DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345194	A. BUILDING ______ B. WING ______	03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENFLORA	5701 FAYETTEVILLE ROAD LUMBERTON, NC 28360

(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
E 000	Initial Comments An unannounced recertification suvey was conducted on 03/11/19 through 03/14/19. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID# WKCZ11.	E 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §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.	F 636		4/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 04/02/2019

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 636	Continued From page 1 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) 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 reviews and staff interviews, the facility failed to complete a 14 day Minimum Data Set (MDS) assessments within the regulatory timeframe for 1 of 15 residents selected to be reviewed for Resident Assessments (Resident #241). Findings included:	F 636	GlenFlora acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. GlenFlora response to this Statement of	

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F 636 Continued From page 2

Resident #241 was admitted to the facility on 09/24/18. A review of the Minimum Data Set (MDS) assessments for Resident #241 revealed a 5 day MDS was completed on 01/17/19, and that it was coded as not being an OBRA (Omnibus Budget Reconciliation Act) assessment, and only was coded as a Prospective Payment System (PPS) 5 day assessment; therefore, a 14 day PPS assessment was required, which was never completed.

An interview and electronic medical record review was conducted with the MDS Coordinator on 03/12/19 at 10:30 AM. The MDS Coordinator confirmed Resident #241's 14 day MDS assessment was never completed until 03/12/19, after the omission was brought to her attention the morning of 03/12/19. The MDS Coordinator explained, the previous MDS nurse resigned, and as the new MDS nurse, she got behind on completing MDS assessments. She added the 14 day MDS assessment for Resident #241 should have been completed by the Assessment Reference Date (ARD) of 01/25/19. The MDS Coordinator acknowledged the 14 day MDS assessment for Resident #141 was not completed within the regulatory time frame.

An interview was conducted with the Administrator on 03/13/19 at 8:35 AM. The Administrator stated it was her expectation that MDS assessments were completed, were accurate, and completed within the required time frame.

An interview was conducted with the Director of Nursing (DON) on 03/13/19 at 2:45 PM. The DON stated it was her expectation that MDS

F 636

Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, GlenFlora reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F 636 Comprehensive Assessments & Timing

The process that led to this deficiency was the facility failed to complete a 14-day Minimum Data Set assessment within the regulatory timeframe for 1 of 15 residents reviewed. The 14-day Prospective Payment System assessment for resident #241 was completed and submitted by the Director of Nursing on 3/12/2019. Receipt of transmission was received.

On 3/12/2019, 100% audit of all transmitted Minimum Data Set assessments within the last 90 days to include resident #241 was completed by the DON to determine if any other late assessments were present. All assessments were completed accurately and within the regulatory timeframe.
On 4/1/2019, all Minimum Data Set staff were in-serviced by the Minimum Data Set Nurse consultant regard the completion of comprehensive assessments and submission of assessments within regulatory timeframe.

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F 636	Continued From page 3 assessments were completed, were accurate, and completed within the required time frame.	F 636	All newly hired Minimum Data Set staff will be in-serviced by the DON regarding the completion of comprehensive assessments and submission of assessments within regulatory timeframe. The Director of Nursing or Assistant Director of Nursing will audit 25% Prospective Payment System assessments utilizing the Minimum Data Set reporting tool in the electronic medical record. Records will be audited weekly for 8 weeks, then monthly for 2 months to ensure that assessments are completed and submitted within the regulatory timeframe. The Director of Nursing will forward the results of the Minimum Data Set audits to the Executive Quality Improvement Committee monthly for 3 months. The Executive Quality Improvement Committee will review the audit tools to determine trends and/or issues that may need further interventions. The Executive Director and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after	F 640		4/5/19

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F 640	Continued From page 4	F 640		

a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

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F 640	Continued From page 5 §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to transmit the resident Minimum Data Set (MDS) quarterly assessment after completion for 1 of 15 residents whose MDS was reviewed (Resident #1). Findings included: Resident # 1 was admitted to the facility on 11/01/17 with diagnoses to include: Hypertension, Arthritis, Osteoporosis, and Macular degeneration. A review of the most recent Minimum Data Set (MDS) dated 01/15/19 and coded as a quarterly assessment indicated Resident #1 was cognitively intact. She required extensive one-person physical assistance with activities of daily living (ADLs). A review of the quarterly MDS dated 01/15/19 was conducted on 03/11/19. It revealed the MDS was not transmitted by the MDS nurse after it was completed. An interview was conducted on 03/11/19 at 4:41 PM with the Director of Nursing who was responsible for transmitting the MDS assessments at the time the resident's quarterly assessment was due and completed. She stated she was the MDS nurse at that time, and did	F 640	F640 Encoding/ Transmitting Resident Assessments The process that led to this deficiency was the facility failed to transmit Minimum Data Set quarterly assessment after completion of 1 of 15 residents reviewed. The Minimum Data Set quarterly assessment for resident #1 was submitted by the Director of Nursing on 3/12/2019. Receipt of transmission was received. On 3/12/2019, 100% audit of all completed Minimum Data Set assessments to include resident #1 was completed by the Director of Nursing to determine if any other completed assessments had not been transmitted after Minimum Data Set staff was in-serviced by the Minimum Data Set Nurse Consultant regarding Automated data processing requirement to include: Encoding data, Transmitting data, Transmittal requirements, and data format. All newly hired Minimum Data Set staff will be in-serviced on Automated data processing requirement to include: Encoding data, Transmitting data, Transmittal requirements, and data	

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F 640	Continued From page 6 complete Resident #1's quarterly assessment. She stated she was not aware that it did not get transmitted on 01/15/19 which was an error on her part. She stated she would correct the error, and that it was her expectation that all MDS assessments were transmitted after completion. An interview was conducted with the Interim Administrator on 03/14/19 at 1:00 PM. She stated it was her expectation that MDS assessments were transmitted timely.	F 640	format. The Director of Nursing or Assistant Director of Nursing will audit 25% transmitted Minimum Data Set assessments utilizing the submission report in the electronic medical record. Records will be audited weekly for 8 weeks, then monthly for 2 months to ensure that assessments are transmitted timely after completion. The DON will forward the results of the transmission Minimum Data Set audits to the Executive Quality Improvement Committee monthly for 3 months. The Executive Quality Improvement Committee will review the audit tools to determine trends and/or issues that may need further interventions. The Executive Director and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		4/5/19

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F 656	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow the care plan for alerting the Registered Dietitian (RD) of any weight fluctuations or declines for 1 of 15 (Resident #37) reviewed for weight loss.	F 656	F656 Develop/ Implement Comprehensive Care Plan The process that led to this deficiency was the facility failed to follow the care	

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F 656		F 656		

F 656

Continued From page 8

Findings included:

Resident #37 was admitted to the facility on 08/16/18 with diagnosis of dementia, anxiety, pressure ulcers and pneumonia.

Record review of the Minimum Data Set (MDS) assessment dated 02/12/19 revealed that the resident had severe cognitive impairments. The resident required total assistance with all of her Activities of Daily Living (ADL), including feeding.

Record review of the care plan dated 12/03/18 revealed a problem of: "Nutritional needs and risk for weight loss/decline related to poor appetite." Approaches for this problem included, "Alert Dietitian of any weight fluctuations or declines.

Review of Resident #37's weights revealed the following significant weight change from 11/26/18 to 03/12/19: 11/26/18 - 125.6 lbs., 02/12/19 - 116 lbs., 02/20/19 - 115 lbs., 03/05/19 - 111 lbs., and 03/12/19 - 109 lbs.

Record review revealed there were no RD notes or assessments to address Resident #37's weight loss or nutritional status from 11/26/18 to 03/14/19.

Record review of the DM's Dietitian Referral Form (DRF) from 10/03/18 through 03/06/19 revealed no Dietitian referral for Resident #37.

During an interview on 03/14/19 at 9:15 AM, the Dietary Manager (DM) revealed she was responsible for placing resident names on the Dietitian Referral Form (DRF), and to notify the Dietitian of any significant weight changes or

F 656

plan for alerting the Registered Dietician of any weight fluctuations or declines for 1 of 15 residents reviewed for weight loss.

On 3/13/2019, the care plan for resident #37 was reviewed and the dietician was notified of resident’s weight loss by dietary manager as indicated in the care plan. The Registered Dietician implemented further interventions as result of the notification.

On 3/17/2019, all care plans of residents having significant weight loss were reviewed by Registered Dietician to ensure that interventions were implemented. On 4/1/2019, all members of the Interdisciplinary care plan team were in-serviced by the Minimum Data Set Nurse consultant regarding development/ implementation of a comprehensive care plan and compliance.

The dietary manager will review all residents with significant weight loss weekly for 8 weeks to ensure the Registered Dietician involvement and inclusion of nutritional interventions deemed necessary by Registered Dietician. The Registered Dietician will be notified weekly of all resident with weight loss and evidence of Registered Dietician involvement will be reflected on care plans.

The Director of Nursing will audit all care plans for those residents identified as having significant weight loss to ensure all nutritional interventions are implemented.

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F 656	Continued From page 9 fluctuations. She said she was aware of Resident #37 poor appetite and weight loss, and was doing what she could with the resident's family to address the resident's declining weight. She stated she did not feel the need to notify the Dietitian about Resident #37's weight loss, that she was addressing the issue. During an interview on 03/14/19 at 9:30 AM, the Dietitian revealed the DM was responsible for putting down information on the dietitian referral form. She said Resident #37's name should have been added to that list, due to her significant weight loss. The Dietitian stated she was not made aware of resident's weight loss, and if she knew, would have put in place additional nutritional interventions. She said the resident got missed somehow, and her name was never added to the DRF. The Dietitian said she should have been notified by the DM of Resident #37's weight loss, per care plan instructions, and wasn't. She said it was her expectation that the care plan be followed. During an interview on 03/14/19 at 9:20 AM, with the Dietary Manager (DM), Registered Dietitian (RD), and Director of Nursing (DON) revealed the DM should have alerted the RD of Resident #37's decline in weight, and did not.	F 656	The care plans will be audited weekly for 8 weeks, then monthly for 2 months using the dietary audit tool. The Director of Nursing will forward the results of the dietary audit tool to the Executive Quality Improvement Committee monthly for 3 months. The Executive Quality Improvement Committee will review the audit tools to determine trends and/or issues that may need further interventions. The Executive Director and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
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	F 692		4/5/19

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F 692

Continued From page 10

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;

§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 observation, staff interview, and record review the facility failed to provide double portions and cranberry juice as ordered by the physician for 1 of 5 sampled residents (Resident #25) reviewed for nutrition. Findings included:

Record review revealed Resident #25 was admitted to the facility on 08/14/17. The resident's documented diagnoses included history of left buttock pressure ulcer, "other" eating disorders, vitamin D deficiency, hypertension, and history of sepsis secondary to urinary tract infection (UTI).

During the decision making process associated with Resident #25's 07/26/18 annual minimum data set (MDS) a care plan was not developed for the resident's nutritional status because he was eating 81% of his meals, and his weight was stable.

Resident #25's weight record documented he

F 692

F 692 Nutrition/ Hydration Status Maintenance

The process that led to this deficiency was the facility failed to provide double portions and cranberry juice as ordered by the physician for 1 of 5 residents reviewed.

On 3/13/2019, the diet order for resident #25 was reviewed by Registered Dietician and resident's meal tray card was corrected to ensure it reflected the current diet instructions. The dietary manager completed meal observations for 48 hours to ensure that the resident did receive the appropriate diet, completed on 3/15/2019.

On 3/13/2019, the DM reviewed tray cards and it was determined that specific diet instructions for those residents on select diets were not being electronically printed

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F 692	Continued From page 11 was 66 inches tall and weighed 136 pounds on 08/10/18, weighed 141 pounds on 11/19/18, and weighed 134 pounds on 02/15/19 (his most recent weight). A hospital Discharge Summary documented Resident #25 was hospitalized between 12/31/18 and 01/03/19 with a diagnosis of sepsis secondary to urinary tract infection (UTI). The resident's 01/16/19 quarterly MDS documented his cognition was intact, he required limited assistance by a staff member with eating, his weight was stable, he received a mechanically altered diet, and he currently had no unhealed pressure ulcers. A 02/19/19 hospital History and Physical documented Resident #25 appeared to be septic due to a UTI/pyelonephritis (viral or bacterial infection of the kidney/kidneys). 02/22/19 post-hospital discharge electronic physician orders documented, "double portions on all meal trays due to weight loss" and "puree diet , honey thick liquids, honey thick cranberry juice with all meals." During an observation on 03/12/19 at 12:29 PM Resident #25 was eating lunch in the main dining room. The resident did not have double portions or honey thick cranberry juice on his meal tray. His select menu tray slip did not document that the resident was to receive either of these items. During an observation on 03/13/19 12:20 PM Resident #25 was eating lunch in the main dining room. The resident did not have double portions or honey thick cranberry juice on his meal tray.	F 692	on the tray cards. The software in dietary was updated to ensure that specific instructions were electronically available on the select diet tray cards. On 3/13/2019, all tray cards were audited by the dietary manager along with diet orders to ensure that tray cards reflect the current specific diet instructions. No issues were noted. On 3/29/2019, all dietary staff was in-serviced by the Executive Director on the importance of following diet instructions, reviewing tray cards and meals served to ensure that instructions are followed. In-services will be completed by 4/5/2019. The dietary manager will audit 25% tray cards for select diets to ensure that tray cards have specific diet instructions for the dietary staff to follow weekly for 8 weeks, then monthly for 2 months. The dietary manager will forward the results of the dietary specific diet audit tool to the Executive Quality Improvement Committee monthly for 3 months. The Executive Quality Improvement Committee will review the audit tools to determine trends and/or issues that may need further interventions. The Executive Director and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345194	A. BUILDING ______ B. WING ______	03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENFLORA	5701 FAYETTEVILLE ROAD LUMBERTON, NC 28360

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F 692	Continued From page 12 His select menu tray slip did not document that the resident was to receive either of these items. During an interview with the Dietary Manager (DM) on 03/13/19 at 12:32 PM she explained that residents participating in the select menu process got a special tray slip on their meal trays which documented their circled food choices for each meal. She stated that the standard tray slip for Resident #25 did document that he was to receive cranberry juice and large portions at all meals. However, she reported that a dietary aide forgot to manually transcribe double portions and cranberry juice onto the resident's select menu tray slips which were what the dietary staff went by when preparing meal trays at the tray line. During an interview with the facility's Registered Dietitian (RD) on 03/14/19 at 9:28 AM she stated double portions would be large servings of all foods on the plate to promote weight gain and/or promote wound healing. She reported cranberry juice would be given to help protect the urinary tract system from infection, especially when residents had a history of UTIs. The RD commented she thought there were ways in which the software system could be adjusted so that nutrition interventions and supplements could be documented electronically on the select menu tray slips without the dietary aides having to transcribe them from the standard tray slips.	F 692	correction.	