STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345316	A. BUILDING: _____ B. WING _____	9/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments for 1 of 15 sampled residents whose MDS were reviewed (Resident #22). The findings included: Resident #22 was admitted to the facility on 9/10/19. A physician order for tube feed enteral nutrition FIbersouce HN at 45 milliliters per hour continuously via pump. The Minimum Data Set (MDS) annual assessment dated 7/29/23 revealed Resident #22 was coded for a feeding tube and was incontinent of bowel and bladder. Resident #22 was coded in the activities of daily living (ADL) functional status section of the assessment as activity did not occur for eating and toileting during the lookback period. An interview was conducted on 9/25/23 at 9:24 am with the MDS Nurse who revealed she incorrectly coded Resident #22's annual assessment for eating and toileting. The MDS Nurse stated she was not sure why she coded the eating and toileting ADL as did not occur for Resident #22. An interview was conducted on 9/27/23 at 2:00 pm with the Interim Director of Nursing (DON) who stated the MDS Nurse was responsible for coding Resident #22's MDS assessment correctly.
F 655	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident 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.

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

The above isolated deficiencies pose no actual harm to the residents

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F 655	Continued From Page 1

(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:
Based on record review, and interviews with staff, the facility failed to formulate a baseline care plan within 48 hours of a resident's admission to the facility for 1 of 1 resident (Resident #200).

The findings included:

Resident #200 was admitted to the facility on 9/21/23 with diagnoses including Unspecified Fracture of Right Pubis.

A record review 9/24/23 at 11:00 A.M. revealed no baseline care plan for Resident #200.

A review of the 5-day Minimum Data Set (MDS) dated 9/25/23 revealed Resident #200 was cognitively impaired and needed extensive assistance with activities of daily living.

An interview with the Minimum Data Set (MDS) Nurse on 9/25/23 at 10:58 AM revealed she was responsible for completing the baseline care plan. She stated she did not complete the baseline care plan because she had not met with the resident.

During an interview with the Director of Nursing (DON) on 9/26/23 at 10:58 A.M. she revealed it was the responsibility of the MDS Nurse to formulate and complete the base line care plan within 48 hours after admission of a resident.