STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

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E 000	Initial Comments The survey team entered the facility on 09/22/24 to conduct a recertification and complaint survey and was unable to return to the facility on 09/27/24 due to adverse weather of a hurricane and unsafe travel conditions. Additional information was obtained offsite on 09/27/24. Therefore, the exit date was 09/27/24.The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #S3BX11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 09/22/24 to conduct a recertification and complaint survey and was unable to return to the facility on 09/27/24 due to adverse weather of a hurricane and unsafe travel conditions. Additional information was obtained offsite on 09/27/24. Therefore, the exit date was 09/27/24. Event ID# S3BX11. The following intakes were investigated: NC00221980, NC00221209, NC00218997, NC00219288, NC00218777, NC00218336, NC00217828, NC00214420, NC00222297 and NC00222289. 19 of the 19 complaint allegations did not result in deficiencies.	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	F 656		10/24/24

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

Electronically Signed | 10/17/2024

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F 656	Continued From page 1	F 656		

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.
(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:

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F 656	Continued From page 2 Based on record review, observation, and staff interviews, the facility failed to develop a comprehensive person-centered plan to address anticoagulant, insulin, and antidepressant use for 1 of 15 residents reviewed for comprehensive care plans (Resident # 18). The findings included: Resident #18 was admitted to the facility on 08/12/24 with diagnoses that included acute respiratory failure with hypoxia, atrial fibrillation, diabetes mellitus, and major depressive disorder. A review of the physician's orders dated 08/12/24 revealed the following orders: - Insulin Lispro (1 unit dial) Subcutaneous Solution Pen Injector 100 unit/milliliter Inject as per sliding scale subcutaneously four times a day for diabetes mellitus - Insulin Glargine Subcutaneous Solution Inject 10 units subcutaneously in the morning for diabetes mellitus - Sertraline HCL Oral Tablet 50 milligrams Give 1 tablet via PEG Tube one time a day for depression - Apixaban Oral Tablet 5 milligrams Give 1 tablet via PEG Tube two times a day for atrial fibrillation A review of the admission Minimum Data Set (MDS) assessment dated 08/18/24 revealed Resident #18 was cognitively impaired, diagnosed with depression and received antidepressant medication for the seven days of the look back period. The MDS further revealed Resident #18 was diagnosed with diabetes and received insulin six days during the look back period. The MDS also revealed Resident #18 was	F 656	F656 Develop/Implement Comprehensive Care Plan 1. The comprehensive Care plan on Resident #18 was revised to include diagnosis of diabetes; insulin dependent. Resident #18 at risk for injury or complications related to the use of anti-coagulation therapy medication-Apixaban. Resident #18 is at risk for complications related to use of Psychotropic drugs medication-Sertalin. The Comprehensive Care Plan was revised on Resident #18 on 9/27/2024. 2. All residents have the potential to be affected. A 100% audit was performed on all residents by the Director of Nursing/Designee to ensure no comprehensive care plan triggers were missed. This audit was completed on 10/17/2024. 3. Education completed by the Director of Nursing/Designee for all Interdisciplinary Staff; Social Worker, Activities Director, Director of Rehab, Dietary Manager, Nursing Leadership, and Licensed Nurses on the Person-Centered Comprehensive Care Plan policy on or before 10/22/2024. 4. To monitor and maintain ongoing compliance, the Director of Nursing/Designee will monitor all new admissions to ensure the Comprehensive Care Plan is completed within seven days of the completion of the Comprehensive Assessment and no more than 21 days after admission. The Director of	

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F 656	Continued From page 3 diagnosed with atrial fibrillation and was marked "yes" for anticoagulant use during the look back period. A review of the care plan dated 08/18/24 revealed that Resident #18 did not have a person-centered care plan that addressed anticoagulant use, insulin use, and antidepressant use. On 09/27/24 at 12:37 PM an interview was conducted with the MDS Nurse, and she stated the admitting nurse was responsible for initiating a baseline care plan and then the MDS nurse built the comprehensive care plan from the baseline care plan. The MDS Nurse stated a traveling MDS Nurse completed Resident #18's admission MDS assessment. Attempts to reach the traveling MDS Nurse via telephone were unsuccessful. An interview was conducted with the Director of Nursing (DON) and Administrator on 09/27/24 at 12:29 PM and the DON stated the admitting nurse was responsible for the initiation of Resident #18's baseline care plan and then the MDS Nurse built on to the baseline care plan when he/she completed the comprehensive care plan. The DON stated the use of anticoagulant medication, insulin, and antidepressant medication should have been picked up and care planned on admission.	F 656	Nursing/Designee will monitor all annual or significant change in status and review and revise the care plan after each assessment. Monitoring will be completed 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks. An ADHOC QAPI meeting was held by the Administrator on 10/17/2024. The Director of Nursing will report the results of the monitoring to the QAPI Committee for review and recommendations for the the time frame of the monitoring period as it is amended by the committee. 5. Date of Compliance 10/24/2024.	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses	F 660		10/24/24

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F 660	Continued From page 4	F 660		

on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as

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F 660	Continued From page 5 appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to arrange home health services upon discharge for 1 of 4 sampled residents (Resident #54) reviewed for discharge planning. Findings included:	F 660	F660 Discharge Planning Process 1. The facility failed to arrange home health services upon discharge on resident #54. Resident #54 discharged from the facility on 5/31/2024. Resident #54 was seen by her Primary Care	

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F 660	Continued From page 6 Resident #54 was admitted to the facility on 3/16/24 with diagnosis of paroxysmal atrial fibrillation, dementia, and congestive heart failure. The admission Minimum Data Set assessment dated 3/23/24 indicated Resident #54 was severely cognitively impaired. The physician's order dated 5/29/24 documented Resident #54 was to discharge home on 5/31/24. The order revealed the resident would need a hospital bed related to her inability to transfer or lay flat. Resident would need a home health agency (HHA) for ADL (activities of daily living) assistance; home health nursing for medication management; physical therapy (PT) and occupational therapy (OT) to evaluate and treat; and a social worker (SW) for the community. The review of the Discharge Plan Documentation dated 5/30/24 completed by the facility's former Social Worker indicated Resident #54 was to be discharged home with her family, home health services and Hospice starting 5/31/24. A hospital bed was ordered for delivery to resident's home on 5/31/24. The Assessment and Plan included in the physician's Discharge Summary dated 5/31/24 indicated Resident#54's family would assist the HHA with the resident's ADL care at home. If the resident decided to participate with PT, the HHA would also provide PT if the resident was willing to participate. During an interview on 9/25/24 at 3:39 p.m., the Business Office Manager revealed the SW, who conducted the discharge planning at the time of Resident #54's discharge, no longer worked at	F 660	Physician's office by provider, Kandi Byrd Sams, FNP with Family Medicine on 6/12/2024 for her follow up appointment status post rehab discharge from facility. Resident #54 was receiving physical therapy with home health services at that time. The Social Services Director has contacted resident #54 family member to offer any additional services. 2. All residents have the potential to be affected. A 100% audit was performed on all residents by the Social Service Director/Designee to ensure the discharge planning is consistent with the patient's discharge rights and to identify discharge needs and a discharge plan to meet those needs is developed and care planned. This audit was completed on 10/17/2024. All discharged residents within the last 30 days were audited by the Social Service Director to ensure a safe discharge with any home health arrangements have been made for the patient's follow up care. This audit was completed on 10/17/2024. No other needs were identified. 3. Education completed by the Administrator/Nurse Practice Educator for all Interdisciplinary Staff (Social Worker, Activities Director, Director of Rehab, Dietary Manager, Nurse Managers) and Licensed Nurses on the policy of Discharge Planning Process to be completed on or before 10/22/2024. 4. To monitor and maintain ongoing compliance, the Social Service	

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F 660	Continued From page 7 the facility. She stated that after searching the resident's medical records and the facility's records, there was no documentation available indicating the SW made a referral for home health assistance for Resident #54. She further revealed the facility contacted the two home health providers the facility typically made referrals to and was informed they had no referrals for this resident. On 9/25/24 at 4:51 p.m., a telephone interview was conducted with the former Social Worker who was able to recall completing discharge planning with Resident #54 and her family member. She stated she made the referral for home health for the resident but could not recall if referral was made via email or during an onsite visit. During an interview on 9/27/24 at 4:22 p.m., the Administrator acknowledged the prior Social Worker failed to follow through with home health services for Resident #54.	F 660	Director/Designee will monitor all planned and unplanned discharges to ensure a safe and orderly discharge is in place including any home health arrangements. This audit will be completed 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks. An ADHOC QAPI meeting was held by Administrator on 10/17/2024. The Social Service Director will report the results of the monitoring to the QAPI Committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. 5. Date of Compliance 10/24/2024.	