STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING ______ B. WING ______	C 10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES NURSING & REHAB CENTER	**523 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301**

(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 The survey team entered the facility on 10/11/2021 to conduct a Recertification survey and a complaint investigation survey. The survey team was onsite 10/11/2021, 10/12/2021, and 10/13/2021. Additional information was obtained offsite on 10/14/2021 and 10/15/2021. Therefore, the exit date was 10/15/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# B42N11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 10/11/21 to conduct a recertification survey and complaint investigation. The survey team was onsite 10/11/2021, 10/12/2021 and 10/13/2021. Additional information was obtained offsite on 10/14/2021 and 10/15/2021. Therefore, the exit date was 10/15/2021. Event ID# B4N11. 15 of the 15 complaint allegations were not substantiated.	F 000		
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	F 644		11/12/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/29/2021

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 644 Continued From page 1

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 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 1 of 1 resident reviewed for PASRR (Resident #11).

The findings included:

Resident #11 was admitted to the facility on 01/18/2018 with diagnoses including coronary artery disease (CAD), peripheral vascular disease (PVD), depression (other than bipolar), psychotic disorder (other than schizophrenia), and Non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 07/23/2021 had Resident #11 coded as moderately cognitively impaired needed extensive assistance with bed mobility, toilet use, and dressing and needed total dependence on staff for transfers.

The comprehensive care plan dated 08/21/2021 had focus' of a cognitive, communication deficits. This deficit may result in behavior issues, indifference, unmet needs, increased confusion with wandering behaviors, paranoia, impulsive/unsafe behavior, perseveration (fixation on/repetition of) and may progress requiring adjustments to treatment/care plan to enhance quality of life.

F 644

For resident #11, a Level II Preadmission Screening and Resident Review (PASRR) application was submitted by the facility Social Services Director (SSD) via North Carolina Medicaid Uniform Screening Tool (MUST) on 10/29/2021. The resident's care plan was reviewed by the Minimum Data Set (MDS) Nurse and resident is currently receiving medical and psych services for his diagnosis. No care changes were needed.

Facility Executive Director (ED) and SSD conducted an audit of PASSRs to ensure proper level of care and quality was being provided to all residents by ensuring each resident had a current PASRR and no expired PASSR existed in the facility. The audit also identified any residents who may have a diagnosis (Dx) that would require a Level II PASRR screen. The audit was completed on 10/22/2021. Findings of the audit revealed that there were no residents identified without a current PASRR and twenty-three residents needed a screen completed. Screens will be completed no later than 11/12/2021.

Any resident who triggered for a

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F 644	Continued From page 2 A reviewed of the North Carolina Department of Health and Human Services PASRR level I determination notification dated 07/12/2017 revealed the level I screen and PASRR number remains valid for the individual's stay. A copy of this notice should be transferred with the individual if he/she relocates to another nursing facility. No further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. A review of the diagnosis/history sheet dated 10/12/2021 revealed Resident #11 was diagnosed with vascular dementia without behavioral disturbance 10/10/2017, vascular dementia without behavioral disturbance 05/01/2020, vascular dementia with behavioral disturbance 04/23/2020, Psychotic disorder with hallucinations 05/01/2020, unspecified psychosis not due to a substance 10/19/2017, other specified depressive episodes 05/01/2020. An interview with the Social Worker (SW) was conducted on 10/12/2021 at 3:58 PM. The SW stated when there is a new mental health diagnosis, they are supposed to refer the resident for a new PASRR level II screening. The SW also stated she was a new employee that started 10/04/2021. An interview with the Administrator was conducted on 10/12/2021 at 4:22 PM. The Administrator stated when a resident has a new mental health diagnosis, there should be a screening for a PASRR level II. The Administrator	F 644	significant change for the past 90 days was also screened by the MDS Nurse by 10/22/2021 to ensure that any new diagnosis which require Level II PASRR screening will have new screening completed as identified. SSD will be responsible for completing PASRR changes and was in-serviced by the facility ED on 10/28/2021 on the new process for monitoring for PASRR changes. The process to complete application is as follows: (a) Print resident current Existing PASRR Notification. (b) Resident review of Face Sheet and diagnosis list (c) Review of PASRR Screen for Listed Diagnosis and condition list as required for review (d) Resubmittal of PASRR Screen based on current list of conditions (e) Review of Care Plan to ensure person centered care. (f) Identify any new diagnosis added that will require a PASRR application. Weekly audits will be conducted x4, monthly x3, and quarterly thereafter by the facility ED, SSD or designee to monitor any activities that would require a PASRR change, i.e.: admissions, readmissions, significant changes, and new diagnosis of mental illness. Any negative findings of the audit tool will be addressed immediately through in-service training and appropriate staff will submit application for PASRR screen. Findings identified will be submitted to the Quality Management Program (QPM) Committee monthly by the facility ED or SSD and/or changes will be made to this	

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F 644	Continued From page 3 also stated a PASRR level II screening was not in place due to a letter from the Physicians stating the resident's diagnosis of dementia superseded the new mental health diagnoses.	F 644	plan as deemed necessary by the Committee.	