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	345391	A. BUILDING _____ B. WING _____	C 03/19/2021

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HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

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E 000	Initial Comments An unannounced Recertification survey was conducted on 3/16/2021 through 3/19/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 5B1K11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted on 3/16/21 through 3/19/21. 2 of the 24 complaint allegations were substantiated resulting in deficiencies. Event ID # 5B1K11.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability	F 645		4/16/21

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

Electronically Signed | 04/16/2021

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F 645	Continued From page 1	F 645		

authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

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

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

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F 645	Continued From page 2 intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) for a resident with an active diagnosis of a serious mental illness for one of one resident reviewed for PASRR (Resident #51). Findings included: Resident #51 was admitted on 10/27/17 with pertinent diagnoses: Bipolar Disorder, Post Traumatic Stress Disorder, Anxiety, and Cerebellar Ataxia Resident #51 PASRR Level I Determination Notification document dated 10/27/17 revealed nursing facility placement was appropriate and that there was no diagnosis that would require a PASRR Level II to be done. This was sent with Resident #51 from another facility where she had previously been living. The quarterly Minimum Data Set (MDS) assessment dated 2/15/21 revealed Resident #51 was not cognitively impaired. The MDS further revealed that Resident #51 was totally dependent on staff for transfers and required extensive assistance with bed mobility and toileting. Resident #51's medical record showed that a current care plan was in place for her diagnosis of Bipolar Disorder. The record also revealed that resident had been treated by a Behavioral Health	F 645	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 3/19/2021 it was discovered that the Resident identified as Resident #55 had not been screened for Level II Preadmission Screening and Resident Review (PASRR) with an active diagnosis of a serious mental illness. The SW verified that the diagnosis for Resident #55 did require PASRR Screening. A diagnosis: Bipolar Disorder, Past Traumatic Stress Disorder, Anxiety, and Cerebellar Ataxia met this requirement and was not completed. The morning of 3/17/21 the facility submitted the PASRR Screening for Resident #55. On 3/17/21 the Social Worker was In-serviced on PASRR screening requirements, and company Policies and Procedures. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/17/21 an audit was completed by Medical Records, Admission Director, and Social Services Director of applicable residents. The audit included a review of	

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F 645	Continued From page 3 group at regularly intervals since admission and was prescribed Risperidone at bedtime and Seroquel 125 mg daily. An interview was conducted with the facility's social worker on 3/19/21 at 8:25 am revealed she was unaware that Resident #51 had a diagnosis of Bipolar Disorder and did not have a PASRR Level II completed. She handed me a copy of a PASRR Level II that she had completed the previous day after looking into Resident #51's chart and agreed that she should have had one completed upon entry to the facility. An interview was conducted with the facility's Administrator on 3/19/21 at 2:39 PM who was aware of Resident #51's diagnoses of Bipolar Disorder but was unaware that she had not had a PASRR Level II completed. The facility's Administrator was made aware that a PASRR Level II has now been submitted for Resident #51.	F 645	all resident diagnosis to see if any other residents needed to be submitted and findings were documented on audit tool. Key IDT team members were in-serviced on 3/18/21 on the new process for monitoring for PASRR changes. The process to complete application is as follows: (A) Print resident current Existing PASSRR notification. (B) Resident review of Face Sheet and Diagnosis list. (C) Review of PASRR Screen based on current list of conditions. (E) Review of Care Plan to ensure person centered care. Upon audit and implementing new process change, identified residents will have a completed application submitted 3/19/21. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Admissions Coordinator will distribute the PASRR screen from acute care setting for approved admissions with diagnosis list for IDT team members to review. The IDT team will review the PASRR upon admission during the daily morning meeting. On 3/19/21 process change initiated for review off Diagnosis list by Social Services Director, Medical Records, MDS, and ED for PASRR Screen submittal for any new residents with Mental Health	

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F 645	Continued From page 4	F 645	Diagnosis or current residents with a SIG change that would warrant new submission for screening. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. As a monitoring tool weekly audits will be conducted for 4 weeks, monthly for three months, and then quarterly thereafter to monitor any activities that would require a PASRR change, i.e.: Admissions, Readmission, Significant Changes, and new diagnosis of mental illness. Findings of the audit tool will be addressed immediately through in-service training and appropriate staff will submit application for PASRR change. All negative findings identified will be submitted to QAPI monthly and/or changes will be addressed and made to this plan as needed necessary. 100% of admissions PASRR will be reviewed during morning meeting daily as audit x 4 weeks, monthly for 3 months. Audit will be reviewed in monthly facility QAPI meeting minutes	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		4/16/21

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F 658	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to transcribe orders for intravenous/PICC line site care for 1 of 1 residents reviewed for PICC line care (Resident #286). Findings include: Resident #286 was admitted to the facility on 8/30/2020 with diagnosis that included osteomyelitis, fracture of the ribs and a fracture of the distal humorous. The Resident was assessed to have a PICC/Intravenous line to the Right upper extremity. A review of the comprehensive minimum data set (MDS) assessment dated 8/30/2020, revealed the named Resident was cognitively intact, required extensive assistance of two people for bed mobility, transfers and toileting. The MDS coded the resident had osteomyelitis and received IV transfusions of antibiotics while a resident. The comprehensive care plan dated 8/30/2020 did not include a focused problem area for intravenous maintenance or infection. An interview was conducted with the Director of Nursing that revealed intravenous line orders would be added to the Medication administration record (MAR) for site assessment and monitoring every shift with weekly dressing changes every 7 days and as needed. A review of the nursing progress notes revealed documentation, dated 9/11/2020, of a dressing change due to dried blood at the site. This was	F 658	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Upon review of resident□s chart on 3/19/21 it was discovered that residents Care Plan did not match her needs. PICC line/Midline information did not get transferred over from Base Care Plan and was not documented on the comprehensive. Resident was discharged from the facility when issues were identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with PICC lines or Midline will be audited to ensure they have the orders for weekly dressing changes, PRN dressing changes and daily monitoring for s/s of infection or pain. Care Plans of residents with IC, PICC line or Midline will be audited to ensure these are on the Care Plan. Residents with peripheral IC□s will be audited to ensure correct orders for site change and monitoring. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 658	Continued From page 6 the only dressing change documentation in the progress notes discovered. A review of the Medication administration record for Resident #286, for the month of September and October 2020 did not include orders for intravenous line site assessment and monitoring. A review of the Treatment administration record for Resident #286, for the month of September and October 2020 did not include dressing change orders for the intravenous site. An interview was conducted on 3/19/2021 at 9:40 AM, with the Administrator and he stated the closed chart for Resident #286 was reviewed by himself and a corporate consultant and they did not find any evidence that a PICC line dressing change occurred more than one time in the months of September and October 2020. He stated it was his expectation that orders be transcribed to the MAR or TAR per facility policy and dressing changes be provided as ordered. A review of the nursing progress note dated 10/5/2020 documented the named Resident was complaining of burning during antibiotic intravenous therapy being delivered through the PICC line. The Antibiotic was stopped, the PICC line was flushed and the pain stopped. On 10/6/2020 at 1:09 PM, a nursing progress note documented the Resident complained of right arm burning. The Nurse Practioner was notified and orders to flush the line were received. The resident requested to be evaluated at the hospital. The Resident was transferred to the hospital and admitted on 10/6/2020.	F 658	recur. All nurses will be educated on required orders for IV, PICC, and or Midline dressing site changes and monitoring. Education for IC, PICC/Midline dressing/Site changes and monitoring will be added to new nurse orientation. Quick reference sheets will be at each nursing station as reminders for nursing staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 100% of residents whether admitted or added post admission with a IV, PICC line or Midline or have one inserted will be audited to ensure orders are transcribed correctly for 4 weeks, at which time we will then audit 50% of resident with IV/PICC/Medline for 4 weeks to ensure care plan accuracy, then 25% of residents with IV/PICC or Midline will be audited for 4 weeks to ensure orders are transcribed correctly. This will then be reviewed for compliance at our monthly QAPI meeting. 100% of residents that are admitted with an IV, PICC line or Midline or have one inserted while at the facility will be audited to ensure Care Plan accuracy for 4 weeks, and then checked at a 50% rate for 4 weeks and following a 25% Audit for 4 weeks to be reviewed in our Monthly QAPI meeting for 3 months.	

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F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete a discharge summary for 1 of 1 resident (Resident #79) reviewed for planned discharge to the community. Findings included:	F 661	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Upon review of the closed chart that facility was unable to locate Discharge	4/16/21

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F 661	Continued From page 8 Resident #79 was admitted to the facility on 12/11/20 with diagnoses that included, in part, congestive heart failure and dementia. The discharge Minimum Data Set (MDS) assessment dated 12/21/20 revealed Resident #79 had severely impaired cognition. The MDS assessment also indicated discharge planning was occurring since Resident #79 expected to be discharged to the community. The baseline care plan indicated Resident #79 was at the facility for a respite stay and would be discharged back to her home in the community upon completion of the respite stay. Resident #79 discharged home on 12/21/20. Resident #79's closed paper chart and electronic health record was reviewed for a discharge summary and was not located in either chart. A discharge summary would have ensured the facility communicated necessary information when Resident #79 discharged home. On 3/19/21 at 4:59 PM an interview was completed with the facility Social Worker (SW) and Director of Operations. The SW stated she was responsible for discharge planning when a resident came to the facility for a short stay and planned to return home to the community. The SW explained Resident #79 came to the facility for a respite stay and then returned home. She said a discharge summary was not completed when the resident discharged home. The SW was aware a discharge summary should have been completed prior to discharge and reported it wasn't completed because the discharge process was inconsistent. During the interview the	F 661	Summary for resident identified as #79. Resident #79 was discharged home on 3/3/21 and picked up by family from local Dialysis center by PACE who then transported resident home. PACE later picked residents belongings and delivered them to residents□ home. Resident□s disposition of medication list, discharge summary, and discharge instructions were not sent with resident. Review and Education were initiated of Discharge process, and Policies and Procedures to include recapitulation of stay. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/3/2021 and 4/14/21, Discharges were audited by key IDT team members and reviewed by Social Services Director, Medical Records, and Director of Nursing for the absence/presence for required discharge documentation; this information ensures residents and families received information surrounding the recapitulation of stay, a final discharge summary, medication (printed and reviewed) and a post discharge Plan of Care. On 4/13/21 Social Services Director and Administrative Team were In-serviced on the Discharge Regulations and the requirements for a safe discharge, to include but not limited to Recapitulation of Stay.	

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F 661	Continued From page 9 Director of Operations revealed she had recently audited closed charts and identified inconsistencies with discharge documentation. She had completed audits of discharged residents back to April 2020 and was still identifying charts that were out of compliance with discharge documentation, including discharge summaries. She had recently educated staff regarding the requirements for discharge documentation. The Director of Operations stated when Resident #79 discharged home in December 2020 the facility should have provided her with a discharge plan of care, medication list and a discharge summary that included a recapitulation of the resident's stay.	F 661	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Discharges will be announced daily in Morning Meeting. Residents discharged the day prior will have a chart review completed to ensure necessary communication and documentation was completed at time of discharge. Social Services Director will complete discharge follow up call within 48 hours after discharge to ensure safe transition from facility. Any identified areas of concern will be communicated to the appropriate agencies. MDS will maintain the Recapitulation of Stay form in the Discharge Notebook with all discharges. All discharges from the facility including unanticipated discharges, respite discharges, any resident that has discharged from this facility will have a recap of services. IDT members will come by first thing in the morning and complete their Recapitulation of Stay items of the form and will leave form remaining in discharge notebook for further review. MDS will be responsible, once the form is completed by all team members, MDS will take the form to Medical Records to be signed by MD, and then scanned in resident record. Indicate how the facility plans to monitor its performance to make sure that	

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F 661	Continued From page 10	F 661	solutions are sustained. Discharge Audits will be completed weekly for 3 months and then quarterly thereafter to ensure safe discharges. Discharge audit will be documented on the Discharge Audit tool. Discharge Audits will be reviewed in monthly facility QAPI meeting	