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	345150	A. BUILDING _____ B. WING _____	C 03/19/2021

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KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

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E 000	Initial Comments An unannounced Recertification survey was conducted on 03/16/21 through 03/19/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QCKS11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/16/21 through 03/19/21. Event ID#QCKS11 7 of the 7 complaint allegations were not substantiated.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:	F 644		4/13/21

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

Electronically Signed | 04/14/2021

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F 644	Continued From page 1 Based on staff interview and record review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) for a resident with an active diagnosis of a serious mental illness for 2 of 4 residents reviewed for PASRR (Resident #7 and Resident #41). Findings included: 1. Resident #7 was admitted on 05/09/2018 with diagnosis including Schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated 03/16/2021 had Resident #7 coded as severely cognitively impaired with the diagnosis of Schizophrenia and Anxiety Disorder (01/31/2021). The care plan dated 03/15/2021 had focuses that included anti-anxiety medications as needed (PRN) related to (r/t) Anxiety Disorder and behavior problem r/t Schizophrenia and Dementia. Resident #7 could be combative with staff and attempt to hit them. Resident #7 had impaired cognitive function/Dementia or impaired thought processes r/t Dementia and Schizophrenia, receives anti-anxiety medications PRN r/t Anxiety Disorder, and receives antipsychotic medications r/t Schizophrenia. Resident #7's PASRR Level I Determination Notification document dated 05/10/2018 read in part "No further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness and a change in treatment needs for those conditions." The March Medication Administration Record (MAR) indicated Resident #7 received, Haloperidol tablet, 4 MG at bedtime related to	F 644	F 644 What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Social Worker failed to screen resident #7 for PASRR Level II following new diagnosis of anxiety disorder and resident #41 for PASRR Level II following new diagnoses of major depressive disorder, schizoaffective disorder-depressive type and adjustment disorder with depressed mood. Resident□s #7 was screened for PASRR Level II on 03/17/2021 and filed on 03/18/2021. Resident #41 was screened on 03/28/2021 and filed on 03/29/2021. No adverse outcomes were identified. Element #2 An audit of all residents was conducted by the District Dir, Care Management for new diagnoses and PASRR Level II screening on 03/29/2021 to identify any residents who require PASRR Level II screening. PASRR Level II screening will be completed and PASRR filed for any identified residents by 04/22/2021. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 Education was provided by the District Dir, Care Management on 03/16/2021 and 03/31/2021 on PASRR review process,	

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F 644	Continued From page 2 Schizophrenia, Lorazepam tablet, 0.5 mg, 1 tablet by mouth every 6 hours as needed for Anxiety, Abilify tablet 7.5 mg by mouth one time a day related to Schizophrenia. An interview was conducted with the facility's Social Worker on 03/19/2021 at 10:30 AM, she revealed Resident #7 had a new diagnosis of Anxiety Disorder and there should have been a new screening for a PASRR level II, that was not completed. An interview was conducted with the facility's Director of Nursing (DON) and Administrator on 3/19/2021 at 10:47 AM, they stated the policy and procedures for PASRR were expected to be followed. 2. Resident #41 was admitted to the facility on 06/22/18 with last re-entry on 2/23/21 after hospitalization. Review of Resident #41's Quarterly Minimum Data Set (MDS) dated 02/27/21 revealed Resident #41 current diagnoses included, in part, depression, schizophrenia, schizoaffective disorder, insomnia due to other mental disorder, and adjustment disorder with depressed mood. Review of the PASRR Level I application dated 12/21/18 revealed the cognitive impairment diagnoses was dementia.	F 644	Level I and Level II PASRR numbers in North Carolina, Definitions of mental disorders, intellectual disabilities and other related conditions, how to pull PASRR numbers in PCC, how to pull diagnoses related to MD/ID/RC in PCC to identify residents that may need level II referral and review of sample care plan for a resident with Level II PASRR status. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: To ensure ongoing compliance, the Care Management MDS Director and Administrator will conduct compliance audits weekly x 12 weeks to ensure Level II Preadmission Screening and Resident Review (PASRR) for residents with an active diagnosis of a serious mental illness. The facility will provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 04/13/2021	

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Review of the PASRR Level I Determination Notification letter dated 01/02/19 revealed that "no further PASRR screening is required unless a significant change occurs with the individual's status that suggest a psychiatric disorder that is not dementia."

Review of Resident #41's medical record dated 08/24/20 revealed three new diagnoses of major depressive disorder, schizoaffective disorder-depressive type, and adjustment disorder with depressed mood.

In an interview on 03/18/21 at 4:30 PM with the Social Worker (SW), she stated when a resident was newly diagnosed with a mental illness the resident needed to be evaluated for a Level II PASRR. The SW stated she was not in the current position when the evaluation should have been completed, she did not know what had happened or why the evaluation was not done.

In a telephone interview on 03/19/21 at 09:18 AM, the SW explained no new application had been submitted for Resident #41.

In an interview on 3/19/21 at 12:06 PM, the MDS Nurse stated the resident was initially diagnosed with having schizophrenia and she thought it was inclusive for all schizophrenia disorders. The Minimum Data Set (MDS) Nurse stated the Social Worker would usually be the one to submit an evaluation for a Level I PASARR change but this slipped their attention since there had been changed in personnel. She confirmed Resident #41's medical record indicated she was admitted to the facility with a Level I PASARR and no Level II PASARR had not been filed. Resident #41 presently was receiving antipsychotics,

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F 644	Continued From page 4 antidepressants, and opioids. She stated there should have been a PASRR II application submitted for a significant change that occurred with this resident. In a telephone interview on 3/19/21 at 1:42 PM, the Administrator stated there should had been a new application submitted for a Level II PASARR evaluation. She stated the facility was in the process of completing recommendations from their mock survey where they identified some concerns with PASSAR. She expressed all residents should be reviewed and screened for any needed Level II PASRR assessments when changes occur.	F 644		
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 (ii) Intellectual disability, as defined in paragraph	F 645		4/13/21

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F 645	Continued From page 5	F 645		

(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 disorder if the individual has a serious mental

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F 645	Continued From page 6 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 staff interview and record review, the facility failed to obtain a Level I Preadmission Screening and Resident Review (PASRR) for a resident with an active diagnosis of a serious mental illness for 1 of 4 resident reviewed for PASRR. (Resident #31) Findings included: Resident #31's halted PASRR Level II Determination Notification document dated 10/06/2017 read in part "No further PASRR level I screening is required unless a significant change occurs with the individual's mental status which suggests a psychiatric disorder that is not Dementia." Resident #31 was admitted 10/09/2017 with a diagnosis of Major Depressive Disorder, and Bipolar Disorder. She was re-admitted 01/02/2020. The quarterly Minimum Data Set (MDS) assessment dated 02/09/2021 revealed Resident #31 was cognitively impaired. She was also coded with diagnosis' including Depression, Bipolar Disorder and Schizophrenia (07/29/2020). The care plan dated 02/12/2020 has the focuses of the potential for a decline in mood related to (r/t) Bipolar Disorder and received antidepressant medication r/t Depression, and antipsychotic medications r/t Bipolar Disorder.	F 645	F 645 What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Social Worker failed to screen resident #31 for PASRR Level II following admission due to diagnoses of schizophrenia and major depressive disorder. PASRR Level II screening was completed on 03/18/2021 and filed on 03/22/2021. No adverse outcomes were identified. Element #2 An audit of all residents was conducted for new diagnoses and PASRR Level II screening by District Dir, Care Management to identify any residents who require PASRR Level II screening on 03/26/2021. No residents were identified. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Inservice was provided by the District Dir, Care Management on 03/16/2021 and 03/31/2021 on PASRR review process, Level I and Level II PASRR numbers in	

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F 645	Continued From page 7 The March Medication Administration Record (MAR) indicated Resident #31 was receiving Seroquel (Quetiapine Fumarate) Tablet 50 MG by mouth at bedtime related to Schizophrenia, Bipolar Disorder and Celexa (Citalopram Hydrobromide) tablet, give 5 mg by mouth one time a day for Depression related to Major Depressive Disorder. An interview was conducted with the facility's Social Worker on 03/17/2021 at 10:30 AM revealed Resident #31 had a halted PASRR level II before she was admitted. She was also aware Resident #31 had a diagnosis of Schizophrenia and should have had a PASRR Level I completed at that time to include all of her mental health diagnoses to receive the correct level of care from the facility. An interview was conducted with the facility's Director of Nursing (DON) and Administrator on 3/19/2021 at 10:47 AM, they stated the policy and procedures for PASRR were expected to be followed.	F 645	North Carolina, Definitions of mental disorders, intellectual disabilities and other related conditions, how to pull PASRR numbers in PCC, how to pull diagnoses related to MD/ID/RC in PCC to identify residents that may need level II referral, review of sample care plan for a resident with Level II PASRR status. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: To ensure ongoing compliance, the Care Management MDS Director and Administrator will conduct compliance audits of residents admitted to the facility, weekly x 12 weeks, to ensure residents with mental disorder or intellectual disability are being identified and referred for PASRR Level II evaluation. The facility will provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 04/13/2021	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		4/13/21

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 9 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to implement their policies and procedures related to personal protective equipment (PPE) and hand hygiene when entering and exiting resident rooms for 1 of 5 sampled residents (Resident # 8) who was on isolation for Enterobacterales (ESBL)(an order of Gram- negative bacteria)and was on contact precautions. The findings included: Record review of facility policy and procedure titled " contact precautions" dated 02/2018	F 880	F880 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Element #1 Nursing Assistant number 1 failed to follow posted Contact Precaution signage prior to entering a resident□s room while delivering a lunch tray by not performing hand hygiene, not wearing gloves, and not donning an isolation gown. Nursing assistant number 1 also failed to follow Contact Precaution guidelines while exiting room by not	

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F 880	Continued From page 10 revealed personnel were to use hand sanitizer or soap and water before and after entering isolation precaution setting. It further revealed staff were to wear full personal protective equipment when working with individuals who were on contact precautions. Resident # 8 was admitted to the facility on 10/14/2017 with diagnoses that included cancer, hypertension, hyperlipidemia and depression. Minimum Data Set (MDS) dated 03/10/2021 indicated the resident's cognition was intact, she required extensive assistance with bed mobility, dressing, toileting and personal hygiene. The MDS also indicated Resident # 8 was always incontinent. Review of the nurse note dated 12/13/20 revealed E. coli/ESBL was found in Resident # 8's urine and she was moved to private room for "infection control." On 03/16/21 at 10:50 AM, an observation was made of Nurse Aide (NA) #1 entering Resident #8's room. She delivers lunch tray. NA # 1 did not wash her hands, was not wearing gloves and a gown. NA# 1 was observed to exit the room and did not perform hand hygiene. Contact precaution signage was observed posted beside the door to Resident #8's room which specified staff were required to wash hands when entering and leaving room, wear mask. If contact with secretions likely, they were to use gown and gloves. During an interview on 03/16/21 at 12:35 PM, NA #1 revealed she had been trained regarding infection control practices, hand hygiene and use of PPE when entering isolation rooms. She	F 880	performing hand hygiene for 1 of 1 resident. A Fishbone/root cause analysis was conducted on 3/16/21 to identify root cause of the area identified in the 2567. The Root cause analysis was facilitated by the Administrator, Director of Nursing, District Director of Clinical Services, and the Infection Preventionist. The Root cause analysis was reviewed with the QAPI committee 4/9/21 and incorporated into the facility plan of correction below. The Directed Plan of Correction will be completed by 4/13/21 with training conducted by the Director of Nursing and the Infection Preventionist. Element #1 Resident #8 had no adverse outcome from the staff member entering their room without applying the appropriate Personal Protective Equipment PPE. Resident # 8 is a long-term care resident and remains on contact precautions for ESBL in the urine. The Certified Nursing assistant was immediately educated on Contact precautions and the appropriate usage of PPE and Hand Hygiene on 3/16/21 by the Director of Nursing. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Element #1 In-service education was provided by the Director of Nursing, SDC/Infection Preventionst beginning 3/16/21 and will be completed by 4/13/21 on Contact Precautions requirements. A	

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F 880	Continued From page 11 indicated she did not see the isolation sign. She was aware that she should have performed hand hygiene and don PPE according to the signage posted but missed to do it when she entered and exited Resident #8 room. An interview with Nurse #1 on 03/16/21 at 12:40 PM revealed residents placed on isolation had a signage and PPE supplies outside their doors for staff to utilize prior to entering the room. She indicated nursing staff had been trained on hand hygiene and the use of PPE when caring for residents in isolation to prevent infection transmission. She indicated she always donned PPE prior to entering the room and performed hand hygiene when entering and exiting residents' rooms. An interview with Director of Nursing (DON) on 03/17/21 at 1:45 PM revealed all staff had been trained regarding infection control practices, policies and procedures including Contact precaution requirements. She stated staff were to perform hand hygiene before and after every resident encounter as well as don PPE as per signage on the resident's door. She also stated Resident # 8 was on contact precaution isolation for ESBL and was still infectious. DON reported Resident #8 was incontinent and requires staff assistance with cleaning after incontinent episode. Therefore, will remain on contact precautions. An interview with the Administrator on 03/17/21 at 2:25 PM revealed all staff were to perform hand hygiene and don PPE as per signage on the door prior to entering the room of residents on isolation	F 880	full house audit of all isolation residents was identified and was conducted by the Director of Nursing, and Infection Preventionist to ensure all isolation rooms have required signage and direct care observations of staff entering and exiting the isolation rooms to be following our Policies and procedures regarding specific PPE requirements, and hand hygiene expectations for contact precautions. What measures will be put into place to ensure the deficient practice does not reoccur: Mandatory all staff education on policies and procedures related to Contact Precautions, appropriate utilization of PPE requirements upon entering and exiting the resident rooms on contact isolation and policies and procedures related to Hand Hygiene. 100% education of all staff initiated 3/16/21 and completed 4/13/21. All new hires and agency staff will have this mandatory education prior to working on the unit. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #1 to ensure ongoing compliance, the Director of Nursing and Infection Preventionist will conduct random audits weekly x 12 weeks to ensure Contact Precautions are being followed with the use of appropriate PPE, and appropriate Hand Hygiene before entering and exiting a resident room on	

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	345150	A. BUILDING _____ B. WING _____	C 03/19/2021

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F 880	Continued From page 12	F 880	contact isolation. If there are any areas of concern, the appropriate education/in-servicing will be immediately provided to staff. All new hires and agency staff will be educated on this policy and procedure during the orientation process prior to initiating work. The results of our auditing process will be reported to monthly QAPI until such time that substantial compliance has been achieved x 3 months Compliance date 4/13/21. Directed Plan of Correction Kenansville Health & Rehabilitation Center On March 16th 2021 a recertification survey along with a complaint investigation survey was conducted in our facility and it was determined that we were out of compliance with F880. An imposition of Directed Plan of Correction was issued. The administrative team held Ad HOC QAPI meeting on 04/09/21 to include the Administrator, DON, SDC/Infection Preventionist, Medical Director, DDCS (District Director of Clinical Services), to review the Plan of Correction prior to submission, complete a Root Cause analysis and make sure we were	

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F 880	Continued From page 13	F 880	conducting all needed training to the staff. The team which includes the SDC and DON has completed the training for all staff in the facility, to include contract workers that work regular hours (HSG/Housekeeping/Dietary). The training for Contact Precautions to include: Hand Hygiene and Donning/Doffing PPE prior to entering and exiting an isolation resident room on 03/16/2021, and will be completed by 04/13/2021. Staff surveillance and audits are being conducted randomly on all shifts and in different departments to ensure proper technique and discover any further learning needs of the staff. The QAPI team believed that the training being conducted at a facility level would be a better intervention than utilizing videos and electronic means of outside training. We believe that it is easier to engage in person than through a computer. Online learning requires much more discipline and self-motivation to stay on task and some things just cannot be taught online. Face-to-face learning lends a hand in organizing trainings and the staff are given the ability to interact with the instructors to ensure proper understanding of training material. Talking to another person, especially someone you are familiar with provides greater clarity and understanding than through other forms of education.	

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F 880	Continued From page 14	F 880	ADMINISTRATOR□S SIGNATURE: Kweilin Belitsos, LNHA	