| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345328 | A. BUILDING _____ B. WING _____ | 12/21/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GIVENS HEALTH CENTER | 600 BARRETT LANE ASHEVILLE, NC 28803 |

| (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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| E 000 | Initial Comments<br><br>An unannounced recertification survey was conducted on 12/18/23 through 12/21/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VJXY11. | E 000 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced | F 561 | | 1/18/24 |

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

Electronically Signed | 01/19/2024

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| F 561 | Continued From page 1<br>by:<br>Based on observation, record review, family and staff interviews the facility failed to honor a resident's choice to have a beard for 1 of 2 residents (Resident #10) reviewed for choices.<br><br>The finding included:<br><br>Resident #10 was admitted to the facility 11/02/22.<br><br>A significant change Minimum Data Set assessment dated 10/28/23 indicated that Resident #10 had severe cognitive impairment.<br><br>On 12/18/23 at 3:39 PM an interview was conducted with Resident #10's family member and an observation were made of Resident #10 during the interview. Resident #10 was sitting in a semi reclined position sleeping. He was neatly groomed with a light growth of a gray beard and mustache. The family member explained that the Resident was always very particular about his facial hair and kept his beard and mustache neatly groomed for the past 30 years or more. She indicated if Resident #10 understood that his beard had been shaved off, he would have been disappointed. She continued to explain that a while back she came in to find that someone had shaved half of her husband's beard off. The family member stated she posted several signs in his room directing the staff not to shave his beard but then she came to the facility one day last week to find that this time someone had shaved his whole beard off. Resident #10's family member expressed the Resident had maintained his beard for 30 plus years. The Resident's family member stated she addressed her concern with Nurse Supervisor #1. | F 561 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1. On 12/20/23 education was provided to NA#1 on the importance of adhering to the residents right to make choices about aspects of his or her life in the facility by the director of nursing.<br><br>2. All male residents were potentially affected by the reported deficient practice. On 01/16/24, the Director of Nursing conducted interviews with male residents or the representative of any resident with cognitive impairments to identify the resident's shaving preferences. All residents report their shaving preferences were being honored by staff. The information collected during the interviews was provided to the MDS nurse to update the residents care plan to reflect these preferences.<br><br>3.The Director of Nursing completed staff education to all nursing staff members on the importance of following resident preferences when performing care. Education was completed by 01/18/24. Additionally, all new nursing staff will be continuing to be educated on the importance of adhering to the residents right to make choices about aspects of his or her life in the facility.<br><br>4.The Director of Nursing and/or designee | |

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| F 561 | Continued From page 2<br><br>At 4:00 PM on 12/18/23 an observation was made of Resident #10's room accompanied by the Resident's family member. There were 3 different signs posted around the Resident's room and bathroom of various directions: "do not shave Resident #10's sideburns", "stop shaving his cheeks" and "stop shaving Resident #10's cheeks, he is supposed to have a full beard, not a goatee".<br><br>An interview was conducted with Nurse Supervisor #1 on 12/20/22 at 11:50 AM. The Supervisor acknowledged that Resident #10's family member came in to find that the Resident's beard had been completely shaved off and was upset at what she found. The Supervisor stated she assured the family member that she would investigate the incident and reported it to the Director of Nursing.<br><br>Interviews were conducted with the Director of Nursing (DON) on 12/20/23 at 12:53 PM and 12/21/23 at 10:10 AM. The DON explained that she was informed of Resident #10's beard being shaved off. The DON stated she apologized to the family member and informed her that Nurse Aide (NA) #1 who was a fairly new nurse aide at the facility had shaved the Resident and despite multiple signs posted around his room she did not notice the signs until after she had finished his shave. The DON stated the NA made a mistake and shaved Resident #10 thinking he needed to be shaved.<br><br>During an interview with Nurse Aide #1 on 12/21/23 at 10:23 AM the NA confirmed she had shaved Resident #10 one day last week before she got him up that morning. The NA stated she | F 561 | will perform weekly audits for four (4) weeks of all male residents to check for adherence to resident preferences for shaving. Audit results will be reported at the monthly Quality Assurance Performance Improvement Committee (QAPI) meetings by the Director of Nursing and/or designee where they will be reviewed and discussed. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance.<br>5.Completion Date 01/18/24 | |

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| F 561 | Continued From page 3<br>thought the Resident looked like he had not been shaved for a few days and thought she would shave him while she had the time. She stated she was not aware that Resident #10 was not supposed to be shaved. The NA stated she did not notice the signs posted in his room until she went into his bathroom to put the razor away, but she had already shaved him. The NA explained she had worked with Resident #10 before but had never paid attention to the signs posted in his room.<br><br>On 12/21/23 at 3:46 PM during an interview with the Administrator stated the NA did not shave him with malicious intent, but she thought she was doing him a service. | F 561 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. | F 578 | | 1/18/24 |

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| F 578 | Continued From page 4<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to ensure the code status information was accurate throughout the medical record for 2 of 2 residents reviewed for advanced directives (Resident #47 and Resident #53).<br><br>The findings included:<br><br>1. Resident #47 was admitted to the facility on 06/03/22.<br><br>A review of the code status notebook maintained at the nursing station on 12/19/23 at 11:05 AM revealed a yellow golden rod code status of Do Not Resuscitate (DNR) dated 06/08/23.<br><br>Resident #47's quarterly Minimum Data Set | F 578 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1.The Code status for residents # 47 and #53 were verified and entered consistently into all relevant locations within the medical record on 12/20/2023.<br><br>2.Every Resident is identified as potentially being affected by the reported deficient practice. An audit was performed by the Health Informatics Director and Medical Records on 12/20/2023 to ensure that no other residents had any discrepant | |

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| F 578 | Continued From page 5 | F 578 | | |

assessment dated 09/24/23 revealed his cognition was severely impaired.

A review of Resident #47's medical record on 12/19/23 at 11:05 AM revealed an advanced directive status of Cardiopulmonary Resuscitation (CPR).

On 12/20/23 at 11:30 AM an interview was conducted with Nurse #1 who explained the residents' code status was maintained in their electronic medical record under their picture on their profile screen. The Nurse also stated their code status was also maintained in the code status notebook which was kept at the nurses' station on the unit. The Nurse reported the medical record on the computer was the most accurate because that was where the changes were made first before the code status notebook.

An interview was conducted with Nurse Supervisor #1 on 12/20/23 at 11:43 AM. The Supervisor explained that the advanced directives were handled during the admission process and the desired code status was documented on the resident's face sheet in the computer and notation such as the DNR paperwork was placed in the code status notebook at the nurses' station. The Supervisor stated medical records was responsible for auditing the code status directives to make sure they matched.

During an interview with the Director of Nursing (DON) on 12/20/23 at 12:10 PM the DON explained that nursing was responsible for putting the residents' code status in the code status notebook at the nurses' station and medical records was responsible for making sure the code status was correct in the electronic medical

advances directive/code status documented in the Medical Record. No other residents were identified.

3.The Health Services Director re-educated the Director of Nursing, nursing supervisors, Social Worker, Health Services Life Enrichment Director, Health Services Life Enrichment Assistant Director, and Medical Records personnel on the documentation procedures for advanced directives and code status on 01/18/2024. All new hires for staff that are responsible for the advanced directives/code status documentation procedures (Director of Nursing, nursing supervisors, Social Worker, Health Services Life Enrichment Director, Health Services Life Enrichment Assistant Director, and Medical Records personnel) will also be educated regarding this process during orientation. An additional chart audit of all resident□s code status was completed on 1/10/2024. One discrepancy (new admission) was identified and was immediately corrected.

4.The Medical Records Personnel and/or designee will perform weekly audits of all new admissions for four (4) weeks for consistent documentation of the resident's advance directive/code status. Audit results will be reported at the monthly Quality Assurance Performance Improvement Committee (QAPI) meetings by the Medical Records Personnel and/or designee where they will be reviewed and discussed. The QAPI Committee will assess and modify the action plan as

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| F 578 | Continued From page 6<br>record. She stated medical records was responsible for ensuring the two places matched.<br><br>On 12/20/23 at 12:25 PM an interview was conducted with Medical Records personnel who explained that she made sure the paperwork and orders pertaining to the residents' advance directives were signed and dated in the electronic health record and made sure the DNR forms were put in the code status notebooks which were maintained at the nurses' desk. The Medical Records staff continued to explain that sometimes the doctors will change the residents' advanced directive during their rounds and will put the code status paperwork in the code status notebooks thinking they were helping out and she thought that was why there was a discrepancy in Resident #47's advanced directive.<br><br>During an interview with the Administrator on 12/20/23 at 3:37 PM he explained that the reason for the discrepancy in Resident #47's advanced directive status was because of human error. He stated regardless of what the electronic health record indicated the nurses knew to go by the forms in the code status notebook at the nurses' desk.<br><br>2. Resident #53 was admitted to the facility on 04/01/23.<br><br>A review of the code status notebook maintained at the nursing station on 12/19/23 at 11:05 AM revealed a yellow golden rod code status of Do Not Resuscitate (DNR) dated 05/25/23.<br><br>Resident #53's quarterly Minimum Data Set assessment dated 10/06/23 revealed his cognition was moderately impaired. | F 578 | needed to ensure continued compliance.<br><br>5. Completion date 01/18/24 | |

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| F 578 | Continued From page 7 | F 578 | | |

A review of Resident #53's medical record on 12/19/23 at 11:05 AM revealed an advanced directive status of Cardiopulmonary Resuscitation (CPR).

On 12/20/23 at 11:30 AM an interview was conducted with Nurse #1 who explained the residents' code status was maintained in their electronic medical record under their picture on their profile screen. The Nurse also stated their code status was also maintained in the code status notebook which was kept at the nurses' station on the unit. The Nurse reported the medical record on the computer was the most accurate because that was where the changes were made first before the code status notebook.

An interview was conducted with Nurse Supervisor #1 on 12/20/23 at 11:43 AM. The Supervisor explained that the advanced directives were handled during the admission process and the desired code status was documented on the resident's face sheet in the computer and notation such as the DNR paperwork was placed in the code status notebook at the nurses' station. The Supervisor stated medical records was responsible for auditing the code status directives to make sure they matched.

During an interview with the Director of Nursing (DON) on 12/20/23 at 12:10 PM the DON explained that nursing was responsible for putting the residents' code status in the code status notebook at the nurses' station and medical records was responsible for making sure the code status was correct in the electronic medical record. She stated medical records was responsible for ensuring the two places matched.

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| F 578 | Continued From page 8<br><br>On 12/20/23 at 12:25 PM an interview was conducted with Medical Records personnel who explained that she made sure the paperwork and orders pertaining to the residents' advance directives were signed and dated in the electronic health record and made sure the DNR forms were put in the code status notebooks which were maintained at the nurses' desk. The Medical Records staff continued to explain that sometimes the doctors will change the residents' advanced directive during their rounds and will put the code status paperwork in the code status notebooks thinking they were helping out and she thought that was why there was a discrepancy in Resident #53's advanced directive.<br><br>During an interview with the Administrator on 12/20/23 at 3:37 PM he explained that the reason for the discrepancy in Resident #53's advanced directive status was because of human error. He stated regardless of what the electronic health record indicated the nurses knew to go by the forms in the code status notebook at the nurses' desk. | F 578 | | |
| F 582 SS=D | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be | F 582 | | 1/18/24 |

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| F 582 | Continued From page 9 | F 582 | | |

charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the

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| F 582 | Continued From page 10<br>facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews with staff the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A services for 1 of 3 residents reviewed for Beneficiary Notification (Resident #10).<br><br>Findings included:<br><br>Resident #10 was admitted to the facility on 11/02/22.<br><br>Review of the beneficiary notifications for Resident #10 revealed a Notice of Medicare Non-Coverage (NOMNC) was signed by Responsible Party (RP) on 11/06/23. The NOMNC showed the facility initiated Resident #10 be discharged from skilled rehab therapy on 11/09/23 due to no further progress. The facility was unable to provide evidence a SNF-ABN was provided to Resident #10 or the RP.<br><br>Review of the beneficiary notification of residents discharged within the last six months revealed Resident #10 was discharged from Medicare Part A on 11/09/23 with remaining benefit days. Resident #10 remained as a resident in the facility.<br><br>During an interview on 12/19/23 at 12:24 PM the Administrator explained the Social Worker (SW) was responsible for providing the NOMNC and SNF-ABN forms. He explained if Resident #10 or his RP did not receive the SNF-ABN form, it was as an oversight made by the SW. | F 582 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1.Resident # 10 expired on 12/22/2023, therefore, no corrective action was possible. The Social Worker was re-educated by her supervisor Life Enrichment (LE) Director and the Health Services Director on 12/19/2023 regarding proper notification of reduction of Medicare benefits.<br><br>2.Every resident with a reduction in Medicare services was identified as potentially being affected by the reported deficient practice. On 12/19/2023, the Social Worker and LE Director performed an audit to ensure no other residents were affected similarly. Each resident having an initiation, reduction, or termination of covered Medicare services since 07/2023 was verified by the LE Director to ensure proper and timely notice was provided. One additional resident was identified as receiving a Notice of non-Medicare Coverage (NOMNC) on 8/23/2023 but did not receive a final SNFABN.<br><br>3.Re-education was provided by the Health Services Director to the Social Worker, Medical Records, Therapy director, Director of Nursing, and MDS | |

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| F 582 | Continued From page 11<br><br>An interview was conducted with SW on 12/21/23 at 12:35 PM. The SW confirmed she was responsible for providing residents with the ABN-SNF form. She explained therapy gave her 5 to 7 days' notice when a resident was close to discharge, and she would check their insurance. For residents who remained in the facility with Medicare Part A and benefit days remaining, she issued both the NOMNC and SNF-ABN forms. The SW stated Resident #10, or his RP did not get the ABN-SNF was an oversight on her part, and considered the mistake was due to human error. | F 582 | Nurse on Medicare notifications on 01/18/2024. This reeducation was specific to denial notification policy and the procedure for the Medicare notifications process.<br><br>4.The Life Enrichment Director and/or designee will monitor, weekly, to ensure that the Social Worker is taking appropriate and timely action related to Medicare reduction of benefits. She will conduct an audit for four (4) weeks of all residents having an initiation, reduction, or termination of covered Medicare services and verify that proper and timely notice is provided. The results of this will be recorded on an audit tool. Audit results will be reported at the monthly Quality Assurance Performance Improvement Committee (QAPI) meetings by the Health Services Life Enrichment Director and/or designee where they will be reviewed and discussed. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>5.Completion date 01/18/2024 | |
| F 636 SS=B | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument. | F 636 | | 1/18/24 |

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| F 636 | Continued From page 12 | F 636 | | |

A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i)

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| F 636 | Continued From page 13<br>through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date (abbreviated as ARD and referring to the last day of the assessment period) for 1 of 9 residents reviewed for resident assessments (Resident #2).<br><br>Findings included:<br><br>Resident #2 was admitted to the facility on 06/02/22.<br><br>Review of Resident #2's electronic health record revealed an annual MDS assessment with an ARD of 08/10/23 was marked as completed on 09/08/23.<br><br>During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator revealed she was currently behind on completing MDS assessments. The MDS Coordinator confirmed Resident #2's annual MDS assessment dated 08/10/23 was late and not completed within the regulatory timeframe.<br><br>During an interview on 12/19/23 at 5:11 PM, the | F 636 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1.Resident # 2 annual Minimum Data Set (MDS) with an ARD of 8/10/23 was completed on 9/8/23, locked and transmitted to the CMS IQIES database on 9/12/23.<br><br>2.Every resident was identified as potentially being affected by the reported deficient practice. On 01/12/24 the Health Services Director audited all Minimum Data Set (MDS) schedules for completion for the most recent comprehensive assessments for all current residents. As of 01/18/2024, all current resident Minimum Data Set (MDS) assessments with the lock date of 01/12/24 or prior have been completed.<br><br>3.On 01/18/24 the Interdisciplinary Team Members (MDS nurse, Dining Services | |

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| F 636 | Continued From page 14<br>Administrator revealed he was aware MDS assessments were not being completed timely. He explained the issue with MDS assessments being late was identified 11/27/23 and a Performance Improvement Plan (PIP) was in process. The Administrator stated he felt the breakdown was due to the increase in the MDS Coordinator's workload as a result of the recent changes to the Resident Assessment Instrument (RAI) guidelines. | F 636 | Director, Dining Services Manager, Social Worker, and Health Services Life Enrichment Assistant Director) that complete minimum data sets (MDS) were re-educated by Health Services Director on the Resident Assessment Instrument (RAI) requirement to complete all annual comprehensive assessments within 14 days of the assessment reference date as well as the completion schedule for all federally required minimum data set (MDS) assessments. The Interdisciplinary Team Members that complete minimum data sets (MDS) have access to and will utilize the MDS Scheduler in the electronic health record software that shows the completion date for all assessments. Currently, the facility is partnering with a Contracted Registered Nurse Consultant to assess the current need for additional MDS support to assist with the timely completion of MDS assessments.<br><br>4.The Contracted Registered Nurse Consultant and/or designee will audit five (5) Minimum Data Sets (MDS) weekly for four (4) weeks and then five (5) Minimum Data Sets (MDS) monthly for two (2) months to ensure the assessments are completed within the required time frames. Audit results will be documented on the audit tool titled Minimum Data Set (MDS) Completion. Audit Results will be reported at the monthly Quality Assurance Performance Improvement (QAPI) Committee meetings by the MDS Nurse and/or designee where they will be reviewed and discussed. The QAPI | |

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| F 636 | Continued From page 15 | F 636 | Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>5. Completion date 01/18/24 | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 days after the facility determined a significant change had occurred for 2 of 9 sampled residents reviewed for hospice and resident assessments (Residents #28 and #47).<br><br>Findings included:<br><br>1. Resident #28 was admitted to the facility on 06/27/22 with diagnoses that included other neurological conditions and malnutrition.<br><br>Review of Resident #36's electronic medical | F 637 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1.The MDS Nurse completed a Significant Change in Status MDS assessment for Resident #28 on 12/14/23.<br>The MDS Nurse completed a Significant Change in Status MDS assessment for Resident# 47 on 06/24/23.<br><br>2. All Residents who were enrolled in hospice, had a change in hospice | 1/23/24 |

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| F 637 | Continued From page 16 | F 637 | | |

record revealed a significant change MDS assessment with an Assessment Reference Date (ARD) of 11/09/23. The MDS assessment was signed as completed on 12/14/23 which was 36 days after the facility determined Resident #28 had a significant change in status.

During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator revealed she was currently behind on completing MDS assessments. The MDS Coordinator confirmed Resident #28's significant change MDS assessment dated 11/09/23 was late and not completed within the regulatory timeframe.

During an interview on 12/19/23 at 5:11 PM, the Administrator revealed he was aware MDS assessments were not being completed timely. He explained the issue with MDS assessments being late was identified 11/27/23 and a Performance Improvement Plan (PIP) was in process. The Administrator stated he felt the breakdown was due to the increase in MDS Coordinator's workload as a result of the recent changes to the Resident Assessment Instrument (RAI) guidelines.

2. Resident # 47 was admitted to the facility on 06/03/22 with diagnoses that included Alzheimer's disease.

Review of Resident #47's medical record revealed an order for Hospice services related to dementia and weight loss dated 06/08/23.

Review of Resident #47's significant change Minimum Data Set assessment for the election of Hospice services was dated 06/24/23.

providers, or discontinued hospice services in 2023 and through 01/10/24 were reviewed by the health services director on 01/12/24 to determine if significant change in status assessments had been completed timely. One deceased resident (8/03/2023) was identified during the audit. However, due to needing current information on the resident, no significant change assessment was completed.

The interdisciplinary team (MDS nurse, Dining Services Manager, Social Worker, and Health Services Life Enrichment Assistant Director) reviewed all other current residents to determine if a significant change in status had occurred that may warrant a significant change in status assessment utilizing the RAI guidelines (consistent patterns of change with either two or more areas of decline or two or more areas of improvement) from baseline as indicated by comparison of the resident's current status to the most recent CMS-required MDS on 1/23/24. No new residents were identified as requiring a significant change.

3.The MDS nurse was re-educated on 1/18/24 regarding the Resident Assessment Instrument (RAI) completion schedule requirements for federally required minimum data set (MDS) assessments, including significant change of status assessments. Currently, the facility is working on assessing the current need for additional MDS support to assist with the timely completion of MDS

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| F 637 | Continued From page 17<br>An interview was conducted with the Minimum Data Set (MDS) Coordinator on 12/21/23 at 12:20 PM. The Coordinator explained that the significant change MDS had to be completed within 14 days of the election of Hospice services then acknowledged the assessment was completed 2 days passed the 14-day timeframe. The Coordinator explained that due to the recent changes in the Resident Assessment Instrument (RAI) process and the number of assessments required she was behind on multiple assessments.<br><br>An interview was conducted with the Administrator on 12/21/23 at 3:40 PM. The Administrator explained that he was aware of the MDS assessments were not being completed in time and stated he felt the breakdown was due to the increase in the MDS Coordinator's workload because of the recent changes to the RAI guidelines. | F 637 | assessments.<br><br>4. The interdisciplinary team (MDS nurse, Dining Services Manager, Social Worker, and Health Services Life Enrichment Assistant Director) or designees will review the current census weekly for 4 weeks to determine if a significant change in status assessments was needed, and if so, completed timely and according to the Resident Assessment Instruction. These results will be recorded on an audit tool. Audit Results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the MDS Nurse and/or designee where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>5. Completion 01/23/24 | |
| F 638 SS=B | Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)<br><br>§483.20(c) Quarterly Review Assessment<br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (abbreviated as ARD and referring to the last day of the observation period) for 7 of 9 residents reviewed | F 638 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice. | 1/18/24 |

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| F 638 | Continued From page 18<br>for resident assessments (Residents #2, #6, #16, #20, #28, #48, and #52).<br><br>Findings included:<br>1. Resident #2 was admitted to the facility on 06/02/22.<br><br>Review of Resident #2's Electronic Health Record (EHR) on 12/19/23 at 3:55 PM revealed the following:<br>a. A quarterly MDS assessment with an ARD of 08/10/23 was marked as complete on 09/08/23.<br>b. A quarterly MDS assessment with an ARD of 11/10/23 with no date of completion.<br><br>During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator revealed she was currently behind on completing MDS assessments. The MDS Coordinator explained Resident #2's quarterly MDS assessment dated 08/10/23 was completed late and the MDS assessment dated 11/10/23 had not yet been done. She confirmed both assessments were not completed within the regulatory timeframe.<br><br>During an interview on 12/19/23 at 5:11 PM, the Administrator revealed he was aware MDS assessments were not being completed timely. He explained the issue with MDS assessments being late was identified 11/27/23 and a Performance Improvement Plan (PIP) was in process. The Administrator stated he felt the breakdown was due to the increase in the MDS Coordinator's workload as a result of the recent changes to the Resident Assessment Instrument (RAI) guidelines.<br><br>2. Resident #6 was admitted to the facility on 05/18/22. | F 638 | 1. The MDS Nurse completed the following Quarterly Assessments:<br>Resident # 2 MDS assessment with ARD 11/10/23 was completed on 12/20/23<br>Resident # 6 MDS assessment with ARD 11/10/23 was completed on 12/17/23<br>Resident # 16 MDS assessment with ARD 11/13/23 was completed on 12/20/23<br>Resident # 20 MDS assessment with ARD 11/09/23 was completed on 12/15/23<br>Resident # 48 MDS assessment with ARD 11/22/23 was completed on 12/26/23<br>Resident # 52 MDS assessment with ARD 11/10/23 was completed on 12/17/23<br><br>2. Every resident was identified as potentially being affected by the reported deficient practice. On 01/12/24 the Health Services Director audited the Minimum Data Set (MDS) schedule for completion of Quarterly Assessments. As of 01/18/24, all quarterly MDS with a lock date on or before 01/12/24 have been completed and submitted.<br><br>3. On 01/18/24 the Interdisciplinary Team Members (MDS nurse, Dining Services Director, Dining Services Manager, Social Worker, and Health Services Life Enrichment Assistant Director) were re-educated by the Health Services Director on the Resident Assessment Instrument (RAI) requirement to complete quarterly review assessments not less frequently than once every three (3) months and within fourteen (14) days of the assessment reference date. The Interdisciplinary Team Members(MDS nurse, Dining Services Director, Dining | |

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| F 638 | Continued From page 19<br><br>Review of Resident #6's Electronic Health Record (EHR) on 12/19/23 at 4:00 PM revealed the following:<br>a. A quarterly MDS assessment with an ARD of 08/10/23 was marked as complete on 09/02/23.<br>b. A quarterly MDS assessment with an ARD of 11/10/23 was marked as complete on 12/17/23.<br><br>During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator revealed she was currently behind on completing MDS assessments. The MDS Coordinator confirmed Resident #6's quarterly MDS assessments dated 08/10/23 and 11/10/23 were completed late and not completed within the regulatory timeframe.<br><br>During an interview on 12/19/23 at 5:11 PM, the Administrator revealed he was aware MDS assessments were not being completed timely. He explained the issue with MDS assessments being late was identified 11/27/23 and a Performance Improvement Plan (PIP) was in process. The Administrator stated he felt the breakdown was due to the increase in the MDS Coordinator's workload as a result of the recent changes to the Resident Assessment Instrument (RAI) guidelines.<br><br>3. Resident #16 was admitted to the facility on 05/23/23.<br><br>Review of Resident #16's Electronic Health Record (EHR) on 12/19/23 at 4:05 PM revealed a quarterly MDS assessment with an ARD of 11/13/23 with no date of completion.<br><br>During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator revealed she was currently | F 638 | Services Manager, Social Worker, and Life Enrichment Assistant Director) that complete minimum data sets (MDS) have access to and will utilize the MDS Scheduler in the electronic health record software that shows the completion dates for all assessments Currently, the facility is partnering with a Contracted Registered Nurse Consultant to assess the current need for additional MDS support to assist with the timely completion of MDS assessments.<br><br>4. The Contracted Registered Nurse Consultant and/or designee will audit five (5) Quarterly Minimum Data Sets (MDS) assessments weekly for four (4) weeks and then five (5) Quarterly Minimum Data Sets (MDS) monthly for two (2) months to ensure assessments are completed within the required time frame. Audit results will be reported at the monthly Quality Assurance Performance Improvement (QAPI) Committee meetings by the Health Services Director and/or designee where they will be reviewed and discussed. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>5. Completion date 01/18/24 | |

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behind on completing MDS assessments. The MDS Coordinator confirmed Resident #16's quarterly MDS assessment dated 11/13/23 has not yet been done and was late.

During an interview on 12/19/23 at 5:11 PM, the Administrator revealed he was aware MDS assessments were not being completed timely. He explained the issue with MDS assessments being late was identified 11/27/23 and a Performance Improvement Plan (PIP) was in process. The Administrator stated he felt the breakdown was due to the increase in the MDS Coordinator's workload as a result of the recent changes to the Resident Assessment Instrument (RAI) guidelines.

4. Resident #20 was admitted to the facility on 05/18/22.

Review of Resident #20's Electronic Health Record (EHR) on 12/19/23 at 4:10 PM revealed a quarterly MDS assessment with an ARD of 11/09/23 that was marked as complete on 12/15/23.

During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator revealed she was currently behind on completing MDS assessments. The MDS Coordinator confirmed Resident #20's quarterly MDS assessment dated 11/09/23 was completed late and not completed within the regulatory timeframe.

During an interview on 12/19/23 at 5:11 PM, the Administrator revealed he was aware MDS assessments were not being completed timely. He explained the issue with MDS assessments being late was identified 11/27/23 and a

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Performance Improvement Plan (PIP) was in process. The Administrator stated he felt the breakdown was due to the increase in the MDS Coordinator's workload as a result of the recent changes to the Resident Assessment Instrument (RAI) guidelines.

5. Resident #28 was admitted to the facility on 06/27/22.

Review of Resident #28's Electronic Health Record (EHR) on 12/19/23 at 4:15 PM revealed a quarterly MDS assessment with an ARD of 08/15/23 that was marked as complete on 09/04/23.

During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator revealed she was currently behind on completing MDS assessments. The MDS Coordinator confirmed Resident #28's quarterly MDS assessment dated 08/15/23 was completed late and not completed within the regulatory timeframe.

During an interview on 12/19/23 at 5:11 PM, the Administrator revealed he was aware MDS assessments were not being completed timely. He explained the issue with MDS assessments being late was identified 11/27/23 and a Performance Improvement Plan (PIP) was in process. The Administrator stated he felt the breakdown was due to the increase in the MDS Coordinator's workload as a result of the recent changes to the Resident Assessment Instrument (RAI) guidelines.

6. Resident #48 was admitted to the facility on 08/02/22.

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| F 638 | Continued From page 22 | F 638 | | |

Review of Resident #48's Electronic Health Record (EHR) on 12/19/23 at 4:20 PM revealed the following:
a. A quarterly MDS assessment with an ARD of 08/22/23 was marked as complete on 09/06/23.
b. A quarterly MDS assessment with an ARD of 11/22/23 with no date of completion.

During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator revealed she was currently behind on completing MDS assessments. The MDS Coordinator explained Resident #48's quarterly MDS assessment dated 08/22/23 was completed late and the MDS assessment dated 11/22/23 had not yet been done. She confirmed both assessments were not completed within the regulatory timeframe.

During an interview on 12/19/23 at 5:11 PM, the Administrator revealed he was aware MDS assessments were not being completed timely. He explained the issue with MDS assessments being late was identified 11/27/23 and a Performance Improvement Plan (PIP) was in process. The Administrator stated he felt the breakdown was due to the increase in the MDS Coordinator's workload as a result of the recent changes to the Resident Assessment Instrument (RAI) guidelines.

7. Resident #52 was admitted to the facility 02/01/23.

Review of Resident #52's Electronic Health Record (EHR) on 12/19/23 at 4:25 PM revealed the following:
a. A quarterly MDS assessment with an ARD of 08/10/23 was marked as complete on 08/31/23.
b. A quarterly MDS assessment with an ARD of

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| F 638 | Continued From page 23<br>11/10/23 was marked as complete on 12/17/23.<br><br>During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator revealed she was currently behind on completing MDS assessments. The MDS Coordinator confirmed Resident #52's quarterly MDS assessments dated 08/10/23 and 11/10/23 were completed late and not completed within the regulatory timeframe.<br><br>During an interview on 12/19/23 at 5:11 PM, the Administrator revealed he was aware MDS assessments were not being completed timely. He explained the issue with MDS assessments being late was identified 11/27/23 and a Performance Improvement Plan (PIP) was in process. The Administrator stated he felt the breakdown was due to the increase in the MDS Coordinator's workload as a result of the recent changes to the Resident Assessment Instrument (RAI) guidelines. | F 638 | | |
| F 641 SS=D | 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 by:<br>Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set Assessments (MDS) in the areas of Preadmission Screening and Resident Review (PASRR) and hospice for 2 of 4 residents reviewed for PASRR and hospice (Residents #6 and #18).<br><br>Findings included: | F 641 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1.On 01/17/24 The MDS Nurse modified Resident # 6 Annual MDS Assessment with an ARD of 5/10/23 to reflect the Level | 1/18/24 |

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| F 641 | Continued From page 24<br><br>1. A PASRR Level II Determination Notification letter dated 05/17/22 for Resident #6 had an expiration date of 06/16/22. It was noted nursing facility placement was appropriate for a limited nursing facility stay lasting no more than 30 calendar days.<br><br>Resident #6 was admitted to the facility on 05/18/22 with diagnoses that included vascular dementia with agitation and depression.<br><br>The annual MDS assessment dated 05/10/23 indicated Resident #6 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions.<br><br>Review of a North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document provided by the facility on 12/18/23 revealed Resident #6 had a 30-day Levell II PASRR effective 05/17/22 with an expiration date of 06/16/22.<br><br>During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator explained she did not realize Resident #6's PASRR number was considered to be a Level II PASRR determination which was why his annual MDS assessment dated 05/10/23 did not accurately reflect his Level II PASRR status.<br><br>During an interview on 12/19/23 at 5:11 PM, the Administrator explained the MDS Coordinator was behind on completing MDS assessments and he felt the reason Resident #6's MDS assessment did not accurately reflect his Level II PASRR status was an oversight due to the MDS | F 641 | II PASRR. On 12/20/23, the MDS Nurse Modified Resident #18 Annual MDS Assessment with an ARD of 10/20/23 to include Hospice care.<br><br>2.Every resident with a Level II PASRR and/or currently receiving hospice services has been identified as being potentially affected by the reported deficient practice. On 01/18/24 the Social Worker developed a list of all residents who currently had a level II PASRR and who were currently on Hospice care. The MDS Nurse then reviewed those resident's most current MDS assessment to ensure those MDS items were coded accurately. Any required corrections or modifications to the MDS assessments were to be completed by the MDS Nurse by 01/18/24.<br><br>3.On 01/18/24 the MDS Nurse was re-educated by the Health Services Director on the Resident Assessment Instrument (RAI) instructions for coding Hospice care and PASRR sections of the MDS assessment.<br><br>4.The Contracted Registered Nurse Consultant and/or designee will review at least two (2) MDS assessments for residents who are receiving Hospice care and two (2) MDS assessments for residents with Level II PASRR's to ensure the current MDS assessment is coded accurately. This will be done weekly for four (4) weeks and then monthly for two (2) months. The findings will be recorded on an audit tool. Audit Results will be | |

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| F 641 | Continued From page 25<br>Coordinator rushing to get MDS assessments completed.<br><br>2. Resident #18 was admitted to the facility on 07/10/18 with diagnoses that included hypertensive heart disease and chronic kidney disease with heart failure.<br><br>Review of Resident #18's Hospice care plan initiated on 10/20/22 revealed in part she had a terminal prognosis for which she had elected hospice services.<br><br>The Hospice Recertification dated 10/18/23 revealed Resident #18 elected to receive hospice services effective 10/20/22.<br><br>The annual MDS dated 10/20/23 did not indicate Resident #18 was receiving hospice care.<br><br>During an interview on 12/19/23 at 4:35 PM, the MDS Coordinator confirmed Resident #18 was receiving hospice care effective 10/20/22. The MDS Coordinator explained she had correctly coded Resident #18's prognosis on the MDS assessment but forgot to code she also received hospice care and stated it was an oversight.<br><br>During an interview on 12/19/23 at 5:11 PM, the Administrator explained the MDS Coordinator was behind on completing MDS assessments and he felt the reason Resident #18's MDS assessment did not accurately reflect she received hospice care was an oversight due to the MDS Coordinator rushing to get MDS assessments completed. | F 641 | reported at the monthly Quality Assurance Performance Improvement (QAPI) Committee meetings by the Health Services Director and/or designee where they will be reviewed and discussed. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance.<br>5. Completion date 01/18/24. | |
| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2) | F 644 | | 1/18/24 |

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| F 644 | Continued From page 26<br><br>§483.20(e) Coordination.<br>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:<br><br>§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 care.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 1 of 2 sampled residents reviewed for PASRR (Resident #6).<br><br>Findings included:<br><br>A PASRR Level II Determination Notification letter dated 05/17/22 for Resident #6 had an expiration date of 06/16/22. It was noted nursing facility placement was appropriate for a limited nursing facility stay lasting no more than 30 calendar days.<br><br>Resident #6 was admitted to the facility on 05/18/22 with diagnoses that included vascular | F 644 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1.The Health Informatics Director obtained a new Preadmission Screening and Resident Review (PASRR) for resident # 6 which was completed on 12/20/2023.<br><br>2.Every resident is identified as potentially being affected by the reported deficient practice. 01/11/2024 the Health Informatics Director performed an audit of all current resident's PASRRs for | |

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| F 644 | Continued From page 27<br>dementia with agitation and depression.<br><br>The annual MDS assessment dated 05/10/23 indicated Resident #6 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions.<br><br>Review of a North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document provided by the facility on 12/18/23 revealed Resident #6 had a 30-day Levell II PASRR effective 05/17/22 with an expiration date of 06/16/22. Further review revealed no evidence a PASRR evaluation was requested or a new PASRR had been obtained.<br><br>During an interview on 12/19/23 at 5:11 PM, the Administrator explained there was no one person responsible for submitting PASRR reevaluation requests as it was an Interdisciplinary Team effort. The Administrator stated he was not sure what happened or why a PASRR evaluation request was not requested prior to Resident #6's PASRR expiration date. The Administrator explained they realized it was an issue when reviewing Resident #6's PASRR information on 12/18/23 and a request for reevaluation was submitted. | F 644 | accuracy. One (1) additional resident was identified as having an expired thirty-day (30) PASRR. On 01/15/2024, the Social Worker requested a PASRR for that resident from NC MUST. This resident received a level two (2) PASRR, and the FL-2 has been completed and submitted to NC MUST.<br><br>3. As a result of this audit, the Health Services Director and the Health Services Life Enrichment Director have reviewed and revised the PASRR protocol to ensure this deficiency does not re-occur. The Interdisciplinary Team (MDS Nurse, Dining Services Director, Dining Services Manager, Social Worker, and Life Enrichment Assistant Director) and the Health Services Life Enrichment Director was re-educated on the revised protocol by Health Services Director on 01/18/2024.<br><br>4.The Health Services Life Enrichment Director will review and monitor, weekly, all new admissions, any resident with serious mental health diagnosis changes, and the list of PASARR□s that have an expiration date to ensure that the Social Worker is taking appropriate and timely action related to PASRR□s. These weekly audits will continue for at least sixty (60) days then randomly after. Audit Results will be reported at the monthly Quality Assurance Performance Improvement (QAPI) Committee meetings by the Health Services Life Enrichment Director and/or Social Worker where they will be reviewed and discussed. The Quality Assurance | |

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| F 644 | Continued From page 28 | F 644 | Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>5. Completion Date 01/18/24 | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(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,<br>(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<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(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<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. | F 645 | | 1/18/24 |

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| F 645 | Continued From page 29<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br>(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.<br>(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-<br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br>(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.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to refer residents who were admitted with mental health disorders for a Level II | F 645 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent | |

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| F 645 | Continued From page 30<br>Preadmission Screening and Resident Review (PASRR) evaluation and determination of specialized services for 1 of 2 residents reviewed for PASRR (Residents #57).<br><br>The findings included:<br><br>A PASRR Determination Notification letter dated 07/31/23 revealed Resident #57 had a Level I PASRR with no expiration date.<br><br>Resident #57 was admitted to the facility on 08/01/23 with diagnoses that included generalized anxiety disorder, major depressive disorder, delusional disorder, and bi-polar disorder.<br><br>The admissions Minimum Data Set (MDS) assessment dated 08/05/23 revealed Resident #57 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #57 received antipsychotics on a routine basis during the MDS assessment period.<br><br>The psychotropic drug use Care Area Assessment (CAA) associated with the admission MDS assessment dated 08/05/23 revealed in part, Resident #57 had a diagnosis of bipolar disorder and received antipsychotic medications. She was seen by the Psychiatrist on 08/04/23 for evaluation of mania and adjustments were made to her medications. It was noted that a care plan would be developed for medication use and side effects.<br><br>Review of a North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document provided by the facility on 12/18/23 revealed | F 645 | the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1.Resident #57 was reviewed by NC MUST on 01/16/2024 and the accurate Preadmission Screening and Resident Review (PASRR) level was obtained.<br><br>2.On 01/11/2024, the Health Informatics Director completed a full audit/review of all current residents and PASRRs for accuracy. Two (2) other residents were identified as having inaccurate PASRRS. On 01/15/2024 the Social Worker requested new PASRRs for those residents from NC MUST. These residents received a level two (2) PASRR and the FL-2 □s are now being completed and will be submitted to NC MUST.<br><br>3.As a result of this audit, the Health Services Director and the Health Services Life Enrichment Director have reviewed and revised the PASRR protocol to ensure this deficiency does not reoccur. The Interdisciplinary Team Members (MDS Nurse, Dining Services Director, Dining Services Manager, Social Worker, and Life Enrichment Assistant Director) and Health Services Life Enrichment Director was educated on the revised protocol by Health Services Director on 01/18/2024.<br><br>4.The Health Services Life Enrichment Director will review and monitor all new admissions, any resident with diagnosis changes, and the list of PASRR□s that have an expiration date to ensure that the Social Worker is taking appropriate and | |

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| F 645 | Continued From page 31<br>Resident #57 had a Level I PASRR effective 07/31/23. There were no requests for a Level II PASRR evaluation submitted or completed since 07/31/23.<br><br>During an interview on 12/19/23 at 5:11 PM, the Administrator explained the current process for submitting PASRR reevaluation reviews was an Interdisciplinary Team effort and he was not sure who should be responsible for submitting PASRR Level II evaluation requests when a resident was admitted with mental health disorders and had a Level I PASRR determination. The Administrator explained the facility usually went by the PASRR information submitted by the hospital with the assumption the hospital had requested a Level II PASRR evaluation when indicated. He stated he now realized they could do better with their process for following-up on a resident's PASRR when a resident was admitted to the facility with mental health disorders. | F 645 | timely action related to PASRR□s. She will review weekly to ensure these PASRRs are at the proper level and/or resubmitted and that any 30-day PASRRS are resubmitted timely. These weekly audits will continue for at least sixty (60) days then randomly after. Audit Results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Health Services Life Enrichment Director and/or Social Worker where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>5. Completion Date 01/18/24 | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as | F 656 | | 1/18/24 |

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| F 656 | Continued From page 32<br>required under §483.24, §483.25 or §483.40; and<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to develop a comprehensive care plan that addressed a resident's individual care needs for 1 of 3 sampled residents whose closed records were reviewed (Resident #65).<br><br>Findings included: | F 656 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1.Resident #65 expired on 9/26/2023 | |

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| F 656 | Continued From page 33<br><br>Resident #65 was admitted to the facility on 08/15/23 with diagnoses that included acute (severe and sudden onset) nondisplaced (bone cracks or breaks but maintains proper alignment) S2/S3 (referring to a sacrum fracture), severed L4-5 (referring to lumbar fracture), and severe, chronic L5 compression (type of fracture or break in the bones that make up the spine) fracture.<br><br>The admission Minimum Data Set (MDS) dated 08/21/23 revealed Resident #65 had intact cognition. She required supervision with eating and locomotion off the unit and extensive staff assistance with all other activities of daily living (ADL). She received scheduled and as needed pain medication and reported a pain level of 09 out of 10 (numerical pain rating scale with 10 being the worst possible pain) that affected day-to-day function.<br><br>The ADL Care Area Assessment (CAA) associated with the admission MDS dated 08/21/23 revealed in part, Resident #65 required assistance with all ADL due to limited mobility. She admitted with a urinary tract infection (UTI), had fractures of the sacrum and fifth lumbar vertebrae and additional diagnoses of spinal stenosis, hypertension, gastrointestinal reflux disease, macular degeneration, weakness, and history of falling. She was working with therapy for strength and mobility, however, limited due to poor pain control and was able to eat independently with tray set-up. It was noted a care plan would be developed for staff assistance and improved self-care.<br><br>The pain CAA associated with the admission MDS dated 08/21/23 revealed in part, Resident | F 656 | therefore no correction was possible.<br><br>2.Every resident is identified as potentially being affected by the reported deficient practice. Care plans were reviewed on 01/16/2024 by the Health Informatics Director for all residents to determine if a comprehensive care plan had been developed. All resident's care plans are currently up to date.<br><br>3.The Interdisciplinary Team (MDS nurse, Dining Services Director, Dining Services Manager, Social Worker, and Life Enrichment Assistant Director) were re-educated by a Health Services Director on 01/18/24 on the importance of developing a care plan and updating care plans to reflect the resident's current condition/problem and care regimen.<br><br>4.The Contracted Registered Nurse Consultant will monitor at least three (3) care plans weekly for two (2) weeks, then monthly for 2 months to determine if the care plan was developed within the regulatory timeframe. The audit results will be recorded on an audit tool titled Care Plans. Audit Results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Health Services Director or designee where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>5.Completion Date 01/18/24 | |

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#65 was having a difficult time with pain control and preferred to lay flat in bed to relieve pain which was interfering with therapy for strength and mobility. It was noted a care plan would be developed for assessment of pain and possible interventions to improve pain relief.

The fall CAA associated with the admission MDS dated 08/21/23 revealed in part, Resident #65 had a fall prior to admission, none since admission, and a care plan would be developed for risk of fall with injury due to weakness, pain, and limited mobility.

Review of Resident #65's comprehensive care plan on 12/20/23 revealed a discharge planning care plan initiated on 08/19/23 and a nutritional care plan initiated on 09/01/23. There were no other care plans developed.

During an interview on 12/21/23 at 12:50 PM, the MDS Coordinator confirmed she was the MDS Coordinator at the time of Resident #65's admission to the facility and was the one who normally completed comprehensive care plans for residents. The MDS Coordinator reviewed Resident #65's care plan and stated she would not consider it to be comprehensive or complete. The MDS Coordinator explained she had only been employed for a year and it took her some time to learn the facility's system which may have been the reason Resident #65's comprehensive care plan was not developed.

During an interview on 12/21/23 at 12:58 PM, the Administrator stated it was his expectation that comprehensive care plans would be developed within the regulatory timeframe.

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| F 695 | Continued From page 35 | F 695 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and resident and staff interviews the facility failed to post cautionary and safety signs that indicated the use of oxygen for 2 of 2 residents reviewed for respiratory care (Resident #3 and Resident # 48).<br><br>The findings included:<br><br>1. Resident #3 was admitted to the facility on 01/25/23 with diagnoses that included heart failure and chronic obstructive pulmonary disease.<br><br>A review of Resident #3's physician orders dated 05/11/23 revealed oxygen at 2-5 liters per minute via nasal cannula to maintain oxygen saturation above 90%.<br><br>An interview and observation made with Resident #3 on 12/18/23 at 10:44 AM revealed the Resident lying in bed wearing a nasal cannula with oxygen being delivered at 3 liters per minute. The Resident explained she wore oxygen all the time. | F 695 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1. During the Survey, the nursing floor staff placed red warning signs indicating oxygen use on the room door of Resident #3 and Resident #48.<br><br>2.Every resident using oxygen is identified as potentially being affected by the reported deficient practice. An observation audit was performed by the Director of Nursing on 12/26/2023 to ensure that all residents on oxygen had red warning signs posted on the room doors indicating the use of oxygen. All were properly in place.<br><br>3.The Health Services Consultant performed an observation audit on 01/12/2024 to follow up and ensure that all residents that are on oxygen had red | 1/18/24 |

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| F 695 | Continued From page 36<br><br>Observations made 12/18/23 at 10:44 AM and 12/19/23 at 3:09 PM revealed there was no warning sign posted on the outside of Resident #3's door to indicate oxygen was in use.<br><br>On 12/20/23 at 11:25 AM an interview was conducted with Nurse #1 who explained the person who initiates the oxygen should post the oxygen in use signs on the resident's door.<br><br>An interview conducted with Nurse Supervisor #1 on 12/20/23 at 11:33 AM. The Supervisor explained that the oxygen set up was prepared before the resident was admitted to the facility which included the red no smoking oxygen in use signs posted on the doorframes.<br><br>An interview conducted with the Director of Nursing (DON) on 12/20/23 at 12:01 PM revealed the oxygen in use signs should be posted on the doorframe of all rooms that had oxygen in use in them. The DON stated the nurses should be checking the doors for the oxygen signs when they made rounds.<br><br>During an interview with the Administrator on 12/21/23 at 3:26 PM the Administrator explained that he had already been made aware that the oxygen signs were not posted on some of the doors of the residents who received oxygen. He indicated his expectation was that nursing be responsible for posting the oxygen in use signs on the residents' doors that receive oxygen.<br><br>2. Resident #48 was admitted to the facility on 08/02/22. Resident #48's diagnoses included dementia and chronic obstructive pulmonary disease (COPD). | F 695 | warning signs indicating the use of oxygen on the room door. All signs were properly in place. Effective 01/15/2024 the Director of Nursing re-educated all facility licensed nursing staff on the need to place the red warning signs indicating oxygen use on the resident□s room door and that the nurse applying the oxygen equipment is also responsible for hanging the warning sign on the door. All new licensed nursing staff will be educated on this procedure during Nursing Orientation.<br><br>4.An observation of signs will be conducted during routine clinical rounds by the Director of Nursing, and the Nursing Administrative Assistant will also perform a visual weekly audit to ensure that each resident receiving oxygen has the red warning sign indicating oxygen use on the room door. These weekly visual audits will be performed for thirty-days (30) days. Audit Results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Director of Nursing or designee. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>5. Completion date 01/18/24 | |

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| F 695 | Continued From page 37 | F 695 | | |

Review of the active physician orders included Resident #48 received continuous oxygen at a rate of 2 liters per minute (LPM) as needed and continuous oxygen at 2 LPM twice daily when working with therapy for hypoxia (low levels of oxygen in the body's tissues).

During an observation made on 12/19/23 at 9:24 AM, Resident #48 was sitting in his room in his wheelchair wearing oxygen via nasal cannula set at 2 liters per minute. There was no warning sign posted on the outside of the entry door to indicate oxygen was in use in the room of Resident #48.

During an interview on 12/20/23 at 11:25 AM Nurse #1 explained she occasionally was the assigned nurse for Resident #48. She revealed the person who initiates oxygen should post the oxygen in use signs on the resident's door.

During an interview on 12/20/23 at 11:33 AM Nurse Supervisor #1 explained the setup for oxygen included to post the red no smoking oxygen in use sign on the doorframe entering the resident's room.

An interview conducted with the Director of Nursing (DON) on 12/20/23 at 12:01 PM revealed the warning signs should be posted on the doorframe of all rooms with oxygen in use. The DON stated the nurses should be checking the doors for oxygen signs when they make rounds.

During an interview on 12/21/23 at 3:26 PM the Administrator revealed he was made aware the warning signs oxygen in use were not posted on some of the doors of the residents who received oxygen. He indicated his expectation was that

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| F 695 | Continued From page 38<br>nursing be responsible for posting the oxygen in use signs on the residents' doors that receive oxygen. | F 695 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will | F 867 | | 1/18/24 |

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| F 867 | Continued From page 39 | F 867 | | |

systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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| F 867 | Continued From page 40<br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by: | F 867 | | |

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| F 867 | Continued From page 41<br>Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put in place following the annual recertification and complaint surveys conducted on 04/09/21 and 08/26/22. This was for a repeat deficiency for failure to provide beneficiary notice originally cited on 04/09/21 and subsequently recited on the annual recertification survey conducted on 12/21/23. The repeat deficiency for failure to develop and implement a comprehensive care plan was originally cited during the recertification and complaint survey conducted on 08/26/22 and subsequently recited on the annual recertification survey conducted on 12/21/23. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.<br><br>Findings included:<br><br>The tags were cross referenced to:<br><br>F582- Based on record review and interviews with staff the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A services for 1 of 3 residents reviewed for Beneficiary Notification (Resident #10).<br><br>During the recertification and complaint survey conducted on 04/09/21, the facility failed to provide the Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice (form CMS-10055 SNF ABN) prior to a resident's discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for | F 867 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1.On 1/15/2024 the Health Services Director contacted the Quality Improvement Organization (QIO) with the State Quality Monitoring by email to enlist facility Quality Improvement support.<br><br>2.On 1/11/2024 the Health Services Director reviewed the survey findings for the repeat deficiencies F582 and F656 and developed monitoring tools for each cited deficiency as part of the plan of correction developed with Director of Nursing, MDS Nurse, Health Services Life Enrichment Director, Admissions Coordinator, Social Worker, Health Informatics Director, Health Services Consultant and Contracted Registered Nurse Consultant.<br><br>3.On 01/18/24 the Health Services Director held a meeting with Departmental leadership consisting of Director of Nursing, Resident Care Coordinator, Social Worker, Administrative Assistant, Health Services Life Enrichment Director, Health Services Life Enrichment Assistant Director, Assistant Dining Services Director, Dining Services Manager Minimum Data Set (MDS) Nurse, Environmental Services Supervisor, Nursing Administrative Assistant, Health Services Admissions Coordinator, and Medical Records Personnel to review the | |

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| (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 867 | Continued From page 42<br>beneficiary notification.<br><br>F656- Based on record review and staff interviews, the facility failed to develop a comprehensive care plan that addressed a resident's individual care needs for 1 of 3 sampled residents whose closed records were reviewed (Resident #65).<br><br>During the recertification and complaint survey conducted on 08/26/22 the facility failed to develop a care plan for hospice care and anticoagulation medication use for 1 of 5 residents reviewed for unnecessary medications.<br><br>During an interview on 12/21/23 at 5:15 PM the Administrator revealed monthly meetings were held to review quality measures and identify trends and audits were completed and modified as needed. He stated the change in leadership and the MDS Coordinator and the new MDS requirements played a role in the repeat of deficiencies. He explained there were issues with the software the facility used that caused the submission of MDS assessments to be rejected and not completed timely that could impact the resident's care plan. For the issuance of the SNF-ABN forms those were overlooked and not included in the review to ensure the Notice of Medicare Non-Coverage (NOMNC) was issued timely. | F 867 | survey findings and plans of corrections for the areas of concern.<br><br>4.On 01/18/2024 the Health Services Director implemented the following continued monitoring measures: a) Ad hoc quality assurance discussion will occur weekly to discuss monitoring results and to make process revisions if corrective measures are not effective and b) the monitoring results will also be reported to the Quality Assurance and Process Improvement Committee (QAPI) monthly for no less than 3 months. The QAPI Committee will then determine if continued monitoring is needed and/or if modifications to the action plan are needed to ensure continued compliance.<br><br>5.On 01/18/2024 the Administrator revised the Quality Assurance and Process Improvement Committee agenda to reflect the new cited deficiencies and monitoring.<br><br>6. Completion date 01/18/24 | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- | F 883 | | 1/18/24 |

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| | 345328 | A. BUILDING _____ B. WING _____ | 12/21/2023 |

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| F 883 | Continued From page 43<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes | F 883 | | |

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| F 883 | Continued From page 44<br>documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews with the resident and staff the facility failed to offer and administer the influenza vaccine for 1 of 5 residents reviewed for immunizations (Resident #5).<br><br>Findings included:<br><br>Review of the facility's policy for resident immunizations revised 11/2017 read in part, "The Director of Nursing (DON) will be responsible for ensuring residents receive immunizations. On admission the facility will request information on previous immunizations and the Medical Records Coordinator and will notify the DON or designee of the history. Prior to immunization, the resident or their legal representative will be provided information and education regarding the benefits and potential side effects of the influenza immunization. Receipt of education and refusal of vaccination will be documented in the medical record. All residents will be offered an influenza vaccine beginning in October of each year, unless medically contraindicated or the resident was already immunized. If immunization is provided in the facility the following information will be documented in the resident's medical | F 883 | Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.<br><br>1.On 12/21/23 consent for flu vaccine was obtained from resident #5 and vaccine was administered by licensed nurse.<br><br>2.All residents were potentially affected by the reported deficient practice. The Director of Nursing completed an audit on Flu vaccination status on 01/18/2024. In the audit, The Director of Nursing found one (1) cognitively impaired resident without a consent for the Flu vaccine. On 01/18/2024 consent was received from the resident's representative and the vaccine was administered.<br><br>3.The Director of Nursing and the Health Informatics Director developed a protocol to encourage and allow cognitively intact residents to make decisions regarding vaccinations. Re-education was completed by the Director of Nursing to all | |

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| F 883 | Continued From page 45<br>record: site of administration; date of administration; manufacturer and lot number of the vaccine; expiration date; and name of the person administering the vaccine."<br><br>Resident #5 was admitted to the facility on 01/25/23 with diagnoses including respiratory failure with hypoxia (low oxygen levels).<br><br>Review of the medical records for Resident #5 revealed she was listed as her own Responsible Party (RP).<br><br>Review of the immunizations record revealed Resident #5 signed consent to receive the covid-19 booster vaccine and it was administered on 07/06/23. There was no consent or declination documentation to support the facility provided education for the influenza vaccine for 2023.<br><br>Review of the quarterly Minimum Data Set dated 11/09/23 revealed Resident #5 cognition was assessed as intact, and the influenza vaccine was not given and was not offered.<br><br>During an interview on 12/21/23 at 3:46 PM the Director of Nursing (DON) revealed she was the Infection Preventionist, and it was joint effort to ensure consent for immunizations were offered to residents. She explained the process was for the Medical Records Coordinator to obtain consent upon admission and the assigned nurse to administer the vaccine and document it was given on the resident's Medication Administration Record and record the lot number and expiration date on the consent form and signed it.<br><br>A follow up interview was conducted with the DON/Infection Preventionist on 12/21/23 at 4:40 | F 883 | nursing supervisors on the revised vaccination procedure completed on 01/18/2024.Nursing Supervisors or designee will be responsible for obtaining flu consents for all residents.<br><br>4.The Director of Nursing will continue to audit all new admissions weekly x 4 weeks during the annual Flu season to ensure all new admits have received the annual Flu vaccine, consents are signed, and Flu vaccine is given upon request of the resident and/or resident representative. Audit Results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Director of Nursing or designee. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance.<br><br>5. Completion Date 01/18/24 | |

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| F 883 | Continued From page 46 | F 883 | | |

PM. The DON was unable to provide documentation to show Resident #5 received education, either gave consent, or declined the influenza vaccine on admission to the facility. The DON explained Resident #5's family member was asked to sign consent for Resident #5 to receive the influenza vaccine when the facility started the annual vaccinations in October 2023 but refused stating Resident # 5 was able to sign for consent herself. The DON confirmed Resident #5 was able to make her own healthcare decisions and when the family member did not sign consent for the influenza vaccine there was no follow up with Resident #5 and it was missed. The DON stated Resident #5 received the pneumococcal vaccine prior to admission and was up to date.

An interview was conducted on 12/21/23 at 4:54 PM with Resident #5. Resident #5 revealed the facility did not offer her the influenza vaccine until today (12/21/23). Resident #5 revealed she was provided education that discussed the benefits of being immunized and on 12/21/23 she chose to and did receive the influenza vaccine.

During an interview on 12/21/23 at 5:06 PM the Administrator stated consent and declination forms for immunizations should be followed up on by the nurse and the DON who was also the Infection Preventionist.