STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345170	A. BUILDING _____ B. WING _____	C 04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL BLUFFS REHABILITATION AND HEALTH CARE CENT	4010 BRIDGES STREET EXTENSION MOREHEAD CITY, NC 28557

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E 000	Initial Comments An unannounced Recertification and Complaint Survey was conducted on 4/18/22 through 4/21/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PT5311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/18/22 through 4/21/22. Event ID #PT5311 1 of the 5 complaint allegations was substantiated but did not result in a deficiency. The following intakes were investigated: NC00181807 and NC00182299.	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.	F 644		5/12/22

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

Electronically Signed | 05/13/2022

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F 644	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to refer a resident for a level II Preadmission Screening and Resident Review (PASRR) when diagnosed with a newly evident serious mental illness for 1 of 2 residents reviewed for PASRR (Residents #12). Findings included: Resident #12 was admitted to the facility on 12/23/20 with no diagnosis of mental health disorders and a level I PASRR. Review of Resident #12 ' s medical record diagnosis sheet revealed newly evident mental diagnoses were identified on the following onset dates: anxiety disorder onset date of 3/16/21 and major depressive disorder onset date of 5/20/21. Review of Resident #12 ' s Annual Minimum Data Set (MDS) dated 10/26/21 indicated Resident #12 was cognitively intact. The resident ' s current active diagnoses included, in part, anxiety disorder and depression. Resident #12 received antidepressants. The MDS indicated the resident had a level I PASRR. In an interview on 4/21/22 at 11:00 AM with the Minimum Data Set Nurse #1 (MDS Nurse #1) she stated when a resident was newly diagnosed with a mental illness the resident needed to be evaluated for a level II PASRR. She confirmed a referral was not made for a reevaluation and acknowledged there should have been a resubmission for a PASRR level II evaluation for Resident #12 when the newly evident mental health diagnoses were identified. She also stated it was a misunderstanding of when and why to	F 644	1. Corrective action for resident(s) affected. Facility conducted audit PASRRs to ensure proper level of care and quality was being provided to all residents by ensuring each resident had a current PASRR and no expired PASRR existed in the facility. Findings of the audit revealed that there were no residents identified without a current PASRR. - 4.22.22 All residents who triggered for a significant change, or received a new qualifying diagnosis for the past 90 days were also screened to ensure that any new diagnosis which require Level II PASRR screening will have new screening completed as identified. - 4.22.22 All current residents will be screened to identify any/all diagnosis that require Level II PASRR screening. Findings documented on Audit Tool: MDS PASSR Accuracy Audit Form. - 4.22.22 2. Corrective action for resident(s) with the potential to be affected. Staff responsible for completing PASRR changes have been in-serviced on the new process for monitoring for PASRR changes. The process to complete application is as follows: (a) Print resident current Existing PASRR Notification. (b) Resident review of Face	

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F 644	Continued From page 2 resubmit the data for the level II PASRR when a newly diagnosed mental health diagnosis was identified. She clarified it was the MDS Nurse that notifies Social Work to resubmit the information and the MDS Nurse failed to make the Social Worker aware of the changes. An interview was conducted with the facility ' s Administrator on 4/21/22 at 11:54 AM. He expressed the PASRR information was expected to be resubmitted immediately by the MDS Nurse to the Social Worker so follow up documentation could be sent forward for reevaluation. He expressed all residents should be reviewed and screened for any needed level II PASRR assessments when mental health changes occur.	F 644	Sheet and diagnosis list (c) Review of PASRR Screen for Listed Diagnosis and condition list as required for review (d) Resubmittal of PASRR Screen based on current list of conditions (e) Review of Care Plan to ensure person centered care (f) Upon new condition/new qualifying diagnosis Review and resubmittal of PASRR (g) Update PASRR Audit tool. 4.22.22 Using the new process change, all identified residents will have a completed Application submitted by 5/12/22. - 5.12.22 3. What measures/systems will be put into place to ensure the deficient practice does not occur again? Distribution of Original Screen by Admission Coordinator from Hospital/Acute Setting prior to Admission with dx List Review. 4.22.22 Review of dx List SW, MDS, and PASRR SCREEN submittal for any residents with Mental Health Diagnosis (New Admissions or Current Admissions with new diagnoses) - 4.22.22 PASSR audit will be conducted by SSD at quarterly care plan meetings to ensure new dx that meet PASSR level II screening requirements are screened appropriately. 4.22.22 4. How will performance be monitored and how often?	

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F 644	Continued From page 3	F 644	Weekly audits will be conducted x4, monthly x3, and quarterly thereafter to monitor any activities that would require a PASRR change, i.e.: admissions, readmissions, significant changes, and new diagnosis of mental illness - 4.22.22 Findings of the audit tool will be addressed immediately through in-service training and appropriate staff will submit application for PASRR change. - 4.22.22 Any and all negative findings identified will be submitted to the QA Committee monthly and/or changes will be made to this plan as deemed necessary by the Committee. - 4.22.22 Date of Last Completion for all audits in QA: 5.26.23. - 4.22.22	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 693		4/21/22

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F 693	Continued From page 4 §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to provide a resident's tube feeding in accordance with the physician's order for 1 of 1 resident (Resident #17) reviewed for tube feeding. Findings included: Resident #7 was admitted to the facility on 12/19/19 with diagnoses that included dysphagia with a feeding tube. Her quarterly Minimum Data Set (MDS) dated 4/8/22 indicated severe cognitive impairment. She received over half of her daily calories and fluids from her tube feeding (TF). Review of physician's orders revealed an order for Glucerna 1.2 at 74 milliliters (ml) per hour to begin at 5:00 PM and stop at 10:00 AM (total 1258 ml per day). An observation was made on 4/19/22 at 8:40 AM of Resident #17's TF pump turned off with the formula bottle removed from the room. An observation was made on 4/20/22 at 8:40 AM of Resident #17's TF pump turned off with the formula bottle removed from the room.	F 693	1. Corrective action for resident(s) affected. Resident A.D. has an order for Glucerna 1.2 cal nocturnal feeding to run from 5p to 10 am. On 4/19 and 4/20/22 it was reported that resident tube feeding did not run from approximately 8:30 am to 10 am. - 4.20.22 In review of the tube feeding history for the last 24 hours, resident received approximately 1038 cc versus the 1258cc that was ordered. Medication error report complete for the incorrect dose and MD notified. - 4.20.22 Resident feeding was changed from a 1000cc bottle to a 1500 cc bottle which allows the feeding to run for the 17 hours as ordered eliminating the need to change bags to complete the feeding as ordered. - 4.20.22 No negative outcome to the resident, resident has shown no significant weight loss and remains stable between 130-131 lbs. for the last 3 months. Per dietician resident's IBW: 110 lbs	

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F 693	Continued From page 5 During an interview on 4/20/22 at 8:45 AM, Nurse #1 revealed that Resident #7 received her TF from 5:00 PM to "between 8-10 AM." She indicated that when the bottle ran out, she would turn the pump off. Nurse #1 confirmed the order was to stop the TF at 10:00 AM. During an interview on 4/20/22 at 2:10 PM, the Registered Dietitian (RD) revealed that Resident #7 should receive her TF over 17 hours starting at 5:00 PM and ending at 10:00 AM. She indicated it should not be turned off early. She further revealed Resident #7 had not lost weight. During an interview on 4/20/22 at 4:35 PM, the Regional Clinical Director of Operations revealed staff should be using a 1500 ml bottle of tube feeding formula and turning it off per order. An observation was made on 4/20/22 at 4:40 PM with assistance from the Assistant Director of Nursing (DON) of Resident #17's TF pump history. The pump indicated Resident #7 had received 1027 ml of TF over the past 24 hours. During an interview on 4/21/22 at 8:25 AM, the DON indicated that Nurse #1 should have followed the physician's order for Resident #7's TF. She confirmed Resident #7 did not get the full TF for the past two days. During an interview on 4/21/22 at 8:30 AM, the Administrator revealed the nurse should have followed the physician's order to ensure Resident #7 received her TF.	F 693	Monthly weights are as follows: 2/4/22: 130.0 lbs. 3/2/22: 131.6 lbs. 4/5/22: 131/4 lbs. 4/19/22: 131.4 lbs. 2. Corrective action for resident(s) with the potential to be affected. 100% audit completed for all other resident with tube feeding. - 4.20.22 All nurses in-serviced regarding the requirement to follow MD orders. In-service included the following: following physician orders as written to ensure 6 rights of medication administration, document accurately the amount given on the MAR, how to read the feeding pump to verify feedings, and notification of MD if order can not be followed as ordered. - 4.21.22 Nurses not in-serviced by 4/21/22 will be in-serviced prior to their next scheduled shift and training will be incorporated in the new hire orientation. - 4.21.22 and thereafter 3. What measures/systems will be put into place to ensure the deficient practice does not occur again? New physician orders will be reviewed in Morning meeting daily by the IDT team and on the weekends by the supervisor to ensure orders are transcribed and followed as ordered. 4.21.22 Audit of tube feeding pumps will be	

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F 693	Continued From page 6	F 693	implemented and recorded on the Tube Feeding Audit tool daily and then weekly, according to monitoring. 4.21.22 and thereafter 4. How will performance be monitored and how often? Tube feedings will be audited daily x 7 days, weekly x4, monthly x3, and then quarterly x3 to ensure compliance with physician orders. - 4.21.22 and thereafter Any and all audit findings will be submitted to the QA Committee monthly and/or changes will be made to this plan as deemed necessary by the Committee. - 4.20.22	