STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 12/18/2023

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SALISBURY REHABILITATION AND NURSING CENTER	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 000	INITIAL COMMENTS A complaint investigation was completed on 12/18/23. See Intake # NC00210310. None of the 3 allegations resulted in a deficiency but 3 citations were identified based on the complaint investigation. See #E7GB11.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		1/2/24

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

Electronically Signed | 12/31/2023

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff, Nurse Practitioner (NP) interviews and record review, the facility failed to notify a residents Responsible Party (RP) for refusals of his prescribed insulin. This was for 1 (Resident #1) of 3 residents reviewed for notification. The findings included: Resident #1 was admitted on 6/7/22 with a diagnoses of Diabetes Mellitus (DM), Blindness, Schizophrenia and Bipolar Disorder. Review of Resident #1's undated Admission Record (face sheet) read his sister was his designated RP and emergency contact. Review of Resident #1's November 2023 insulin orders included the following: *Humalog insulin sliding scale: Inject as per	F 580	The responsible party for resident #1 was updated on 12/6/23 by the Unit Manager related to the status of his prescribed insulin to include refusals. All current residents are at risk for this deficient practice. The Unit Managers and the Director of Nursing (DON) will complete audits of the current residents for the last 60 days to ensure responsible parties are being notified of changes in conditions to include resident refusals of medications. The licensed nurses to include agency nurses will be educated by the DON and/or the Staff Development Coordinator by 1/01/24 related to ensuring that responsible parties are being notified of resident changes in condition to include medication refusals.	

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F 580	Continued From page 2 sliding scale subcutaneously before meals for Diabetes: if 201 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; 401+ = 5 units If blood glucose greater than 400, give 5 units and call the Physician, *Solostar insulin: Inject 14 units subcutaneously two times a day at 8:00 AM and 8:00 PM *Humalog insulin: Inject 14 units subcutaneously before meals. Review of Resident #1's November 2023 Medication Administration Record (MAR) included documentation he refused his Solstar insulin on 11/18/23 at 8:00 PM, Solostar insulin on 11/19/23 at 8:00 PM and his Humalog insulin 11/24/23 at 11:00 AM. Review of a nursing note dated 11/18/23 at 10:13 PM read Resident #1 refused his Solostar insulin of 14 units at 8:00 PM stating he wanted to wait until morning to get his blood sugar rechecked. Education was provided on long acting insulin but he continued to refuse. Nurse #1 wrote this note. Review of a nursing note dated 11/19/23 at 9:44 PM read Resident #1 refused his Solostar insulin of 14 units at 8:00 PM. No further documentation was included in his nursing note. Nurse #2 wrote this note. Review of a nursing note dated 11/24/23 at 12:12 PM read Resident #1 refused his Humalog 14 units before meals. No further documentation was included in his nursing note. Nurse #3 wrote this note. Review of Resident #1's care plan last revised on 12/7/23 included DM as an identified problem	F 580	The newly hired licensed nurses and new agency licensed nurses will not be allowed to work until the education is completed. The progress notes, physician orders, medication administration records, and risk incidents will be reviewed by the DON/designee during morning clinical meeting and the weekend supervisor will review on the weekend for 12 weeks to ensure that resident responsible parties are being notified of changes in condition to include medication refusals. The results of the reviews of the progress notes, physician orders, medication administration records and risk incident will be discussed in the monthly QAPI committee meeting for at least three months. The interdisciplinary team will recommend revisions to the plan as indicated to maintain substantial compliance.	

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F 580	Continued From page 3	F 580		

area. No concerns were noted in regards to the interventions.

His quarterly Minimum Data Set dated 12/11/23 indicated he was cognitively intact, exhibited no behaviors and received 7 of 7 days of prescribed insulin.

Telephone calls with messages left by the facility and surveyor were made to Nurse #1 and Nurse #2 with no return calls.

Review of a nursing note dated 12/6/23 at 9:58 AM completed by the Unit Manager read Resident #1's RP was upset over his lack of care. The note read Resident #1's documentation in his medical record of his insulin refusals were reviewed with his RP. The note read Resident #1's RP would like to be notified about every time he refused his prescribed insulin. The Unit Manager documented Resident #1 was cognitively intact and they would have to ask him for permission to let her know.

Telephone calls with message left by the surveyor were made to Resident #1's RP with no return calls.

In an interview on 12/18/23 at 2:20 PM, Nurse #3 confirmed she wrote the nursing note dated 11/24/23 at 12:12 PM that read Resident #1 refused his lunch dose of his Humalog. She stated she did not think to notify the RP of his refusal because he was alert and oriented. Nurse #3 stated she did not check his medical record to see who his RP was and assumed he was his own. Nurse #3 stated she only recalled notifying the NP

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F 580	Continued From page 4 A telephone interview was completed on 12/18/23 at 12:20 PM with the NP. She stated the facility always let her know when he refused his insulin. She stated she was not aware that the facility was not notifying his RP for his insulin refusals. In an interview with the Unit Manager on 12/18/23 at 2:00 PM, she stated Resident #1's RP came to the facility on 12/6/23 to discuss her concerns regarding his care. She stated she printed off the documentation of his insulin refusals prior to his hospitalization 11/27/23 for his RP. The Unit Manager stated Resident #1's RP wanted to be notified for any refusals of his insulin but she explained that since he was cognitively intact, he would have to give the facility permission to notify her. A review of Resident #1's medical record's Admission Record (face sheet) with the Unit Manager was completed. She noted that it read his sister was his RP and stated she thought it was his responsibility to tell his sister if he wanted her to know. In an interview with the Director of Nursing on 12/18/23 at 3:25 PM, she stated the facility nurses should let Resident #1's RP know of any insulin refusals regardless of his cognition.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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		1/2/24

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F 656	Continued From page 5 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the	F 656	Resident #1 Comprehensive Care Plan	

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F 656	Continued From page 6 facility failed to develop a comprehensive care plan in the area of resident's refusal of medications. This was for 1 (Resident #1) of 3 residents reviewed for comprehensive care planning. The findings included: Resident #1 was admitted on 6/7/22 with a diagnosis of Diabetes Mellitus (DM). Review of Resident #1's August 2023 Medication Administration Record (MAR) and a nursing note dated 8/10/23 at 12:43 PM read he refused in lunch time dose of his prescribed insulin. Another nursing note dated 8/16/23 at 11:50 PM read he refused his 8:00 PM prescribed dose of insulin. Review of Resident #1's October 2023 MAR and a nursing note dated 10/18/23 at 12:28 AM read he refused his 8:00 PM prescribed dose of insulin. Review of Resident #1's November 2023 MAR and nursing notes dated 11/18/23 at 10:13 PM , 11/19/23 at 9:44 PM and 11/24/23 at 12:12 PM, he refused his prescribed dose of insulin. His quarterly Minimum Data Set (MDS) dated 12/11/23 indicated he was cognitively intact, exhibited no behaviors and received 7 of 7 days of prescribed insulin. Review of Resident #1's care plan last revised on 12/7/23 did not include his insulin refusals as an identified problem area. An interview was completed on 12/18/23 at 2:35 PM with the MDS Nurse. She stated she reviewed the MAR's and nursing notes for Resident #1 prior to his care plan revision date of	F 656	was updated on 12/18/23 by the Minimum Data Set (MDS) nurse in the area of refusal of medications. The current residents are at risk related to this deficient practice. The Director of Nursing, Unit Managers, and the Minimum Data Set (MDS) nurse will review the comprehensive care plans completed in the last 60 days to ensure care plans have been completed for residents that refuse medications. The Regional Clinical Reimbursement Nurse will provide education to the MDS nurses on ensuring that comprehensive person-centered care plans are developed for each resident to include residents that refuse medications by 1/1/24. The Director of Nursing and the Staff Development Coordinator will educate the licensed nurses related to ensuring that comprehensive person-centered care plans are developed for each resident to include residents that refuse medications. The newly hired licensed nurses, MDS nurses and new agency licensed nurses will not be allowed to work until the education is completed. The MDS nurse will complete audits of at least 10 residents weekly for 12 weeks to ensure comprehensive person-centered care plans are developed for each resident to include residents that refuse medications. The results of the audits will be discussed in the monthly QAPI committee meeting for at least three months. The interdisciplinary team will recommend revisions to the plan as indicated to maintain substantial	

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F 656	Continued From page 7 12/7/23 and must have overlooked his repeated refusals of his insulin. She stated she would develop a care plan for his history of insulin refusal. An interview was completed on 12/18/23 at 3:25 PM with the Director of Nursing. She stated Resident #1's refusals of insulin should have been addressed in his comprehensive care plan revised on 12/7/23.	F 656	compliance.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.	F 867		1/2/24

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§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its

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performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

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F 867	Continued From page 10 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following a complaint investigation dated 9/3/21 for two deficiencies in the area of comprehensive care planning at F656 and notification of changes at F580. Also, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following the recertification survey dated 5/6/22 for one deficiency in the area of notification of changes at F580. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included. This tag is cross referenced to: F656- Based on staff interviews and record review, the facility failed to develop a comprehensive care plan in the area of resident's refusal of medications. This was for 1 (Resident #1) of 3 residents reviewed for comprehensive care planning.	F 867	Quality Assessment and Assurance (QAA) Committee will be held by 1/1/24 by the Administrator related to ensuring the facility has effective systems to obtain information and/or feedback from facility staff, residents and residents' representatives to identify problems and opportunities for improvement. The current residents are at risk related to this deficient practice. The interdisciplinary team will be educated by 1/1/24 by the Chief Nursing Officer related to ensuring the QAA Committee maintain and implement processes to obtain information and/or feedback from facility staff, residents and resident representatives to identify problems and opportunities for improvement. The Administrator will be responsible for monitoring the Quality Assurance Performance Improvement Plan process monthly for 3 months to ensure that the facility remains in compliance for identified deficiencies. The Administrator will report the findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	

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F 867	Continued From page 11 During a complaint investigation dated 9/3/21, the facility failed to provide a care plan for behaviors of eating items from the trash and placing nonedible items in his mouth and a care plan for physical aggression and agitation. F580- Based on staff interviews and record review, the facility failed to notify a residents Responsible Party (RP) for the refusals of his prescribed insulin. This was for 1 (Resident #1) of 3 residents reviewed for notification. During complaint investigation dated 9/3/21, the facility failed to provide notification of change in condition. The facility did not notify the Physician or the Responsible Party the resident had ingested an unidentified object and failed to notify the Responsible Party that another resident tested positive for COVID-19 and was transferred to the COVID-19 quarantine unit. F580- Based on staff interviews and record review, the facility failed to notify a residents Responsible Party (RP) for the refusals of his prescribed insulin. This was for 1 (Resident #1) of 3 residents reviewed for notification. During a recertification survey dated 5/6/22, the facility failed to notify a resident's legal guardian when the resident was involuntarily committed to an acute care hospital. An interview was completed on 12/1829/23 at 3:30 PM with the Administrator. He stated he felt the repeat citations at F656 and F580 could be attributed to the frequent turnover in staffing and need to ensure agency staff and newly hired staff	F 867		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY REHABILITATION AND NURSING CENTER	**635 STATESVILLE BOULEVARD SALISBURY, NC 28144**

(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 867	Continued From page 12 were aware of the facility expectations.	F 867		