STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 05/06/2024

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LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 5/6/24. Event ID# CL1411. The following intake was investigated NC00216242. The complaint allegation did not result in deficiency.	F 000		
F 656 SS=D	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 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.	F 656		5/29/24

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

Electronically Signed | 05/16/2024

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F 656	Continued From page 1 (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 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 residents reviewed for comprehensive care plan (Resident #1). The facility failed to develop care plans for cognitive loss/Dementia, urinary Incontinence and Indwelling catheter, functional abilities, dehydration/fluid maintenance, dental care, pain, communication, nutritional status, and pressure ulcer/injury. Findings Included: Resident #1 was admitted to the facility on 11/8/23. Diagnoses included multiple fractures and pressure ulcers. He was discharged to the hospital on 12/9/23 and did not return to the facility. Resident #1's admission Minimum Data Set (MDS) assessment dated 11/13/23 revealed the Care Area Assessment (CAA) summary identified	F 656	F656 Resident #1□s discharged from the facility on 12/9/23. Residents with cognitive loss/dementia, urinary incontinence and indwelling catheters, functional abilities, dehydration/fluid maintenance, dental care, pain, communication, nutritional statuses, and pressure ulcer/injury have the potential to be affected by the deficient practice. On 5/10/24 the Minimum Data Set Nurse reviewed current residents to ensure comprehensive care plans are completed as indicated according to the RAI manual. On 5/10/24 the Minimum Data Set Nurse was educated by the regional nurse Consultant on the completion of the comprehensive care plan within 21 days. Furthermore, education was provided that	

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F 656	Continued From page 2 care plans would be developed for cognitive loss/Dementia, urinary Incontinence and Indwelling catheter, functional abilities, dehydration/fluid maintenance, dental care, pain, communication, nutritional status, and pressure ulcer/injury. Review of the medical record revealed a nutrition care plan dated 11/8/23. There were no other care plans available for Resident #1. During an interview on 5/6/24 at 3:12 pm, MDS Nurse #1 revealed the care plans for Resident #1 had not been completed after checking Resident #1's electronic medical records (EMR). She stated she was not sure why this was not done. She referred the surveyor to another MDS Nurse (#2) who worked remotely. During a telephone interview on 5/6/24 at 3:13 pm, MDS Nurse #2 checked Resident #1's EMR and stated the comprehensive care plan was not done. She stated she was not sure what happened. She stated that she typically completed all the residents' comprehensive care plans right after she completed the MDS CAAs. She did not know how she missed it. During an interview on 5/6/24 at 3:08 pm, the Director of Nursing (DON) stated the comprehensive care plans should be based on the CAAs and completed within seven days from the resident assessment.	F 656	comprehensive care plan must be updated to address the interventions used when cognitive loss/dementia, urinary incontinence and indwelling catheters, functional abilities, dehydration/fluid maintenance, dental care, pain, communication, nutritional statuses, and pressure ulcer/injury. Regional Minimum Data Set Nurse will audit five residents a week for four weeks, three residents a week for four weeks and then two residents a week for four weeks to ensure comprehensive care plan is in place. The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Completion Date: 5/29/24	
F 867 SS=D	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	F 867		5/29/24

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F 867	Continued From page 3	F 867		

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.

§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.

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F 867	Continued From page 4	F 867		

§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.

§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

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F 867	Continued From page 5 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: (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 record review, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey of 5/28/21 and 5/26/23 and the current complaint investigation survey of 5/6/24. This failure occurred for a repeat	F 867	F867 The facility□s Quality Assurance Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation survey that occurred on 05/28/21 and 05/26/23. This failure was for one	

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F 867	Continued From page 6 deficiency originally cited in the area of comprehensive resident centered care plans that was subsequently recited on the current complaint investigation survey of 5/6/24. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI Program. The findings included: This tag is cross referenced to: 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 residents reviewed for comprehensive care plan (Resident #1). The facility failed to develop care plans for cognitive loss/Dementia, urinary Incontinence and Indwelling catheter, functional abilities, dehydration/fluid maintenance, dental care, pain, communication, nutritional status, and pressure ulcer/injury. During a recertification and complaint investigation survey of 5/28/21, the facility failed to develop a comprehensive person-centered plan of care that included the daily use of an antipsychotic and antianxiety medication for a resident. During a recertification and complaint investigation survey of 5/26/23, the facility failed to develop a care plan with measurable goals and objectives to address nutrition for a resident. An interview was conducted on 5/6/24 at 4:40 pm with the Administrator and the Director of Nursing. The Administrator stated he headed the facility's	F 867	deficiency that was originally cited in the areas of F656 Develop and Implement a Comprehensive Care Plan and was subsequently recited on the current complaint investigation of 05/06/24. Plan of correction was put into place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of the plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Regional Nurse Consultant educated the Administrator and Director of Nursing on the appropriate functioning of the QAPI. In addition, the Administrator initiated in-service to all administrative staff on 5/13/24 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This inservice included ensuring accuracy of audits, extending audits when appropriate, and	

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F 867	Continued From page 7 Quality Assurance and Performance Improvement (QAPI) Committee. The committee consisted of the Director of Nursing (DON), Staff Development Coordinator (SDC), Medical Director, Pharmacist, Dietary Manager, Maintenance Director, and himself. He revealed the facility was working on falls with injuries, pest control, and recently added care plans.	F 867	reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education. The Quality Assurance Performance Improvement Committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction. Date of Compliance: 5/29/24	