STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING _____ B. WING _____	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 3-21-22 through 3-23-22. Event ID# 13PO11 4 of the 4 complaint allegations were not substantiated. NC00186966 and NC00185451	F 000		
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 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 record review, resident, staff, Registered Dietician and Physician interview the	F 692	1. Resident #2 suffered no ill effects related to this incident. The facility failed	4/8/22

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

Electronically Signed | 04/05/2022

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F 692	Continued From page 1 facility failed to transcribe and implement a Physician's order for 1 of 1 resident (Resident #2) reviewed for dietary needs. Findings included: Resident #2 was admitted to the facility on 12-29-21 with multiple diagnoses that included diabetes and chronic kidney disease stage 5. The admission Minimum Data Set (MDS) dated 1-3-22 revealed Resident #2 was cognitively intact. Review of Resident #2's Medical Record revealed he had an appointment on 3-15-22 with an outside Physician for his kidney disease. Documentation showed a prescription was provided to the facility for Resident #2 to receive a strict diabetic diet and a low phosphorous diet. Resident #2's medical record revealed an active order (initiated on 12-29-21) that read CCD (consistent carbohydrate diet) diet, and NAS (no added salt) diet. Resident #2 was interviewed on 3-21-22 at 8:10am. The resident discussed a concern about the diet he was receiving. He explained he had been to his kidney doctor last week (3-15-22) and the doctor had placed him on a no carbohydrate diet. Resident #2 stated he had continued to receive several carbohydrates on his meal tray and when he had asked for an alternate meal, the alternate also had many carbohydrates. Nurse #2 was interviewed on 3-22-22 at 10:05am. The nurse explained the process of transcribing orders from an outside physician.	F 692	to transcribe and implement a physician order in regards to Resident #2's diet change per the recommendation of consulting physician. 2. All Facility residents that have a change in a diet order have the potential to be affected by this deficient practice. All diet orders will be audited by 04-04-2022 DON/nursing/designee. 3. All Nursing staff will be in-serviced on proper policy and procedures in relation to when a physician gives a diet order change, whether a verbal order/telephone order or a written order, to change a resident's diet must be followed and completed per the directed physician order and communicated to the dietary department by the DON/ designee by 04-06-2022. 4. The DON/ designee will audit all new dietary orders/recommendations to ensure MD orders are being properly followed and communicated to the dietary department five times a week for six weeks. Then two times a week for six weeks to ensure nursing is following all MD orders in relation to diet changes. Audit Results and any concerns identified will be reported/ trended to our Quality Assurance committee monthly times three. 5. Date of compliance 04-08-2022	

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F 692	Continued From page 2	F 692		

She stated when a resident returned to the facility from a Physician appointment, the paperwork would be processed by the nurse and any new orders were reviewed by the facility physician. The nurse said once the order was approved by the facility Physician, the order was transcribed into the electronic medical record. She explained Resident #2's diet order would have been processed the same way but with a dietary form filled out for the dietician. Nurse #2 stated she did not know what happened to the order but was aware Resident #2 had not had a diet change since his admission to the facility.

A phone interview was attempted with Nurse #3 on 3/22/22 at 11:33am and on 3/23/22 at 9:22am. She was unable to be reached. Nurse #3 was assigned to Resident #2 on 3/15/22 when he returned from his outside physician appointment with a new order for a strict diabetic diet and low phosphorous diet. This new order was not transcribed or implemented for Resident #2.

The Dietary Manager (DM) was interviewed on 3-22-22 at 10:21am. The DM explained when a resident had a change in their diet ordered, she would receive a diet slip with the new diet order. She stated she was not aware of the order for a diet change on Resident #2 and had not received a diet slip with the new diet order.

The Registered Dietician (RD) was interviewed by telephone on 3-23-22. The RD explained when a resident was ordered a new diet, the DM would receive a dietary slip with the new diet order. She stated the DM and herself were unaware of any new diet order from Resident #2's kidney doctor. The RD also said if she had been made aware of the new order, she would have discussed the

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F 692	Continued From page 3 changes with Resident #2 and placed all high phosphorous foods as dislikes on the resident's meal card so staff would know not to serve the resident foods that were high in phosphorous. The Facility Physician was interviewed by telephone on 3-22-22 at 4:01pm. The Physician stated she had approved the new dietary order for Resident #2 and was not aware the order had not been processed. She stated she would have expected the order to be processed and a conversation between all parties including the kidney doctor to discuss what type of diet were options in a long-term care setting. The Administrator was interviewed on 3-22-22 at 12:35pm. The Administrator stated she did not know how the order was missed and not conveyed to the DM. She explained once the order was approved, the nurse should have processed the order and provided the DM with a dietary slip with the new diet order.	F 692		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		4/8/22

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F 842	Continued From page 4	F 842		

must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 5 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff and Physician interview the facility failed to document resident blood sugars and insulin for 1 of 1 resident (Resident #2) reviewed for medication administration. Findings included: Resident #2 was admitted to the facility on 12-29-21 with multiple diagnoses that included diabetes, chronic kidney disease stage 5. The admission Minimum Data Set (MDS) dated 1-3-22 revealed Resident #2 was cognitively intact and was coded for receiving 5 insulin injections. Resident #2's care plan dated 1-11-22 revealed a goal that he would not have any complications related to diabetes. The interventions for the goal were in part to provide diabetic medications as ordered by the Physician, fingerstick blood sugars as ordered by the Physician. Physician order dated 12-29-21 read finger stick	F 842	1. Resident #2 suffered no ill effects related to this incident. Resident # 2, it was noted that nursing did not document his insulin and a fasting blood sugar in Electronic Medical Record (EHR). The expectation is that staff must document tasks as completed per the physician order. 2. All Facility residents have the potential to be affected by this deficient practice. DON/designee will complete an audit for signature compliance of all residents receiving insulin and blood sugar checks for compliance. DON/Designee will review the missed medication report daily to ensure there is 100% insulin medication and blood sugar checks documented for all residents with insulin and blood sugar test orders in the facility and that all physician ordered insulin medications and blood sugar tests are properly documented on the MAR, and administered to the residents per MD orders on 04-08-2022. 3. Facility staff will be in serviced on the	

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F 842	Continued From page 6 blood sugars before meals and at bedtime. Physician order dated 12-29-21 read Humulin R (insulin) inject 20 units with meals. Review of Resident #2's Medication Administration Record (MAR) for January 2022 revealed Resident #2 had no documentation of his blood sugar being checked or receiving insulin as scheduled at 6:30am on the following days; 1-5-22, 1-15-22, 1-18-22, 1-23-22, and 1-27-22. Nurse #1 was interviewed by telephone on 3-22-22 at 11:10am. The nurse stated she had performed finger stick blood sugar checks on Resident #2 and provided his insulin as ordered on 1-5-22, 1-15-22, 1-18-22 and 1-23-22. She stated she had just forgotten to document in the MAR. The Administrator was interviewed on 3-22-22 at 12:35pm. The Administrator stated she expected the staff to document the tasks they completed. The facility Physician was interviewed by telephone on 3-22-22 at 4:01pm. The Physician stated she expected staff to document anytime they obtain a blood sugar reading and provide a medication to a resident.	F 842	proper policy and procedure for documenting tasks from MD orders and properly completed in the Medication Administration Record in the Electronic Health Record. Education to include expectations of all medication administration documentation and documentation of completed of tasks. This will be completed by the DON/ designee by 04-06-2022. 4. The DON/ designee will audit the missed medication report daily for six weeks then two times a week for six weeks to ensure all insulin and blood sugar checks are documented and accurately signed off completed in Electronic Health Record. Audit Results and any concerns identified will be reported/ trended to our Quality Assurance committee monthly times three. 5. Compliance date: 04-08-2022	