STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/01/25 through 04/04/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SBGB11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/01/25 through 04/04/25. Event ID# SBGB11. The following intakes were investigated NC00225735 and NC00224602. 1 of the 7 complaint allegations resulted in a deficiency.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or	F 645		4/18/25

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

Electronically Signed | 04/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 645	Continued From page 1	F 645		

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental

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F 645	Continued From page 2 disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit follow up documents for completion of a Preadmission Screening and Resident Review (PASRR) level I screen to determine appropriate placement for 1 of 3 residents sampled for PASRR (Resident #46). The findings included: A review of the diagnosis list for Resident #46 included diagnoses of psychotic disorder 05/24/2023 and bipolar disorder 06/12/2023. A review of the North Carolina Medicaid Long Term Care Facility Level (FL)2 Form dated 01/22/2024 revealed diagnoses including psychotic disorder 05/24/2023 and bipolar disorder 06/12/2023. Resident #46 was admitted to the facility on 02/03/2024 with diagnoses including psychotic disorder and bipolar disorder. A review of the North Carolina PASRR level I screen submitted 02/28/2024 revealed diagnoses including bipolar disorder, and psychotic disorder. The screen requested additional information to include the most recent history and physical (H&P), FL2 signed by physician, psychiatric notes and comprehensive notes. The facility did not	F 645	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to submit follow up documents for completion of a Preadmission Screening and Resident Review (PASRR) for Resident # 46. On 4/16/25 the Social Worker (SW) submitted a PASRR referral for Resident #46. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A 100% audit was completed on 4/16/25 by the Regional Reimbursement Manager to identify any residents with newly diagnosed mental disorders, intellectual disabilities, related conditions, or with a significant change in assessment for a Level II PASARR review. Any residents identified with needing a Level II PASARR screening were reviewed and new FL2s and Screening Tools will be completed and submitted to NCMUST.	

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F 645	Continued From page 3 submit the information requested and never received a letter of determination for proper placement of Resident #46. The care plan dated 03/04/2025 had a focus of a history of mood distress as evidenced by finding little interest or pleasure in doing things. The quarterly Minimum Data Set (MDS) dated 03/10/2025 revealed Resident #46 was cognitively intact with moods that included little interest or pleasure in doing things, feeling down, depressed, and/or hopeless. An interview with the Administrator was conducted on 04/03/2025 at 1:22 PM. The Administrator stated the Social Worker (SW) was responsible for completing the PASRR screenings. The SW left her position in February of 2025, and they were interviewing potential SWs currently. On 02/28/2024, a PASRR level I was started but additional information was requested for submission to get a determination for placement of Resident #46. The SW did not submit the information requested for the completion of the screening. The Administrator also stated the additional information should have been submitted and he did not know why it was not completed. The Administrator further stated he was receiving assistance with PASRRs from their sister facility until a SW position was filled.	F 645	On 4/17/25 an ad hoc QAPI was held to discuss the deficient practice and implement a plan of correction with auditing tools. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Admissions Director, Business Office Manager, Social Worker, and Minimal Data Set nurse were educated on 4/17/25 by the Administrator on resident assessments and the requirements for PASRR screenings prior to a resident's admission or a new diagnosis that requires a new PASRR screening. A three-step identification process was implemented on 4/17/25 to ensure all new admission residents will be reviewed to ensure they have a correct PASRR. The three-step process includes the following: 1. The Admission Director will review all new admission PASRRs. 2. The Social Worker will monitor all residents receiving psych visits/services for new diagnosis and ensuring the admission PASRRs have correct listed diagnosis. 3. MDS will notify the SW of significant changes on resident assessment. Any significant changes in assessment, residents receiving visits from psych services, or diagnosis of mental disorders, intellectual disabilities, or related conditions will be audited and a new	

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F 645	Continued From page 4	F 645	PASARR screening will be conducted if applicable. The DON will be responsible for ensuring staff do not work until education has been completed. She was also informed by the Administrator to add the education to the new hire education for admissions staff, business office manager, social worker, and MDS Coordinators. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Social Worker will conduct an audit of any residents receiving psych services and newly admitted residents and the Admission Coordinator will review PASARR screenings prior to a new admission to the facility ensuring PASARR has been done and obtaining number. The audits will be completed as follows: weekly for 4 weeks, then every 2 weeks for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary.	

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