STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345415	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE REHABILITATION AND LIVING CTR	1010 LAKEVIEW DRIVE PINEVILLE, NC 28134

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/22/24 through 1/25/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# FH4V11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/22/24 through 1/25/24. Event ID# FH4V11. The following intakes were investigated: NC00205560, NC00206227, NC00206375, NC00206406, NC00209339 and NC00211624. 4 of the 15 complaint allegations resulted in deficiency.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		2/21/24

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

Electronically Signed | 02/19/2024

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F 623	Continued From page 1	F 623		

discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 2 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a written discharge notification to the Resident's Responsible Party (RP) for 1 of 1 resident (#335) reviewed for	F 623	The facility discharged resident #335 to the hospital and issued a 30-day discharge notice to the resident in the hospital and not the RP. RP was notified	

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F 623	Continued From page 3 discharge. The findings included: Resident #335 was admitted to the facility on 8/11/23 and discharged to the hospital on 8/14/23 with diagnoses including dementia and bipolar. A discharge Minimum Data Set (MDS) assessment dated 8/14/23 indicated Resident #335's was cognitively intact. His functional abilities were not documented on the MDS. A review of the hospital discharge summary dated 8/11/23 indicated Resident #335 was not taking suboxone medication (treats narcotic dependence) and suboxone was not listed on his medication list when he was discharged to the facility on 8/11/23. A review of an admission speech therapy encounter note dated 8/11/23 revealed Resident #335 scored 3 out of 15 on the cognitive screening tool whereas he was unable to remain focused on task during the cognitive assessment. The note further revealed the Resident cognition and receptive/ expressive language were severely impaired. A nursing progress note dated 8/14/23 indicated Resident #335 was disoriented on admission and possibly sedated on 8/11/23. The note further indicated on 8/14/23, Resident #335 presented with wild mood swings, outbursts of anger, paranoia, was ambulatory, unable to redirect and demanded his suboxone medication. An order was obtained from the Medical Director to send the Resident to the hospital for an inpatient psychiatric stay.	F 623	in writing by 2/21/24 by administrator. Effective 2/12/2024 Administrator or social worker will audit 30-days of discharge to ensure it was an appropriate discharge and notifications completed. No additional negative findings. On 2/12/2024 Administrator educated department heads on 30-day discharge notices issued before resident is discharged to the hospital. Effective 2/12/2024 newly hired department heads will be educated during orientation by Administrator on 30-day discharge process. An audit will be completed by Administrator or social worker (SW) as follows: all 30 day discharge residents weekly x 12 weeks to ensure appropriate with all notifications. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 2/21/2024	

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A review of #335's nursing progress note dated 8/14/23 indicated he was transferred to the hospital on 8/14/23 due to being a harm to self or others.

During further review of the medical record dated 8/15/23 indicated a discharge notice was issued to Resident #335 and Ombudsman (via email) due to safety of others with his behaviors aimed at nursing staff. There was no documentation that the resident's RP was provided a written discharge notice.

A review of a progress note written by the Administrator dated 9/14/23 revealed the facility was contacted by DHSR on 9/14/23 regarding the discharge and the facility completed an onsite visit to Resident #335 who remained hospitalized, required a sitter, was medicated, and would require memory care/ assisted living placement with locked unit, once discharged.

During an interview on 1/25/24 at 2:31 PM the RP indicated she never received a written discharge notice from the facility. Instead, she received a call from the facility staff indicating he was discharged from the facility. The RP further indicated Resident #335 was discharged from the hospital to an unlocked assisted living in November 2023.

During an interview on 1/25/24 at 11:00 AM the Director of Nursing (DON) indicated Resident #335 was sedated when he arrived at the facility on 8/11/23 and a few days later, he became increasingly agitated, irate, and was demanding his suboxone although the medication was not on his discharge summary and the facility did not have an order for suboxone. After further

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F 623	Continued From page 5 investigation, it was determined Resident #335 did not require assistance with care although the initial hospital referral indicated he required assistance with care. The DON further indicated law enforcement were contacted and responded to the facility due to Resident #335's behavior. He was transferred to the hospital on 8/14/23 and an emergency discharge notice was issued to Resident #335 on 8/15/23 while at the hospital, due to not being safe in the facility environment. The DON further indicated the hospital case manager was informed of the discharge and Resident #335's RP was notified of the discharge via telephone but was not provided written notification. During an interview on 1/25/24 at 4:04 PM the Marketing Director revealed she served Resident #335 the discharge notification at the hospital and had the assigned hospital nurse sign as a witness. She further revealed she did not provide a written discharge notice to Resident #335's RP and was not instructed to do so. During a phone interview on 1/25/24 at 12:05 PM Administrator #2 indicated she issued an emergency discharge notice to Resident #335 due to agitation and threatening behavior to staff. She further indicated she did not issue a written discharge notice to the RP, although a notice was delivered to the Resident at the hospital and the Ombudsman was also notified. Administrator #2 did not know why the RP was not notified in writing about the emergency discharge but that the RP was notified via telephone.	F 623		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		2/21/24

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F 636	Continued From page 6 §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. 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	F 636		

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F 636	Continued From page 7 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) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (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.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete admission and annual Minimum Data Set (MDS) assessments within the regulated time frames for 5 of 6 residents reviewed for completion of comprehensive MDS assessments (Residents #71, #78, #44, #186, and #39). The findings included: 1. Resident #71 was admitted to the facility on 12/7/23. The admission MDS with an assessment reference date (the last day of the assessment period) of 12/11/23 was reviewed and revealed the assessment was signed completed on 1/8/24.	F 636	The facility failed to complete a Comprehensive Minimum Data Set (MDS) assessment for resident #71, resident #78, resident #44, resident #186 and resident#39 within 14 days. Resident #71 Comprehensive assessment on 12/11 /2023 by MDS nurse Resident #78 Comprehensive assessment on 12/24/2023 by MDS nurse Resident #44 Comprehensive assessment on 8/18/2023 by MDS nurse Resident #186 Comprehensive assessment on 1/21/2024 by MDS nurse Resident #39 Comprehensive assessment on 12/6/2023 by MDS nurse.	

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F 636	Continued From page 8 The MDS Coordinator was interviewed on 1/25/24 at 10:37 AM. She explained she had been off work and was trying to catch up. She stated she had identified many comprehensive assessments which were late and had been working on them with help from the Corporate Consultant. The Corporate Consultant was interviewed on 1/25/24 at 11:09 AM. She explained that a plan of correction for the late assessments was started on 1/8/24 but it was not yet completed. The Administrator was interviewed on 1/25/24 at 3:40 PM and stated the MDS comprehensive assessments should have been completed by their due dates. She stated the MDS Coordinator had received help to completed assessments by corporate and were working on preventing late assessments. 2. Resident #78 was admitted on 12/23/23. The admission MDS with an assessment reference date (the last day of the assessment period) of 12/24/23 was reviewed and revealed the assessment was signed completed 1/15/24. The MDS Coordinator was interviewed on 1/25/24 at 10:37 AM. She explained she had been off work and was trying to catch up. She stated she had identified many comprehensive assessments which were late and had been working on them with help from the Corporate Consultant. The Corporate Consultant was interviewed on 1/25/24 at 11:09 AM. She explained that a plan of correction for the late assessments was started on 1/8/24 but it was not yet completed.	F 636	Effective 2/12/2024 current residents were reviewed by MDS Nurse to ensure Comprehensive Assessments were completed within the required timeframe. No additional negative findings On 2/7/2024 Regional MDS Consultant educated MDS nurses on completing the comprehensive MDS within the required timeframe. Effective 2/7/2024 newly hired MDS staff will be educated during orientation or training by Regional MDS Consultant on completing the comprehensive assessment within the required timeframe. Administrator and/or director of nursing (DON) will audit 3 comprehensive assessments weekly x 12 weeks to ensure comprehensive assessments are completed within the required timeframe. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 2/21/2024	

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The Administrator was interviewed on 1/25/24 at 3:40 PM and stated the MDS comprehensive assessments should have been completed by their due dates. She stated the MDS Coordinator had received help to completed assessments by corporate and were working on preventing late assessments.

3. Resident #44 was admitted on 8/15/23.

The admission MDS with an assessment reference date (the last day of the assessment period) of 8/18/23 was reviewed and revealed the assessment was signed completed on 8/31/23.

The MDS Coordinator was interviewed on 1/25/24 at 10:37 AM. She explained she had been off work and was trying to catch up. She stated she had identified many comprehensive assessments which were late and had been working on them with help from the Corporate Consultant.

The Corporate Consultant was interviewed on 1/25/24 at 11:09 AM. She explained that a plan of correction for the late assessments was started on 1/8/24 but it was not yet completed.

The Administrator was interviewed on 1/25/24 at 3:40 PM and stated the MDS comprehensive assessments should have been completed by their due dates. She stated the MDS Coordinator had receivied help to completed assessments by corporate and were working on preventing late assessments.

4. Resident # 186 was admitted on 1/8/24.

The admission MDS with an assessment reference date (the last day of the assessment

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period) of 1/21/24 was reviewed on 1/25/24 and revealed the assessment was not signed as completed.

The MDS Coordinator was interviewed on 1/25/24 at 10:37 AM. She explained she had been off work and was trying to catch up. She stated she had identified many comprehensive assessments which were late and had been working on them with help from the Corporate Consultant.

The Corporate Consultant was interviewed on 1/25/24 at 11:09 AM. She explained that a plan of correction for the late assessments was started on 1/8/24 but it was not yet completed.

The Administrator was interviewed on 1/25/24 at 3:40 PM and stated the MDS comprehensive assessments should have been completed by their due dates. She stated the MDS coordinator had received help to completed assessments by corporate and were working on preventing late assessments.

5. Resident #39 was admitted on 2/26/22.

The annual MDS with an assessment reference date (the last day of the assessment period) of 12/6/23 was reviewed and revealed the assessment was signed completed 12/29/23.

The MDS Coordinator was interviewed on 1/25/24 at 10:37 AM. She explained she had been off work and was trying to catch up. She stated she had identified many comprehensive assessments which were late and had been working on them with help from the Corporate Consultant.

The Corporate Consultant was interviewed on

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F 636	Continued From page 11 1/25/24 at 11:09 AM. She explained that a plan of correction for the late assessments was started on 1/8/24 but it was not yet completed. The Administrator was interviewed on 1/25/24 at 3:40 PM and stated the MDS comprehensive assessments should have been completed by their due dates. She stated the MDS Coordinator had received help to completed assessments by corporate and were working on preventing late assessments.	F 636		
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly assessments within the regulated time frames for 5 of 6 residents reviewed for completion of quarterly MDS assessments (Residents #52, #10, #44, #34, and #57). The findings included: 1. Resident #52 was admitted to the facility on 11/13/23. The quarterly MDS assessment with an assessment reference date (the last day of the assessment period) of 12/12/23 was reviewed and revealed the assessment was signed as completed on 1/5/24.	F 638	The facility failed to complete a Quarterly assessment for resident #52, resident #10, resident #44, resident #34, and resident #57. Resident #52 Quarterly assessment on 12/12/2023 by minimum data set (MDS) nurse. Resident #10 Quarterly assessment on 12/6/2023 by MDS nurse completed. Resident #44 Quarterly assessment on 11/18/2023 by MDS nurse completed. Resident #34 Quarterly assessment on 12/5/2023 by MDS nurse completed. Resident #57 Quarterly assessment on 12/1/2023 by MDS nurse completed. Effective 2/12 /2024 current residents	2/21/24

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F 638	Continued From page 12 The Corporate Consultant was interviewed on 1/25/24 at 11:09 AM. She explained that a plan of correction for the late assessments was started on 1/8/24 but it was not yet completed. The Administrator was interviewed on 1/25/24 at 3:40 PM and stated the MDS quarterly assessments should have been completed by their due dates. She stated the MDS Coordinator had been receiving help to completed assessments by corporate and were working on preventing late assessments. 2. Resident #10 was admitted to the facility on 5/26/22. The quarterly MDS assessment with an assessment reference date (the last day of the assessment period) of 12/26/23 was reviewed and revealed the assessment was signed completed on 1/14/24. The Corporate Consultant was interviewed on 1/25/24 at 11:09 AM. She explained that a plan of correction for the late assessments was started on 1/8/24 but it was not yet completed. The Administrator was interviewed on 1/25/24 at 3:40 PM and stated the MDS quarterly assessments should have been completed by their due dates. She stated the MDS Coordinator had been receiving help to completed assessments by corporate and were working on preventing late assessments. 3. Resident # 44 was admitted to the facility on 8/15/23.	F 638	were reviewed by MDS Nurse to ensure Quarterly Assessments were completed for each resident. No additional negative findings. On 2/7/2024 Regional MDS Consultant educated MDS nurses on completing a Quarterly Assessments for each resident per requirements. Effective 2/7/2024 newly hired MDS staff will be educated during orientation or training by Regional MDS Consultant or administrator on completing a Quarterly assessment for each resident. Administrator and/or director of nursing (DON) will audit 3 Quarterly assessments weekly x 12 weeks to ensure MDS assessments are completed within the required timeframe. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 2/21/2024	

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The quarterly MDS assessment with an assessment reference date (the last day of the assessment period) of 11/18/23 was reviewed and revealed the assessment was signed as completed on 12/7/23.

The Corporate Consultant was interviewed on 1/25/24 at 11:09 AM. She explained that a plan of correction for the late assessments was started on 1/8/24 but it was not yet completed.

The Administrator was interviewed on 1/25/24 at 3:40 PM and stated the MDS quarterly assessments should have been completed by their due dates. She stated the MDS Coordinator had been receiving help to completed assessments by corporate and were working on preventing late assessments.

4. Resident # 34 was admitted to the facility on 6/22/21.

The quarterly MDS assessment with an assessment reference date (the last day of the assessment period) of 12/5/23 was reviewed and revealed the assessment was signed as complete on 12/26/23.

The Corporate Consultant was interviewed on 1/25/24 at 11:09 AM. She explained that a plan of correction for the late assessments was started on 1/8/24 but it was not yet completed.

The Administrator was interviewed on 1/25/24 at 3:40 PM and stated the MDS quarterly assessments should have been completed by their due dates. She stated the MDS Coordinator had been receiving help to completed assessments by corporate and were working on

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F 638	Continued From page 14 preventing late assessments. 5. Resident # 57 was admitted to the facility on 10/11/22. The quarterly MDS assessment with an assessment reference date (the last day of the assessment period) of 12/1/23 was reviewed and revealed the assessment was signed as complete on 12/19/23. The Corporate Consultant was interviewed on 1/25/24 at 11:09 AM. She explained that a plan of correction for the late assessments was started on 1/8/24 but it was not yet completed. The Administrator was interviewed on 1/25/24 at 3:40 PM and stated the MDS quarterly assessments should have been completed by their due dates. She stated the MDS Coordinator had been receiving help to completed assessments by corporate and were working on preventing late assessments.	F 638		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		2/21/24

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F 655	Continued From page 15 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a baseline care plan within the required timeframe for a new admission for 1 of 3 residents (Resident # 288). The findings included:	F 655	The facility failed to develop a baseline care plan within 48 hours of admission for resident #288. Baseline care plan of resident #288 completed on 1/29/2024 by minimum data set (MDS) nurse.	

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F 655	Continued From page 16 Resident #288 was admitted to the facility on 1/11/24 with diagnoses that included neurocognitive disorder with lewy bodies and Parkinson's disease. The admission Minimum Data Set (MDS) dated 1/11/24 was still in progress and had not been completed. A review of Resident #288's medical record showed that the baseline care plan was started on 1/12/24 and had only one section completed, which was general information section. The general information section was completed on 1/16/24. Resident #288's functional status, health conditions, dietary, therapy and social services were not completed. On 1/25/24 at 9:56 AM, a phone interview conducted with Nurse #3 who initiated the baseline care plan on 1/12/24 revealed that she didn't know why only one section was completed. Nurse #3 stated that she generally would fill out all the sections. Nurse #3 stated she thought another staff was also helping with the baseline care plan, but she couldn't remember who that was. On 1/25/24 at 10:36 AM, an interview with the MDS Coordinator #2 revealed that the baseline care plan was not completed in a timely fashion. She stated the baseline care plan is to be completed by the nurse doing the admission. The care plan should be completed within 48 hours after admission. On 1/25/24 at 3:41 PM an interview with the Director of Nursing (DON) disclosed that the baseline care plan should be initiated right away	F 655	On 2/12/2024 Director of Nursing (DON) and/or assistant director of nursing (ADON) reviewed current residents to ensure baseline care plans were completed within 48 hours and in medical record. No additional negative findings. On 2/5/2024 Director of Nursing and/or assistant director of nursing (ADON), Unit manager (UM) educated current license nurses (including agency) on completing baseline care plan within 48 hours of admission. Effective 2/5/2024 any License Nurses (including agency) that have not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or ADON, UM. Effective 2/21/2024 all License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or ADON, UM on completion of the baseline care plan within 48 hours of admission. DON will audit new admissions 3 times weekly to include admissions on Friday, Saturday, and Sunday admissions x 12 weeks to ensure baseline care plan has been completed within 48 hours. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues	

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F 655	Continued From page 17 and finished within 72 hours. She stated the nurse doing the admission should have completed the baseline care plan. She also stated that having remote staff and staff changes with MDS entry is part of the issue for missing care plans. On 1/25/23 at 4:23 PM an interview with the Administrator revealed that the baseline care plan was supposed to be completed on the day of admission. The nurse doing the admission should complete it within 24-48 hours.	F 655	identified are corrected. Completion date: 2/21/2024	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		2/21/24

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F 656	Continued From page 18 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews, the facility failed to develop and implement an individualized person-centered care plan that addressed activities of daily living (ADL), psychotropic drug use (Resident #7), and tube feeding (Resident #298) for 2 of 9 residents whose care plans were reviewed. The findings included: 1. Resident #7 was admitted to the facility on 6/10/23 with diagnoses that included bilateral knee osteoarthritis (type pf arthritis that occurs when flexible tissue at the ends of bones wears down), delusional disorder, and dementia.	F 656	The facility failed to add ADL□s and Psychotropic drug use on resident #7 Comprehensive care plan and tube feeding on resident #298 Comprehensive care plan. ADL and Psychotropic drug use was updated to the care plan of resident #7 by minimum data set (MDS) nurse before 2/21/24 Tube feeding was updated to the care plan of resident #298 by MDS nurse before 2/21/24. On 2/12/2024 Director of Nursing and/or assistant director of nursing (ADON), unit manager (UM), MDS nurse reviewed	

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F 656	Continued From page 19 The modification of admission Minimum Data Set (MDS) assessment dated 6/15/23 indicated Resident #7 was cognitively intact, had no behaviors, and required extensive physical assistance with bed mobility, eating, toilet use, and personal hygiene, and was totally dependent on staff assistance with dressing and bathing. She did not have range of motion impairment to either upper or lower extremities. The MDS further indicated that Resident #7 received antipsychotic medications for 6 days and antidepressant medications for 4 days during the assessment period. The Care Area Assessment (CAA) dated 6/15/23 for activities of daily living (ADL) functional/rehabilitation potential indicated Resident #7 required staff assistance with ADL at this time. She was non-ambulatory and required staff assistance with transfers and mobility. She required assistance with feeding. The CAA further indicated that the ADL functional/rehabilitation potential will be addressed in the care plan with the overall objectives of slowing or minimizing decline, avoiding complications, and minimizing risks. There was a note that indicated "will proceed to care plan to focus on providing assistance with ADL." The Care Area Assessment (CAA) dated 6/15/23 for psychotropic drug use indicated Resident #7 was at risk for adverse effects related to psychotropic medication usage. She was ordered and received antipsychotic and antidepressant medications daily. She has had no noted adverse effects at this time. The CAA further indicated that the psychotropic drug use will be addressed in the care plan with the overall	F 656	current residents care plans to ensure resident-centered interventions (including tube feeding, ADLs, and psychotropic drug use as appropriate) are reflected on care plans. Any negative findings were addressed and corrected at time of audit. On 2/12/2024 Director of Nursing and/or ADON, unit manager educated current license nurses (including agency) on ensuring comprehensive care plans are resident centered (including tube feeding, ADLs, and psychotropic drug use as appropriate). Effective 2/12/2024 newly hired licensed nurses including agency nurses will be educated during orientation or training by Director of Nursing and/or ADON, unit manager on ensuring comprehensive care plans are resident centered (including tube feeding, ADLs, and psychotropic drug use as appropriate). Director of Nursing will audit 2 comprehensive care plans weekly x 12 weeks to ensure comprehensive care plans are resident centered (including tube feeding, ADLs, and psychotropic drug use as appropriate). Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 2/21/2024	

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objectives of avoiding complications and minimizing risks. There was a note that indicated "will proceed to care plan to focus on monitoring for adverse effects related to psychotropic medication usage."

The most recent quarterly MDS dated 12/8/23 indicated Resident #7 was cognitively intact, had no range of motion impairment to either upper or lower extremities, and was dependent on staff assistance with toileting hygiene and shower/bathing. She received antipsychotic and antidepressant medications, and a gradual dose reduction was documented as clinically contraindicated on 7/25/23.

Resident #7's care plan which was last updated on 1/22/24 did not include a care plan for ADL and psychotropic drug use.

An interview with MDS Coordinator #2 on 1/25/24 at 8:27 AM revealed she started in her current position on 11/8/23 and she was responsible for developing and updating the care plans. MDS Coordinator #2 stated she last updated Resident #64's care plan on 1/22/24 when she was asked to go through the residents listed on the matrix and make sure they had a care plan for the medications that they received. MDS Coordinator #2 stated she acknowledged that Resident #7 was listed as receiving antidepressant and antianxiety medications on the matrix, but she did not see a care plan for psychotropic drug use. She also stated that she did not see a care plan for ADL for Resident #7. MDS Coordinator #2 further reviewed Resident #7's care plan and shared that she added a care plan for urinary catheter on 1/22/24. She stated that she was not sure how the care plan for psychotropic drug use

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and ADL were missed. She further stated that one of the corporate staff completed Resident #7's quarterly MDS and they probably did not update her care plan then.

An interview with the Director of Nursing (DON) on 1/25/24 at 3:39 PM revealed that in order for the floor staff to take care of Resident #7, she didn't think there would be specific interventions in her care plan that weren't already reflected in her medical record. The DON stated that behavior monitoring was already in her medication record, and they should have monitoring of behaviors and monitoring of side effects of psychotropic drugs on the medication administration record. The DON stated that it would be ideal if these interventions were included in Resident #7's care plan but she didn't think not having them on the care plan would prevent the staff from monitoring Resident #7. The DON also stated that ADL should be on Resident #7's care plan. The DON shared that they had MDS nurses who monitored and updated the care plans. The MDS nurses referred to the care plans often and they needed to make sure the specific needs were on the residents' care plans and that they were being met. The DON stated that it was not an excuse but that they have had changes in their MDS department related to staff and they had corporate people and outside personnel helping with MDS and care plans.

2. Resident #298 was admitted to the facility on 7/20/23 with diagnoses that included dysphagia (difficulty swallowing foods or liquids).

Resident #298's care plan dated 11/20/23 did not include a care plan to address his tube feed and

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F 656	Continued From page 22 nutrition. The quarterly Minimum Data Set (MDS) dated 1/5/24 indicated Resident #298 was cognitively intact and used a feeding tube for nutritional intake. An interview with MDS Coordinator #1 on 1/24/24 at 10:30 AM revealed that the feeding tube should be a part of the care plan and the Dietician usually did the dietary and nutritional care plans. An interview with the Dietician on 1/24/24 at 12:05 PM disclosed that she initiated most dietary care plans. If it was a resident who required nutrition through a feeding tube, she would always initiate a care plan. The Dietician stated that Resident #298 had been in and out of the hospital so often that she did not do a care plan for the tube feeding. On 1/25/24 at 3:44 PM an interview with the Director of Nursing (DON) revealed that the MDS Nurses were responsible for making sure care plans were complete. The DON indicated that the remote staff and MDS staff changes were part of the issue with missing care plans. Typically, a feeding tube for nutrition care plan would be initiated by the Dietician. On 1/25/24 at 4:19 PM an interview with the Administrator disclosed that the feeding tube should be a part of the care plan and should have been in place for Resident #298.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		2/21/24

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F 677	Continued From page 23 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews and staff interviews, the facility failed to provide nail care for 2 of 9 residents dependent on staff for activities of daily living (Resident #44 and #1). The findings included: 1. Resident #44 was admitted to the facility on 8/15/23 with diagnoses inclusive of Parkinson's disease. The quarterly Minimum Data Set assessment (MDS) dated 11/18/23 indicated Resident #44 had severe cognitive impairment and required setup with eating, oral hygiene, and toileting. The MDS also indicated Resident #44 had not rejected care. A revised care plan dated 12/1/23 revealed Resident #44 had an activities of daily living (ADL) self-care performance deficit related to Parkinson's disease and he required staff assistance to complete ADL tasks daily. An observation and interview conducted on 1/22/24 at 11:10 AM revealed Resident #44's fingernails on both hands were long with jagged edges. Resident #44 stated his fingernails were cleaned the previous week by one staff member then was told a different staff would have to trim his nails and that did not happen. He explained that his fingernails had not been trimmed in a long time and that he wanted them to be cut. He	F 677	Nails were trimmed for resident #1 on 1/24/2024 CNA. Nails were trimmed for resident #44 on 1/25/2024 by CNA. On 2/12/2024, Director of Nursing (DON) and/or assistant director of nursing (ADON), unit manager (UM) reviewed current dependent residents to ensure ADL care is provided according to the plan of care and to their preference for nail care. No additional negative findings. On 2/13/2024 the Director of Nursing and/or ADON, UM will educate the current Certified Nursing Assistants including agency Certified Nursing Assistants on providing ADL care to dependent residents including nail care. Effective 2/13/2024 any Certified Nursing Assistants including agency Certified Nursing Assistants that have not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or ADON, UM. Effective 2/13/2024 all Certified Nursing Assistants, including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or ADON, UM on providing ADL care to dependent residents including nail care.	

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F 677	Continued From page 24 also stated he had never declined to have his nails trimmed. A follow up observation was conducted on 1/23/24 at 9:34 AM and revealed Resident #44's fingernails on both hands remained unchanged (long with jagged edges). A follow up observation was conducted on 1/24/24 at 11:08 AM and revealed Resident #44's fingernails on both hands remained unchanged (long with jagged edges). A review of bathing sheets from 11/2023 through 1/2024 and progress notes from 12/2023 through 1/2024 in the electronic medical record indicated Resident #44 had no refusals of care. During an interview on 1/24/24 at 11:39 AM Nurse Aide (NA) #1 indicated she usually worked with Resident #44 and had provided nail care in the past. She further indicated there was a designated NA (NA#4), who was on light duty, and was assigned to provide nail care to certain residents. However, NA #1 stated she would perform nail care if she recognized the need if NA #4 had not provided nail care. During an interview on 1/24/24 at 3:35 PM the Director of Nursing (DON) expected Resident #44 to receive nail care on shower days. She then explained NA #4 was assigned to provide nail care (clean and file) and although the activities staff provided nail care as an activity, they could only file resident fingernails. 2. Resident #1 was admitted to the facility on 1/3/24 with diagnoses inclusive of peripheral vascular disease, dementia, and anemia.	F 677	The DON and/or ADON, UM will monitor 5 residents to ensure residents are receiving ADL care weekly (nail care) x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Completion date: 2/21/2024	

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The quarterly MDS assessment dated 1/5/24 indicated Resident #1 had severe cognitive impairment and required maximum assistance for toileting, dressing, and personal hygiene and had not refused care.

An observation and interview conducted on 1/22/24 at 11:35 AM revealed Resident #1's fingernails on both hands were long with jagged edges and had dark brown matter under both thumbnails.

A follow up observation was conducted on 1/23/24 at 9:55 AM and revealed Resident #1's fingernails on both hands remained unchanged (long with jagged edges and dark brown matter under both thumbnails).

A follow up observation was conducted on 1/24/24 at 11:19 AM and revealed Resident #1's fingernails on both hands remained as they did on 1/22/24 (long with jagged edges and dark brown matter under both thumbnails).

A follow up observation on 1/24/24 at 3:09 PM revealed Resident #1's fingernails had been cleaned and cut.

During an interview on 1/24/24 at 12:15 PM NA #3 revealed she was assigned to providing nail care to residents and she cleaned Resident #1's fingernails on 1/19/24. However, when she arrived at work on 1/22/24, she observed brown matter under his fingernails and did not get a chance to clean them again.

During an interview on 1/24/24 at 11:55 AM NA #2 indicated she did not cut Resident #1's

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F 677	Continued From page 26 fingernails during personal care because of the thickness of his fingernails. NA #2 further indicated when she provided personal care to Resident #1, she would give him a wet soapy cloth and he could wash his hands without assistance. She was not sure why his fingernails had not been cut or who was supposed to cut them. During an interview on 1/24/24 at 3:30 PM the DON reported NAs have attempted to file Resident #1's fingernails at times due to the thickness of the nails. The DON stated Resident #1 was hospitalized at the end of December and his fingernails had not been trimmed or filed since he returned from the hospital. The DON stated she expected Resident #1 to receive nail care that included cleaning/ removing debris from his fingernails during personal care and on shower days.	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		2/21/24

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F 692	Continued From page 27 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assess and address weight loss for 1 of 3 residents reviewed for nutrition (Resident #1). The findings included: Resident #1 was readmitted to the facility on 1/3/24 with diagnoses inclusive of peripheral vascular disease, dementia, and anemia. A physician's order dated 1/4/24 indicated Resident #1 had an active order for regular diet, pureed texture, regular (thin) consistency for dysphagia. A physician's order (10/10/23) indicated health shakes two times a day for history of protein-calorie malnutrition one 4 oz serving with breakfast and dinner meal trays was discontinued on 1/3/24, when Resident #1 returned from a hospitalization. A physician's order dated 1/10/24 indicated weekly weights. Per the medical record, no weights were documented during the week of 1/10/24 and the next weight was documented on 1/19/24. A review of Resident #1's weights revealed the following:	F 692	The facility failed to assess and address weight loss for resident #1. Health shakes were made available to resident #1 on 1/25/2024. Resident # 1 was assessed by Registered dietitian RD by 2/14/24 with no change in plan of care. On 2/12/2024 the Director of Nursing and/or assistant director of nursing (ADON), unit manager (UM) assessed current residents to ensure they are receiving dietary supplements as ordered. No additional negative findings. By 2/15/24 the registered dietitian (RD) assessed all residents with significant weight loss with new interventions placed as appropriate. On 2/13/2024 Director of Nursing and/or ADON, UM educated current Certified Nursing Assistances and License Nurses (including agency) on ensuring residents are receiving dietary supplements as ordered. On 2/13/2024 any Certified Nursing Assistances and License Nurses (including agency) that have not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or	

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F 692	Continued From page 28 9/4/23 218 pounds 9/11/23 216 pounds 9/29/23 206.6 pounds 10/9/23 210 pounds 10/11/23 189.6 pounds 10/16/23 205.5 pounds 10/25/23 188 pounds 10/30/23 189.6 pounds 11/2/23 202 pounds 11/7/23 199 pounds 11/13/23 202.4 pounds 11/30/23 196.2 pounds 1/4/24 185 pounds 1/5/24 reweight 187 pounds 1/19/24 170.2 pounds 1/24/24 reweight 179.8 pounds A review of Resident #1's medical record did not reveal dietary notes that addressed the recent weight loss on 1/19/24. A review of Resident #1's meal tickets dated 1/23/24 and 1/24/23 revealed he received dietary shakes at each meal. A review of Resident #1's medical record from November 2023 through January 2024 did not indicate he was at the end of life. The quarterly Minimum Data Set (MDS) assessment dated 1/5/24 indicated Resident #1 had severe cognitive impairment and required set up with eating. The MDS indicated a weight of 187 pounds and was checked "yes" for significant weight loss of 5% or more in the last month. A revised care plan dated 5/23/22 indicated Resident #1 had potential nutritional risk related to mechanically altered diet to facilitate chewing	F 692	ADON, UM. On 2/13/2024 all Certified Nursing Assistances and License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or ADON, UM on ensuring residents are receiving dietary supplements as ordered. Director of Nursing or ADON will audit residents receiving dietary supplements 3x week X 4 weeks and weekly X 8 weeks to ensure supplements are provided as ordered . The Director of Nursing, Assistant Director of Nursing, or unit manager will review weekly/monthly weights 1 time per week x 12 weeks to ensure all significant weight loss has been addressed by the RD. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 2/21/2024	

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and swallowing due to edentulous status; history of Covid-19, protein/calorie malnutrition; Lymphedema, encephalopathy; elevated BMI with a goal to have adequate intake of meals and supplements to maintain nutritional status as evidenced by no significant weight change, no signs/symptoms of malnutrition, no signs or symptoms of dehydration and would maintain skin integrity through next review date. Interventions included: Administer medications as ordered; Monitor/record/report to physician as needed for signs/symptoms of malnutrition; Significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months; Obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow up as indicated; Obtain, record, and monitor weight per facility policy/physician order; Provide and serve supplements as ordered, monitor acceptance of supplement. The revised care plan had not been updated since 5/23/22.

During an interview on 1/24/24 at 11:57 AM NA #2 indicated when she was assigned to Resident #1, he fed himself, drank a dietary supplement, and at times had a decreased appetite, as evidenced by eating 50-100 % of at least one or two meals.

During an interview on 1/24/24 at 4:02 PM the Registered Dietician (RD) revealed that Resident #1 triggered (dietary notification/flagged through a report) for weight loss of 5% or more on 1/19/24 and she did not assess him or make any recommendations although she was at the facility on 1/23/24. She would normally make a recommendation such as re-weight or submit an order for interventions, because of the trigger and she could not recall why she did not. The RD

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F 692	Continued From page 30 further revealed she was responsible for receiving notification of weight changes via a weekly report, after nursing staff enter resident weights. Those weight results were usually reviewed during weekly risk meetings that included the interdisciplinary team. She indicated she should have followed up on the significant weight loss on 1/19/24 and assessed Resident #1 when she was at the facility on 1/23/24. During an interview on 1/25/24 at 11:25 AM the Director of Nursing indicated Resident #1 had good food intake and had previously been monitored for weight loss. She further indicated she was not aware of the recent weight loss and per the medical record, the Resident's nutritional shakes were discontinued when he was readmitted to the facility on 1/3/24. However, he continued to receive nutritional shakes with each meal. Her expectation was for the triggered weight loss to be discussed in the risk meeting on 1/19/24 and for the RD to submit recommendations/ interventions and notify the nurse practitioner or physician to address the weight loss.	F 692		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental	F 740		2/21/24

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F 740	Continued From page 31 and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, the Nurse Practitioner and the Mental Health Services Representative, the facility failed to obtain mental health services for 1 of 1 resident reviewed for behavioral and emotional status (Resident #64). The findings included: Resident #64 was admitted to the facility on 9/21/23 with diagnoses that included depression. A progress note dated 10/2/23 by the Nurse Practitioner indicated Resident #64 was seen for routine medical follow-up. Resident #64 endorsed feelings of depression. He stated that he had not slept well for 5 nights. Resident #64 stated that his Escitalopram (antidepressant used to treat depression and generalized anxiety disorder) was not working. He was currently on 20 milligrams (mg) which was the maximum dose. The NP indicated she would place order for psychiatric consult. Resident #64 was originally prescribed Alprazolam (sedative used to treat anxiety and panic disorder) 0.5 mg twice daily as needed. Resident #64 reported he had tried taking Melatonin (hormone that plays a role in sleep) for sleep in the past and it did not work. Resident #64 denied using Trazodone (antidepressant and sedative) in the past. The NP indicated she would place an order for Trazodone 25 mg every night. There was no order in Resident #64's medical record dated 10/2/23 for a psychiatric consult.	F 740	Resident #64 was seen by psychiatry by 2/14/24 with no change in plan of care. On 2/13/2024 Director of Nursing and/or assistant director of nursing (ADON), unit manager (UM) will assess current residents for the need of mental health services, including order review. No additional negative findings. On 2/13/2024 Director of Nursing, ADON, or UM educated current nursing staff (including agency) on notifying Social Services and Director of Nursing if resident needs mental health services, or new order for these services obtained. Services will be set up with facility provider and/or services will be outsourced. Effective 2/13/2024 newly hired nursing staff including agency staff will be educated during orientation by Director of Nursing and/or ADON, UM, on notifying Social Services and Director of Nursing if resident needs mental health services, or new order for these services obtained. Director of Nursing and/or ADON will evaluate 3 residents for the need of mental health services, including new order for these services weekly x 12 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results	

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A progress note dated 10/6/23 by the NP indicated Resident #64 was seen for follow-up of anxiety and depression. Resident #64 endorsed feelings of depression. He stated he was feeling better since Alprazolam 0.5 mg was scheduled twice daily. He was currently on Escitalopram 20 mg and awaiting psychiatric referral.

A nurses' progress note dated 10/17/23 at 11:52 PM by Nurse #1 indicated Resident #64 stated that he had been feeling depressed and the depression had "taken over." He denied having any suicidal ideations. The NP was notified and an order for a psychiatrist consultation had been made. Staff had been made aware of the resident's change in mental health and will continue to monitor.
An order for psychiatry consultation for depression was scheduled on 10/17/23 in Resident #64's medical record and was marked completed on 10/18/23 by Nurse #1.

A phone interview with Nurse #1 on 1/25/24 at 8:09 AM revealed Resident #64 told him on 10/17/23 that his depression had taken over and that he wanted to see a psychiatrist. Nurse #1 stated he felt bad about Resident #64 because he was depressed but he wasn't sure what the process was at the facility. Nurse #1 stated he knew Resident #64 needed to be seen by any provider who could talk to him about his depression, and he was advised by the other nurses who worked on the same shift to leave a note under the door of the medical providers' room. Nurse #1 denied having received any order or having entered any order for psychiatry consultation for Resident #64. Nurse #1 added that he thought Resident #64 had been seen by psychiatry because the next time he worked with

of weekly audits to ensure any issues identified are corrected.

Completion date: 2/21/2024

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him, Resident #64 mentioned to him that he talked to the NP about being depressed. Nurse #1 stated that he assumed the NP had taken care of obtaining psychiatric consultation for Resident #64.

A progress note dated 10/18/23 by the NP indicated Resident #64 was seen due to reports from nursing that he was experiencing increased depression. He endorsed feelings of depression. He stated he had a feeling of worthlessness. Last week, Resident #64 was seen and stated he was feeling better since adding Alprazolam 0.5 mg scheduled twice daily. He was currently on Escitalopram 20 mg daily which was the maximum daily dose. He denied suicidal or homicidal ideations. The NP indicated Resident #64 was Awaiting psychiatric referral. Resident #64 stated he had not been eating and had no appetite. He stated this happens when he gets in a depressed state. The NP indicated she would place an order to start Bupropion (antidepressant) 100 mg twice daily. The NP indicated she would increase the Bupropion to three times daily as indicated.

A progress note dated 12/11/23 by the NP indicated Resident #64 was seen for depression. Resident #64 reported feeling very depressed, and really wanting to see a psychiatrist. The NP indicated the referral was pending and she would follow up with staff to expedite the referral. "Resident #64 is on maximum dose of Bupropion as well as Escitalopram. He is currently taking Alprazolam 0.5 mg scheduled twice daily as well. However, he reported sleeping a lot during the day". (The NP) did not think increasing this would be beneficial. The NP documented she would like to start Resident #64 on Mirtazapine

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(antidepressant) however, would need the assistance of psychiatry to help with transition, as well as more appropriate medications for this resident. He denied suicidal or homicidal ideations. The NP indicated Resident #64 was awaiting psychiatric referral.

The most recent quarterly Minimum Data Set assessment dated 12/30/23 indicated Resident #64 was cognitively intact, had no depressive symptoms and no behaviors. He received anti-anxiety and antidepressant medications.

An order to consult psychiatry related to Resident #64 requesting for a psychiatry consult for depression was scheduled on 1/17/24 in Resident #64's medical record and was marked completed on 1/18/24 by Nurse #2.

Attempts were made to contact Nurse #2, but they were unsuccessful.

An interview with Resident #64 on 1/22/24 at 10:54 AM revealed he had asked to see a psychiatrist and they had not taken care of it. He stated that he had moods that went up and down, and that he was going through depression. He also stated that sometimes he did not get up out of the bed because of his depression. Resident #64 further stated that since his admission at the facility, he had not been seen by a psychiatrist.

Resident #64's care plan last revised on 1/24/24 indicated he received antidepressant medications related to depression and insomnia, and anti-anxiety medications related to anxiety disorder. Interventions included to refer for psychological evaluation as ordered by the doctor.

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An interview with the Nurse Practitioner (NP) on 1/25/24 at 9:18 AM revealed she knew for sure that she gave a verbal order to a staff member that Resident #64 needed a psychiatric referral, but she couldn't remember who. During the interview, she searched in Resident #64's medical record and stated she couldn't find an order for 10/2/23. She stated that there was an issue with Resident #64's insurance but she didn't know much about it, and he had been waiting to see a psychiatrist. The NP shared that after the first time she saw him at the facility, she wanted him to see a psychiatrist because he had complained of depression. She stated that she was managing him in the meantime, and she didn't think the delay in obtaining a psychiatric consultation for Resident #64 caused a negative outcome. The NP further stated Resident #64's depression had been up and down and would continue to be up and down, and a psychiatrist probably would have ordered the same medications that he was currently on. The NP stated a psychiatrist needed to see Resident #64 first to make sure he was getting the right medications for his depression, and they would be able to refer Resident #64 to a psychotherapist from whom Resident #64 would benefit more.

An interview with the Business Office Manager on 1/25/24 at 12:19 PM revealed Resident #64 did not have any issues with his insurance and if he needed to be seen by a psychiatrist, he could have been seen without her checking if it was covered by his insurance. The Business Office Manager stated the staff normally did not need to check with her before a resident was seen for a psychiatric consult unless there was an issue with

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the insurance. She also stated that the Social Services Director was responsible for arranging the psychiatric consults.

An interview with the Social Services Director (SSD) on 1/25/24 at 12:26 PM revealed that if the NP gave an order for a psychiatric consult, the nurses would let her know that it needed to be done. She then would get the resident to sign the consent form or call a family member and obtain a verbal consent. The SSD stated that she initially obtained a verbal consent by phone from Resident #64's responsible party on 10/9/23 and she faxed this consent and referral form to the mental health provider's office on 10/9/23. During the interview, the SSD showed this consent form, and it was signed by the NP on 10/9/23. The SSD stated that Resident #64 was on the caseload to be seen by psychiatry due to his diagnoses and psychiatric medications when he was admitted to the facility. She said she did the referrals by batches which explained why she did the initial referral on 10/9/23. After she had faxed this form, she thought they had included Resident #64 on the list until December when she found out that Resident #64 still had not been seen by the psychiatrist. She The SSD stated she discovered this after Resident #64 was discussed at a utilization review meeting that he was still waiting to be seen by a psychiatrist. The SSD further stated that she called the representative at the mental health services and found out that she needed to send another consent because they changed the form to which two signatures were required if a verbal consent was obtained. The SSD obtained another verbal consent from Resident #64's responsible party on 12/12/23 and faxed it to the mental health services group. The SSD stated that she noticed

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there were other psychiatric referrals that did not get added to the list of residents to be seen by the mental health provider. So, she sent the representative an e-mail about this concern on 1/24/24 and requested for them to add the new residents to the list and send the new list to her. The SSD reported she had not heard back from the mental health services representative. The interview further revealed that the SSD had not talked to the NP about obtaining a psychiatric consult for Resident #64. The SSD shared that the psychiatrist typically came to the facility once a week, but they had requested for them to come more frequently because they had a lot of residents who needed psychiatric services. She also shared that there was a psychotherapist who came to the facility once or twice a month. The SSD said she couldn't remember if Nurse #2 notified her about Resident #64's order for psychiatric referral on 1/17/24 and she would need to check if she received an e-mail from Nurse #2 because sometimes the nurses sent her an e-mail if they needed to notify her of orders for psychiatric consults.

During a follow-up interview with the SSD on 1/25/24 at 12:57 PM, she shared that the administrative team had a meeting with the psychiatric providers last week and they brought to their attention about the concern that they had been faxing consent forms for new residents, but they did not get added to the list of residents to be seen. They gave them a copy of the consent forms during their visit last week and this included Resident #64's referral.

A phone interview with the Mental Health Services Representative (MHSR) on 1/25/24 at 3:57 PM revealed they did recently change the

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consent form to where two signatures were required for verbal consents and the referral for psychiatric consult was also on the same form. The MHSR stated that she did not see Resident #64 in their system as an active resident, but she would have to refer to the intake department who received the referrals for new residents to get more information.

During a follow-up phone interview with the MHSR on 1/25/24 at 4:24 PM, she stated that she confirmed that they did not receive a consent and referral form for Resident #64. The MHSR stated that if the facility faxed a form over to them, it probably didn't go through. The MHSR further stated they always send the schedule for the psychiatric provider's next visit at least 48 hours in advance so if they noted that the new resident was not on the list, they should have called her to make sure they received the consent and referral form. The MHSR disclosed that the provider's assistant normally e-mailed the schedule to a number of administrative staff including the Director of Nursing, the Assistant Director of Nursing, the Social Services Director, and the Administrator to make sure someone was available at the facility to review it prior to the psychiatric provider's visit.

An interview with the Director of Nursing (DON) on 1/25/24 at 3:39 PM revealed she met with the psychiatric providers last week and expressed her concern that they had been sending them referrals, but she had not been seeing notes that they were following up with the new residents. The DON shared that the facility's system was that if they received an order for psychiatric referrals, they would send the referral and consent form to the psychiatric provider and then

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F 740	Continued From page 39 she would receive an e-mail of the list of residents to be seen on the next visit. The DON stated she received an e-mail on either 1/11/24 or 1/12/24 and she noticed that the new residents they had just sent referrals for did not make it on the list, so she spoke with them on 1/16/24. The DON further stated that the psychiatric provider came to the facility every other week and that should have been the maximum wait time for a resident to get seen for a psychiatric consult. The DON shared that she told them that it was not acceptable for a resident to wait longer than two weeks to see a psychiatric provider. An interview with the Administrator on 1/25/24 at 4:18 PM revealed she had just started working at the facility last week and she was part of the meeting with the mental health services group, but she could not remember the details of the meeting and she relied on the DON to lead it. The Administrator stated that whenever they sent referrals to the psychiatric providers, they need to follow through with the order and make sure that they were seen by the psychiatrist as ordered. She shared that she was aware that the DON had been having issues with the psychiatric providers and their referrals not being processed and residents not being seen as they should.	F 740		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		2/21/24

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F 812	Continued From page 40 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired food stored for use from 1 of 3 refrigerators (the walk-in refrigerator) in the kitchen. This had the potential to affect food served to residents. The findings included: On 1/22/24 at 10:38 AM an observation of the kitchen's walk-in refrigerator with the Dietary Manager (DM) revealed one opened case of lettuce. The box contained approximately 6 heads of lettuce that were brown and black in color, withered on the outside and brown and slimy on the inside. During the observation, the DM stated the lettuce was expired, and it would not have been used. The DM stated she and the cooks checked the refrigerator at the start of each workday for expired food. The DM said the box of lettuce was not checked for freshness earlier in the day. The Administrator stated on 1/25/24 at 3:40 PM the assigned kitchen staff should have checked the produce and removed all expired produce.	F 812	Lettuce was discarded on 1/23/2024 by district manager at time of discovery. On 2/12 /2024 Dietary staff and district dietary manager checked pantry and refrigerator for expired food and food with signs of spoilage with no additional findings. On 2/13/2024 District Dietary Consultant educated dietary staff, including dietary manager, on discarding expired/spoiled items. On 2/13/2024 Dietary Manager or designee educated dietary staff on discarding expired items, foods with signs of spoilage. After 2/13/24 no dietary staff member was allowed to work until education completed. Effective 2/13/2024 newly hired dietary staff will be educated during orientation by Dietary Manager on discarding expired items. . An audit will be completed by Regional	

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F 812	Continued From page 41	F 812	Dietary Consultant or Dietary Manager to ensure no expired or food with signs of spoilage present weekly x 12 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 2/21/2024	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. 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: §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. §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.	F 867		2/21/24

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F 867	Continued From page 42 §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will 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.	F 867		

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F 867	Continued From page 43 §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. §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. §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. §483.75(g) Quality assessment and assurance. §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:	F 867		

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F 867	Continued From page 44 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification surveys conducted on 10/8/21 and 7/29/22, and the complaint investigation survey conducted on 4/3/23. This was for repeat deficiencies in the areas of baseline care plan, activities of daily living care provided for dependent residents, and nutrition/hydration status maintenance that were originally cited on 7/29/22 during the recertification survey, and subsequently recited during the current recertification survey completed on 1/25/24. Develop/implement comprehensive care plan was originally cited on the complaint survey on 4/3/23 and was also subsequently recited during the recertification survey on 1/25/24. Food procurement and storage was originally cited on 10/8/21 during the recertification survey, and subsequently recited during the recertification survey on 7/29/22, the complaint survey on 4/3/23 and the recertification survey on 1/25/24. The continued failure of the facility during four federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included:	F 867	The facility received repeated deficiency tags on 1/25/2024 for F655, F656, F677, F692, and F812. Appropriate plans of correction implemented for each deficiency with repeat cite. On 2/15/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F655 to be lack of auditing for continued follow-up. On 2/15/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F656 to be changes in staff. On 2/15/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F677 to be lack of auditing for continued follow-up. On 2/15/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F692 to be lack of auditing for continued follow-up. On 2/15/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F812 to be lack of auditing for continued follow-up. On 2/15/24 Quality Assessment and Assurance committee and IDT will review reviewed previous Quality Assessment	

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F 867	Continued From page 45 This tag is cross referenced to: F655 - Based on record review and staff interviews, the facility failed to complete a baseline care plan within the required timeframe for a new admission for 1 of 3 residents (Resident # 288). During the recertification survey on 7/29/22, the facility failed to develop a baseline care plan that addressed interventions to promote healing of unstageable pressure ulcers that were present on admission for 1 of 6 residents reviewed for pressure ulcers. F656 - Based on record reviews, and staff interviews, the facility failed to develop and implement an individualized person-centered care plan that addressed activities of daily living (ADL), psychotropic drug use (Resident #7), and tube feeding (Resident #298) for 2 of 9 residents whose care plans were reviewed. During the complaint investigation survey on 4/3/23, the facility failed to initiate and implement a care plan for a resident who frequently refused to attend scheduled hemodialysis treatments for 1 of 2 residents reviewed for dialysis. F677 - Based on observations, record review, resident interviews and staff interviews, the facility failed to provide nail care for 2 of 9 residents dependent on staff (Residents #44 and #1) for activities of daily living (ADL). During the recertification survey on 7/29/22, the facility failed to provide shaving assistance, nail care, and skin care for 4 of 10 residents reviewed	F 867	and Assurance minutes to determine trends and opportunities for improvement including repeat deficiencies. As a result of this audit root cause was identified for F655, F656, F677, F692, F812. On 2/5/2024 Administrator educated department heads on ensuring procedures are implemented and monitored per the plan of correction for repeat tags, and newly identified areas. Administrator will audit results of plan of correction audits for F655, F656, F677, F692, and F812 weekly x 12 weeks. Administrator will audit Quality Assurance monthly x 3 months to ensure procedures are implemented and monitored. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 2/21/2024	

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for activities of daily living for dependent residents.

F692 - Based on record review and staff interviews, the facility failed to assess and address weight loss for 1 of 3 residents (Resident #1) reviewed for nutrition.

During the recertification survey on 7/29/22, the facility failed to assess interventions for significant weight loss and have systems in place to identify further weight loss for 1 of 1 resident reviewed for weight loss.

F812 - Based on observations and staff interviews the facility failed to remove expired food stored for use from 1 of 3 refrigerators in the kitchen (the walk-in refrigerator). This had the potential to affect food served to residents.

During the recertification survey on 10/8/21, the facility failed to ensure dishware was sanitized according to manufacturer guidelines, store potentially hazardous foods within the manufacturers' recommended temperature range to minimize risk for contamination and spoilage and failed to remove spoiled food stored for use. These practices had the potential to affect food served to residents.

During the recertification survey on 7/29/22, the facility failed to label, and date opened food for 2 of 2 nourishment room refrigerators and failed to defrost 1 of 2 nourishment room freezers. The facility also failed to ensure dietary staff covered facial hair while working in the kitchen.

During the complaint investigation survey on 4/3/23, the facility failed to maintain and serve a

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE REHABILITATION AND LIVING CTR	1010 LAKEVIEW DRIVE PINEVILLE, NC 28134

(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
F 867	Continued From page 47 potentially hazardous food, at least 135 degrees Fahrenheit. This had the potential to affect 5 of 5 residents with diet orders for pureed diets. An interview with the Administrator on 1/25/24 at 4:29 PM revealed their QAA committee met monthly where they go over processes and talk about identified issues and plans of correction for previously cited concerns. The Administrator stated she was new to the facility and hadn't participated in a QAA meeting yet but she would have to look at the root cause analysis and find out where the breakdown was for the repeat citations.	F 867		