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	345316	A. BUILDING ______ B. WING ______	**10/09/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	**2275 RUIN CREEK ROAD HENDERSON, NC 27537**

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E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to establish a comprehensive Emergency Preparedness (EP) plan. The facility failed to maintain and update the EP plan, develop a process for cooperation and collaboration with local, tribal, regional, state and federal EP officials, develop a communication plan, develop subsistence for staff and patients, develop a means of tracking staff and patients, develop a method of sharing information and medical documentation, develop a means of	E 001	A comprehensive Emergency Preparedness manual has been purchased and will be developed for the facility by 11/5/19 to address, but not limited to, A. Plans for an annual review by the QA committee B. Procedures for EP collaborations with local, regional, state, and federal EP officials C. Communication Plan	11/5/19

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E 001	Continued From page 1 sharing the EP plan with residents or responsible party (RP), put into place EP training and testing plans, conduct and put into place EP testing and simulation and document information in the EP regarding the emergency generator. The findings included: A review of the facility ' s Emergency Preparedness plan material on 10/10/19 revealed: A. The EP plan was not maintained and had not been updated annually. B. The EP plan did not address the procedures for EP collaboration with local, tribal, regional, state and Federal EP officials. C. The EP plan did not address a communication plan. D. The EP plan did not address subsistence needs for staff and patients. E. The EP plan did not address procedures for tracking of staff and patients. F. The EP plan did not address policies and procedures for medical documents. G. The EP plan did not address a means of sharing the EP plan with residents or responsible party (RP). H. The facility failed to develop and put into place EP training and testing plans. I. The facility failed to conduct and put into place	E 001	D. Subsistence needs for staff and patients E. Procedures for tracking staff and patients F. Procedures for medical documents G. A means of sharing the EP plan with residents or RP H. EP training and testing plans I. Conducting EP testing and simulation exercises J. Information regarding the emergency generator location The Administrator will present the completed Emergency Preparedness Manual to the Quality Assurance Committee for review by 11/5/19. The Emergency Preparedness plan will be audited by the Administrator monthly for 3 months to assure the EP is up to date and training plans, testing plans, and simulation exercises have been completed as planned. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee once a month for three months. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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E 001	Continued From page 2 EP testing and simulation exercises. J. The EP plan lacked information regarding the emergency generator location. On 10/9/19 at 10:22 AM an interview was conducted with the Administrator who stated they had discussed emergency preparedness during the August 2019 QAPI meeting and their discussion would be documented in the QAPI meeting notes. The Administrator stated all staff were in serviced on any type of disasters that could happen and how to handle the situation. The Administrator stated they had not held a community emergency drill.	E 001		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include a diagnosis of psychosis on the Minimum Data Set (MDS) Assessment for 1 of 18 residents whose MDS Assessments were reviewed (Resident #13). The findings included: Resident #13 was admitted to the facility on 2/26/18. The diagnoses listed on the clinical record included cerebrovascular accident (stroke), non-Alzheimers dementia and psychosis. The Care Plan for Resident #13 dated 5/14/19 revealed the resident took an antipsychotic medication related to a diagnosis of depression	F 641	Resident #13 - The 8/8/19 quarterly MDS assessment was modified on October 21st, 2019 by the MDS RN to include the Psychosis diagnosis. All current residents with antipsychotic medication orders were audited by 11/5/2019 by the MDS RN to assure an active psychiatric/mood disorder diagnosis is listed in the resident's medical record. The psychiatric/mood disorder diagnosis was then compared to Section 1 (active diagnosis) of the current MDS for each resident to assure accurate coding on the MDS assessments. An	11/5/19

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F 641	Continued From page 3 and senile dementia with delusional features. The interventions included the following: Administer medication as ordered. Monitor for effectiveness and adverse effects. Notify the physician of any changes. Pharmacy consult to review medication regimen. Review of the Quarterly MDS dated 8/8/19 revealed Resident #13 had severe cognitive impairment and no behaviors. The MDS revealed the resident required extensive to total assistance of activities of daily living. Section N (Medications) noted the resident received an antipsychotic medication and was received on a routine basis only. A page at the beginning of the Care Plan revealed the Care Plan for Resident #13 was last reviewed on 8/16/19 with no changes to the plan of care for antipsychotic medications. An interview was conducted with the MDS nurse on 10/8/19 at 11:50 AM. The MDS Nurse stated she started working at the facility on August 5, 2019 and completed this assessment on August 8, 2019. The MDS Nurse stated she did not see a diagnosis on the chart but psychosis should have been coded on the MDS. On 10/8/19 at 1:58 PM the Geriatric, Neuropsych Family Nurse Practitioner stated when they first picked up the resident in 2018 she had a diagnosis of senile dementia with delusional features which was psychosis. On 10/8/19 at 3:21 PM an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation for the appropriate diagnosis to be coded on the MDS	F 641	audit tool was utilized assessments were completed by he MDS RN by 11/5/2019. The MDS RN was re-educated by an Independent RN consultant on 10/23/2019 regarding coding of active psychiatric/mood disorder diagnosis in section I0100-I8000 of the MDS assessments. MDS RN will review the medical record including transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consult and official diagnostic reports, and other sources as available to identify active diagnosis and assure they are coded accurately on the MDS assessment. The Administrator will review at least 3 MDS assessments weekly for 4 weeks then monthly for 2 months to determine if Psychiatric/Mood disorders are coded correctly on Section I0100 - I8000 Active Diagnosis of the MDS Assessments. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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F 641	Continued From page 4 Assessment. On 10/9/19 at 9:45 AM an interview was conducted with the Administrator who stated it was her expectation the MDS be coded according to the diagnosis.	F 641		
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 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	F 656		11/5/19

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F 656	Continued From page 5 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, observations and staff interviews, the facility failed develop a care plan for 1 of 1 sampled residents (Resident # 44) reviewed for a knee immobilizer. The findings included: Resident # 44 was admitted to the facility on 7/30/19 with diagnoses including left leg fracture, heart failure, hyperlipidemia and hypertension. Review of Resident # 44 ' s care plan dated 8/12/19 and updated on 9/10/19 revealed there was no care plan for the knee immobilizer. During an interview on 10/8/19 at 3:10 PM the Minimum Data Set Nurse stated she did not care plan the knee immobilizer. She revealed Resident #44 ' s knee immobilizer was discontinued on 9/17/19. In an interview on 10/8/19 at 3:40 PM the Director of Nursing stated the knee immobilizer should have been on the care plan.	F 656	Senior Citizens Home maintains high standards for both resident care and documentation, and the accuracy of the MDS as integral to proper development of proper plans of care for our residents. There was no corrective action necessary for Resident #44 since the knee immobilizer has been discontinued prior to the time in which the issue was identified (9/17/29). A list of all residents using assistive splints, braces, or immobilizers was developed by the MDS RN, Director of Nursing, and Rehab Director on 10/23/19. Care plans were reviewed on 10/23/19 by the MDS RN to determine if the device was included on the care plan. An audit tool was utilized by the MDS RN on 10/23/19 to document the results. If the care plan was not evident or accurate, one was implemented or revised accordingly by the MDS nurse. The MDS team (MDS RN, Social Worker,	

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F 656	Continued From page 6	F 656	Director of Nursing, Staff Development Coordinator, Administrator in Training, and Administrator) will be in-serviced by an independent RN consultant on care plan development and updating care plans to reflect the resident's current condition/problems and care regiment. The training was held on 10/23/2019. The MDS RN will review new orders for splints/braces/immobilizers to ensure they are updated on the care plans timely. The Administrator will monitor at least 3 care plans each week for 4 weeks, the monthly for 2 months to determine accuracy and that the plan reflects and includes the current care regimen and condition of the resident. The Consultant will also assist with monitoring at least 5 care plans during the visit scheduled for November 2019. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility	F 727		11/5/19

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F 727	Continued From page 7 must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to staff Registered Nurse (RN) coverage for at least 8 consecutive hours a day for 3 weekend days of the past 68 consecutive days reviewed (8/18/19, 8/24/2019, and 8/25/2019). The findings included: A review of 8/1/2019 through 10/7/2019 staff assignment sheets was conducted on 10/8/2019. The assignment sheets for 8/18/2019, 8/24/2019 and 8/25/2019 did not indicated a registered nurse was on duty. The daily staff posting sheets for 8/18/2019, 8/24/2019, and 8/25/2019 indicated "0" (zero) for the RNs on duty. On 10/8/2019 at 3:16 PM, an interview was conducted with the Director of Nursing (DON) who stated she knew there was supposed to be an RN working at the facility daily. The DON stated the agency RN who was scheduled to work on 8/18/2019 was a "no call, no show" and the facility did not have a RN that day. On 10/9/2019 at 10:17 AM, an interview was conducted with the Administrator who stated she was aware there were some days an RN was not staffed at the facility, and they did not have a	F 727	There was no corrective action necessary for 8/18/19, 8/24/19, and 8/25/19. The scheduled RN called out on the above dates and the only nurses we could get to work those days were LPN's. The Director of Nursing will ensure that there is 8 hours of RN coverage daily and will review the staffing sheets daily to ensure that coverage is sufficient. The Director of Nursing will address RN call outs and assign back up RN coverage. The Director of Nursing will educate the Staff Developer and RN supervisor on the On Call procedures by October 25th, 2019. The Director of Nursing, Staff Developer, and RN Supervisor will rotate on call weekends to ensure the appropriate coverage. If RN staffing is needed the on call staff member will be responsible for coming in to work. The Director of Nursing will ensure that there is proper RN coverage by auditing staff daily. The Director of Nursing will maintain accurate Daily Staffing sheets to reflect 8 hours of RN coverage on a daily basis. Corrective action will be reviewed in	

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F 727	Continued From page 8 waiver for daily RN staffing. The Administrator stated the RN who was scheduled on 8/24/19 and 8/25/2019 had called out prior to the weekend and the position was covered by a Licensed Practical Nurse (LPN). The Administrator stated she expected the RN position to be covered on weekends, and the facility had plans going forward for the DON to cover the position when needed.	F 727	Quality Assurance Risk Meeting for 3 months. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		11/5/19

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F 758	Continued From page 9 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete an assessment for AIMS (Abnormal Involuntary Movement Scale) for 1 of 4 residents (Resident #20) who received antipsychotic medication. The findings included: Resident #20 was admitted to the facility on 5/20/2019 with diagnosis to include dementia with behavioral disturbance, and behavioral and psychological symptoms of dementia (BPSD). A record review revealed Resident #20 received Seroquel (antipsychotic medication) continuously since 5/20/2019.	F 758	Resident #20 - AIMs assessment was completed on October 15th, 2019. DON completed an audit of all residents to identify residents receiving antipsychotic medications and requiring the completion of an AIMs assessment. The audit will be completed by Nov. 5th 2019 and the results of the audit will be documented on a QA tool. If the AIMs assessment has not been completed for the identified residents, one was completed by November 5th, 2019. The Director of Nursing will re-educate the Staff Developer and nursing Supervisors on the processes for completing the AIMs	

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F 758	Continued From page 10 A review of the clinical record found no assessment for AIMS (Abnormal Involuntary Movements). Tardive Dyskinesia is a chronic and potentially irreversible drug induced movement disorder and one of the possible side effects of antipsychotic medications. An AIMS test is done to detect and tract involuntary movements in a person taking antipsychotic medication. Resident #20s quarterly Minimum Data Set (MDS) assessment dated 8/22/2019 revealed her cognition was severely impaired and she required total assistance from staff for activities of daily living. Resident #20 received antipsychotic medication for 7 of the 7 lookback days. On 10/8/2019 at 3:19 PM, an interview was conducted with the MDS nurse who stated she was new to the facility and had noticed some residents did not have an AIMS evaluation in their medical record. The MDS stated she was trying to evaluate residents as she completed their assessments, but she had not assessed Resident #20. On 10/8/2019 at 3:30 PM, an interview was conducted with the Director of Nursing (DON) who stated usually the AIMS recommendations came from the Pharmacy, but she was unable to find a pharmacy recommendation for the AIMS test for Resident #20. The DON stated she would have expected Resident #20 to have an AIMS evaluation on her chart since she was admitted in May. The DON stated she expected the nursing staff or the MDS nurse to conduct an AIMS for the residents after their admission.	F 758	assessment on admission and quarterly. The Director of Nursing and Staff Developer will audit all new admission's medications to see if a AIMs assessment is required. The AIMs assessment will be completed on admission and quarterly while the resident is receiving antipsychotic medication. The Director or IDT team will review new orders daily in the morning clinical meeting to ensure compliance with completing the AIMs assessment. The Director or Nursing will audit 3 residents receiving antipsychotic medication per week for 4 weeks and then monthly for 2 months to ensure the AIMs assessment was completed accordingly. Results of the audit will be reviewed and discussed in the Quality Assurance Committee meeting. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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F 865	Continued From page 11	F 865		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility's Quality Assessment and Assurance (QA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place following the 9/28/18 recertification survey. This is for one deficiency originally cited in the 9/28/18 survey and again cited in the 10/9/19 survey. The deficiency was in the area of accuracy of resident assessment. This continued failure of the facility during the past two recertification surveys represented a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included:	F 865	It is the policy and practice of Senior Citizens Home to maintain a quality assessment and assurance committee (QAA) consisting of the outlined members that meet monthly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action designed to correct identified quality deficiencies. The facility has policies and procedures designed to maintain these goals. Quality assurance monitoring, physician reviews, consultant reviews, and staff training are examples of the many components utilized.	11/5/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING ______ B. WING ______	10/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27537

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F 865	Continued From page 12 This tag is cross referenced to: F 641. F 641: Accuracy of Assessment: Based on observations, record review and staff interview the facility failed to accurately code a diagnosis of psychosis on the Minimum Data Set for 1 of 18 residents. In an interview on 10/9/19 at 11:32 AM the Administrator stated they would continue to review their QA process, have a consultant help them improve and correct their QA process, as they move forward.	F 865	A root cause analysis was conducted using the "why method" to determine what factors may have led to the miscoding of the Diagnosis as cited in F641. Based on the findings the following systematic changes were made... MDS RN will review the medical record including transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, and nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available to identify active diagnosis and assure they are coded accurately on the MDS assessment. The administrator will review at least 3 MDS assessments weekly for 4 weeks then monthly for 2 months to determine if Section I0100 - I8000 Active Diagnosis is coded correctly. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. The facility Quality Assessment and Assurance Program (QAA) was re-assessed by the Administrator and Director of Nursing on 10/23/2019. The following revisions were made and approved by the Medical Director and QAA committee members: - The agenda was revised to include the reporting and audit results as stated	

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F 865	Continued From page 13	F 865	above for F641 - Discuss the effectiveness of the new systematic change implemented to capture appropriate active diagnosis on the MDS assessments and make revisions as needed.	