated that Resident #41 still required the Xanax since she had been on it long term and did not include a stop date.<br><br>An interview with CP #1 on 12/12/19 at 8:35 AM revealed she had sent recommendations for the physician to clarify the number of days for the Xanax on 10/23/19 and 11/22/19. She further stated no stop date was provided for the 10/23/19 recommendation and she had sent another recommendation on 11/22/19 and was unaware if there had been a response and planned to follow up the next time she was in the facility. She further revealed it was her normal practice to discuss with the Director of Nursing (DON) or contact the physician if she did not receive a response by the third monthly drug regimen review and that would be December for Resident #41.<br><br>An interview with Physician #1 on 12/12/19 at 8:09 AM indicated he was aware of the Centers for Medicaid and Medicare (CMS) regulation that indicated PRN psychotropic medication required a duration for a PRN psychotropic medication such as the Xanax prescribed for Resident #41. He stated he was usually good about review of antianxiety medications but had "just not gotten around to looking at her medications and providing a stop date".<br><br>An interview with the Administrator on 12/12/19 at 11:01 AM revealed the physician should provide a stop date for PRN psychotropic medications per CMS regulations. | F 758 | PT, and PRN RN's, LPN's, on the following procedures: 01-09-2019<br><br>Psychotropic Drugs- PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>Any in-house staff member who did not receive in-service training by 01-09-2019 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br><br>The Director of Nursing or Support Nurse will conduct audits to ensure PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>These audits will be conducted weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure | |

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| F 758 | Continued From page 19<br>2. Resident #39 was admitted to the facility on 11/4/19 with diagnoses that included heart failure and diabetes.<br><br>A physician ' s order dated 11/10/19 indicated Xanax (an anti-anxiety medication) 0.5 milligrams (mg) by mouth every 6 hours as needed for anxiety. There was no stop date written for the as needed Xanax order.<br><br>The admission Minimum Data Set (MDS) assessment dated 11/11/19 indicated Resident #39 was cognitively impaired and received an antianxiety medication 1 day during the look back period.<br><br>The Consultant Pharmacist (CP) monthly drug regimen review for Resident #39 indicated the CP recommended the physician clarify the time limit for the resident ' s Xanax order on 11/22/19. There had been no response.<br><br>An interview was conducted on 12/12/19 at 12:49 PM with Physician #2 who indicated he was aware the order for the Xanax, which was ordered to be administered on an as needed basis, should have had a stop date and he would expect the facility to contact him regarding the stop date. He continued he was not at the facility daily and only had a few residents as patients.<br><br>An interview with the Administrator on 12/12/19 at 11:01 AM revealed the physician should provide a stop date when writing orders for as needed psychotropic medications. | F 758 | corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.<br>The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.<br><br>Date of Compliance:<br><br>01/09/2019 | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2) | F 761 | | 1/9/20 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345404 | A. BUILDING _____ B. WING _____ | C 12/12/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THREE RIVERS HEALTH AND REHAB | 1403 CONNER DRIVE WINDSOR, NC 27983 |

| (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 |
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| F 761 | Continued From page 20<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to discard expired medications in 2 of 2 medication room refrigerators.<br><br>Findings included:<br><br>1. On 12/10/19 at 1:36 PM, during the long-term care hall medication room storage observation, 2 open vials of purified protein derivative (PPD) were found in the medication room refrigerator. These 2 open vials of PPD had 1 vial which was dated 10/25/19 and 1 vial which was undated. | F 761 | F761<br>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be | |

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| F 761 | Continued From page 21<br><br>An interview on 12/10/19 at 1:44 PM with Nurse #2 indicated that both vials should have been discarded since one had been open more than 30 days and the other one was undated. She confirmed PPD should be dated when opened and then discarded after being open 30 days.<br><br>An interview on 12/10/19 at 1:52 PM with the Director of Nursing (DON) indicated both open PPD vials should have been discarded and should not have been available for resident use. She further stated PPD should be dated when opened and discarded 30 days after opened per manufacturer recommendations.<br><br>An interview on 12/11/19 at 3:08 PM with the Administrator revealed expired medications should be discarded, the facility should follow manufacturer recommendations and should not be available for resident use.<br><br>2. On 12/10/19 at 2:15 PM during the rehabilitation medication room storage observation, 2 open, undated vials of purified protein derivative (PPD) were found in the medication room refrigerator. These 2 open vials of PPD were undated.<br><br>An interview on 12/10/19 at 2:22 PM with Nurse #5 indicated that both vials should have been discarded.<br><br>An interview on 12/10/19 at 1:52 PM with the Director of Nursing (DON) indicated both open PPD vials should have been discarded and should not have been available for resident use. She further stated PPD should be dated when opened and discarded 30 days after opened per | F 761 | corrected by the dates indicated.<br><br>Plan for correcting specific deficiency. The process that led to deficiency cited.<br><br>1. On 12/10/2019, in the long term care medication storage room, 2 open vials of PPD (1 vial which was dated 10/25/19 and 1 vial was undated) were discarded by the Director of Nursing.<br>2 On 12/10/2019, in the rehab medication room, 2 open vials of PPD not dated were discarded by the Director of Nursing.<br><br>A 100% audit of medications storage rooms was conducted to ensure the drugs and biologicals used in the facility are labeled and dated according to the regulation. This was completed by the Director of Nursing on 01-03-2019.<br><br>On 12/31/19, The Director of Nursing began in servicing all FT, PT, and PRN RN's, LPN's, on the following procedures:<br><br>Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.483.45(h) Storage of Drugs and Biologicals483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and | |

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| F 761 | Continued From page 22<br>manufacturer recommendations.<br><br>An interview on 12/11/19 at 3:08 PM with the Administrator revealed expired medications should be discarded, the facility should follow manufacturer recommendations and should not be available for resident use. | F 761 | biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to thekeys.483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Any in-house staff member who did not receive in-service training by 1-9-2019, will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br><br>The Director of Nursing or Support Nurse will conduct audits to ensure the drugs and biologicals used in the facility are labeled and dated according to the regulation.<br>These audits will be conducted weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by | |

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| F 761 | Continued From page 23 | F 761 | QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.<br>The title of the person responsible for implementing the plan of correction.<br>The Administrator is responsible for implementation and completion of the acceptable plan of correction.<br><br>Date of Compliance:<br><br>01/09/2020 | |