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	345288	A. BUILDING ______ B. WING ______	C 04/28/2022

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COMPASS HEALTHCARE AND REHAB ROWAN, LLC	1404 S SALISBURY AVENUE SPENCER, NC 28159

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/25/2022 through 4/28/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 7MXX11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey was conducted 4/25/2022 to 4/28/2022. 6 of the 6 complaint allegations were unsubstantiated. The followings intakes were investigated: NC00183337, NC00183007, NC00180874.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		5/23/22

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

Electronically Signed — 05/13/2022

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 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to develop a care plan that addressed discharge goals and plans for 5 of 7 residents (Residents #39, #53, #21, #12 and #7) reviewed for discharge planning. Findings included: 1. Resident #39 was admitted to the facility on 6/10/20 with diagnoses that included, in part, hypertension and diabetes. The annual Minimum Data Set (MDS) assessment dated 3/17/22 revealed Resident #39 was cognitively intact. The assessment further indicated an active discharge plan was not in place for the resident to return to the community.	F 656	Resident #12, #21 and #53 have been discharged, therefore a care plan update cannot be completed. Resident #7 and #39 had care plans reviewed and updated by the MDS Nurse and Social Worker to ensure discharge care plans were in place and accurate and person centered on 5/3/22. The MDS Nurse and the Social Worker conducted a comprehensive care plan audit for all other residents to ensure discharge care plans were in place and accurate on 5/3/22. Education will be provided for the	

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F 656	Continued From page 2 The comprehensive care plan, updated 3/7/22, did not include information that addressed discharge planning. In an interview with Resident #39 on 4/25/22 at 11:34 AM, he stated he had told staff in the past that he wanted to go home. On 4/27/22 at 10:07 AM an interview was completed with the Social Worker (SW). She typically completed the cognitive, mood, behavior, and return to community sections of the MDS assessment and created care plans for the sections in conjunction with the MDS Coordinator. The SW explained if discharge planning/return to community "triggered" on the MDS assessment, she completed a discharge care plan since the resident indicated a desire to return to the community. If the resident had not expressed a desire to return home or to the community then she had not completed a care plan that specifically addressed discharge plans and goals. She added Resident #39 had expressed a desire to discharge home with his family member. The MDS Coordinator was interviewed on 4/27/22 at 10:29 AM. She explained if a resident was at the facility for long term care, she had not developed a care plan that addressed discharge plans. If a resident came to the facility for short term rehabilitation and expressed a goal of return home, then she added a discharge care plan. She said the SW typically communicated the resident's discharge plan and then she added the information to the comprehensive care plan. The MDS Coordinator shared she and the SW addressed discharge goals in their care plan notes but had not consistently added the	F 656	interdisciplinary team by the Administrator regarding the need for care plans to accurately reflect the discharge plan for a resident on the comprehensive care plan on 5/18/22. The MDS Nurse will audit for comprehensive discharge care plans according to the weekly care plan schedule weekly times four weeks, then monthly for three months. Data obtained during the audits will be analyzed for patterns and trends and reported to the QAPI committee by the MDS Nurse monthly for three months. The QAPI committee will evaluate the outcome of the audits to determine if continued audits are necessary to maintain compliance and for continued quality improvement	

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F 656	Continued From page 3	F 656		

information into the comprehensive care plan. She added Resident #39 was at the facility for long term care.

During an interview with the Director of Nursing (DON) on 4/27/21 at 11:05 AM she stated facility staff discussed a resident's discharge plans and goals upon admission. She was not aware that discharge planning information needed to be included in the comprehensive care plan.

2. Resident #53 was admitted to the facility on 10/28/21 with the diagnosis of an unspecified open wound to her lower back and pelvis.

The admission assessment dated 11/23/21 indicated Resident #53 was cognitively intact.

The care plan dated 11/4/21 did not include discharge planning for Resident #53.

The Physician's Note dated 12/15/22 indicated Resident #53's condition was stable for discharge to the assisted living building.

Review of the Director of Nursing's Note dated 2/16/22 documented Resident #53 was initially admitted to the facility for short term rehabilitation with the goal of returning to her home. The note further revealed that after discussion with the physician and the Director of Nursing on 2/15/22 concerning the resident's improvements, the resident agreed to transfer to the assisted living building.

The Interdisciplinary Discharge Summary dated 2/16/22 revealed Resident #53 had progressed back to her baseline and was discharged due to a

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F 656	Continued From page 4 change in level of care. The discharge minimum data set dated 2/16/22 indicated Resident #53's discharge to the community was planned. During an interview on 4/28/22 at 3:50 p.m., the Minimum Data Set Coordinator acknowledged discharge planning was not included in Resident #53's Care Plan. She stated that the error was an oversight. 3. Resident #21 was admitted to the facility on 2/28/22 with diagnoses that included, in part, congestive heart failure and diabetes. The admission MDS assessment dated 2/28/22 revealed Resident #21 had severely impaired cognition. The assessment further indicated the resident's discharge goal was "unknown or uncertain." The comprehensive care plan, updated 3/8/22, did not include information that addressed discharge planning. On 4/27/22 at 10:07 AM an interview was completed with the SW. She typically completed the cognitive, mood, behavior, and return to community sections of the MDS assessment and created care plans for the sections in conjunction with the MDS Coordinator. The SW explained if discharge planning/return to community "triggered" on the MDS assessment, she completed a discharge care plan since the resident indicated a desire to return to the community. If the resident had not expressed a	F 656		

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F 656	Continued From page 5	F 656		

desire to return home or to the community then she had not completed a care plan that specifically addressed discharge plans and goals.

The MDS Coordinator was interviewed on 4/27/22 at 10:29 AM. She explained if a resident was at the facility for long term care, she had not developed a care plan that addressed discharge plans. If a resident came to the facility for short term rehabilitation and expressed a goal of return home, then she added a discharge care plan. She said the SW typically communicated the resident's discharge plan and then she added the information to the comprehensive care plan. The MDS Coordinator shared she and the SW addressed discharge goals in their care plan notes but had not consistently added the information into the comprehensive care plan. She added Resident #21's family had not given a clear indication if the resident's stay was short term or if she would be at the facility for long term care.

During an interview with the DON on 4/27/21 at 11:05 AM she stated facility staff discussed a resident's discharge plans and goals upon admission. She was not aware that discharge planning information needed to be included in the comprehensive care plan.

4. Resident #12 was admitted to the facility on 10/29/20 with diagnosis that included, in part, dementia.

The quarterly MDS assessment dated 2/4/22 revealed Resident #12 had impaired short term and long term memory and severely impaired daily decision making skills.

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F 656	Continued From page 6	F 656		

The comprehensive care plan, updated 3/7/22, did not include information that addressed discharge planning.

On 4/27/22 at 10:07 AM an interview was completed with the SW. She typically completed the cognitive, mood, behavior, and return to community sections of the MDS assessment and created care plans for the sections in conjunction with the MDS Coordinator. The SW explained if discharge planning/return to community "triggered" on the MDS assessment, she completed a discharge care plan since the resident indicated a desire to return to the community. If the resident had not expressed a desire to return home or to the community then she had not completed a care plan that specifically addressed discharge plans and goals.

The MDS Coordinator was interviewed on 4/27/22 at 10:29 AM. She explained if a resident was at the facility for long term care, she had not developed a care plan that addressed discharge plans. If a resident came to the facility for short term rehabilitation and expressed a goal of return home, then she added a discharge care plan. She said the SW typically communicated the resident's discharge plan and then she added the information to the comprehensive care plan. The MDS Coordinator shared she and the SW addressed discharge goals in their care plan notes but had not consistently added the information into the comprehensive care plan. She added Resident #12 was at the facility for long term care.

During an interview with the DON on 4/27/21 at 11:05 AM she stated facility staff discussed a resident's discharge plans and goals upon

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F 656	Continued From page 7 admission. She was not aware that discharge planning information needed to be included in the comprehensive care plan. 5. Resident #7 was admitted to the facility on 11/17/21 with diagnosis that included, in part, dementia. The quarterly MDS assessment dated 1/21/22 revealed Resident #7 was cognitively intact. The comprehensive care plan, updated 2/7/22, did not include information that addressed discharge planning. On 4/27/22 at 10:07 AM an interview was completed with the SW. She typically completed the cognitive, mood, behavior, and return to community sections of the MDS assessment and created care plans for the sections in conjunction with the MDS Coordinator. The SW explained if discharge planning/return to community "triggered" on the MDS assessment, she completed a discharge care plan since the resident indicated a desire to return to the community. If the resident had not expressed a desire to return home or to the community then she had not completed a care plan that specifically addressed discharge plans and goals. The MDS Coordinator was interviewed on 4/27/22 at 10:29 AM. She explained if a resident was at the facility for long term care, she had not developed a care plan that addressed discharge plans. If a resident came to the facility for short term rehabilitation and expressed a goal of return home, then she added a discharge care plan. She said the SW typically communicated the resident's discharge plan and then she added the	F 656		

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F 656	Continued From page 8 information to the comprehensive care plan. The MDS Coordinator shared she and the SW addressed discharge goals in their care plan notes but had not consistently added the information into the comprehensive care plan. She added Resident #7 was at the facility for long term care. During an interview with the DON on 4/27/21 at 11:05 AM she stated facility staff discussed a resident's discharge plans and goals upon admission. She was not aware that discharge planning information needed to be included in the comprehensive care plan.	F 656		