STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING ______ B. WING ______	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/8/24 through 1/11/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID 62BQ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/8/24 through 1/11/24. Event ID# 62BQ11. The following intakes were investigated NC00209370 , NC00208318, NC00207898, NC00204909, NC00203967, NC00201884, NC00197831, NC00197231, and NC00197205. 6 of the 25 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		2/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/27/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to speak respectfully to a resident during an interaction (Resident #22) and failed to have a privacy cover on a resident's catheter bag (Resident #37) and for 2 of 6 resident reviewed for dignity. Findings included: 1. Resident #22 was admitted to the facility on 8/9/18. A review of Resident #22's quarterly Minimum Data Set (MDS) assessment dated 12/22/23 revealed he was cognitively intact. His hearing	F 550	¿ Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 37 privacy bag was placed on by the Certified Nursing Assistant on 1-9-24. Employee # 1 suspended pending investigation and re-educated on dignity by the Administrator / Clinical Competence Coordinator prior to returning to work.	

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F 550	Continued From page 2 was adequate. He exhibited no hallucinations, psychosis, behaviors, or rejection of care during the assessment period. A review of Resident #22's comprehensive care plan revealed in part a problem area initiated on 1/26/23 of behavior symptoms related to verbal behaviors directed towards others that included Resident #22 calling staff names such as "stupid" and "dumb". An intervention was to maintain a calm environment and approach to Resident #22. On 1/10/24 at 11:13 AM an interview with Resident #22 indicated Receptionist #1 was rude to him. He stated a few months ago, in August 2023, he was at the front desk and Receptionist #1 asked him to move away from the desk because she was talking on the phone. Resident #22 stated he didn't want to move, and she told him he was "acting like a butthole". He went on to say he had not mentioned this to anyone because he didn't want to start any trouble. He stated this had made him angry and hurt his feelings at the time. On 1/10/24 at 1:23 PM an interview with Receptionist #1 indicated she recalled an instance with Resident #22 where he was sitting at the front desk while she was talking on the phone. She stated at times needed to have confidential conversations with families or funeral homes. She went on to say she had asked Resident #22 to sit somewhere else while she was on the phone, and he had gotten upset. Receptionist #1 stated Resident #22 told her she was "acting like an old butthead" and she told him he must have been talking about himself. She further indicated she probably should have handled the situation differently.	F 550	¿ Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing and/or Nurse Managers reviewed all residents with catheters for application of catheter privacy bags, no residents identified without a privacy cover. The Administrator and/or Department managers interviewed the alert and oriented residents related to being treated with dignity. 30 out of 30 residents stated there were being treated with dignity within the facility. ¿ Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 1-9-2024, the Clinical Competency Coordinator and/or Nurse Managers began education for all Licensed Nurse and Certified Nursing Assistants providing privacy bags for all residents with catheters. Any Licensed Nurse and/or Certified Nursing Assistant not educated by 2-1-2024, will be educated prior to their next scheduled shift. This education will be provided to all newly hired Licensed Nurses and Certified Nursing Assistants during their general orientation. On 1-10-2024 the Clinical Competency Coordinator and/or Nurse Managers began education for all Staff on treating residents with dignity. Any Staff member not educated by 2-1-2024will be educated	

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F 550	Continued From page 3	F 550		

On 1/10/24 at 1:40 PM an interview with the Administrator indicated she had not been aware of this interaction between Resident #22 and Receptionist #1. She stated Receptionist #1 should not have responded in this way to Resident #22. She went on to say if Receptionist #1 had not agreed with what Resident #22 was saying, she should have just not said anything.

2. Resident #37 was admitted to the facility on 1/18/21. His active diagnoses included chronic kidney disease, autonomic neuropathy in diseases classified elsewhere, difficulty in walking, neuromuscular dysfunction of bladder, and benign prostatic hyperplasia with lower urinary tract symptoms.

Review of Resident #37's minimum data set assessment dated 11/17/23 revealed he was assessed as cognitively intact. He had no behaviors and used an indwelling catheter.

During observation on 1/8/24 at 2:00 PM Resident #37 was observed in bed with no cover observed on his catheter bag. The catheter bag was on the side of the bed that faced the door. His roommate's bed blocked the view of the catheter bag from the hall, but Resident #37's urine was visible to anyone in the resident's room.

During observation on 1/9/24 at 8:31 AM Resident #37 was observed to have no cover on his catheter bag and urine was visible to anyone in Resident #37's room.

During an interview on 1/9/24 at 8:32 AM Resident #37 stated his catheter bag had a cover. When told the catheter bag did not have a cover,

prior to their next scheduled shift. This education will be provided to all newly hired Staff member during their general orientation.

The Director of Nursing and/or Nurse Managers are conducting rounds daily for 5 days then weekly for four weeks then monthly thereafter to identify that any resident with a catheter has a privacy bag over their catheter drainage bag.

The Department Managers (Social Work, Activities, Nursing, Dietary) are conducting resident interviews related to treatment with dignity and respect daily for 5 days then weekly for four weeks then monthly thereafter to identify that all resident□s are being treated with dignity and respect.

¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

The Director of Nursing will track, trend and analyze the rounding tools for privacy bags monthly and will present the findings to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then quarterly. The Administrator will track, trend and analyze the rounding tools for resident dignity and respect and will present the findings to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then quarterly

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F 550	Continued From page 4 he stated he would like a cover on his catheter bag. During an interview on 1/9/24 at 8:36 AM Nurse Aide #1 stated Resident #37 had a catheter bag privacy cover on 1/7/24 and did not know why it was not on today and he should have a cover for his catheter bag for dignity. She did not notice this morning that he did not have a catheter cover and she would go get one now. During an interview on 1/9/24 at 8:42 AM the Director of Nursing stated they had issues with the supply company getting catheter bags with built-in covers. She stated residents should have a cover for dignity, and the facility had covers for bags that did not have built in covers and staff sometimes forget to move the catheter bag cover with the catheter bag during transfers from the wheelchair chair to bed. She concluded he should not have gone since yesterday without a catheter bag cover for dignity.	F 550	¿ Include dates when corrective action will be completed. 2-2-2024	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		2/2/24

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F 761	Continued From page 5 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep medications in a locked medication cart for 1 of 4 medication carts observed (Medication Cart #1). Findings included: During observation on 1/8/24 at 2:34 PM Medication Cart #1 was found by the surveyor to be unlocked and unattended outside the nursing station. Two nurse aides were inside the nurse's station and two cognitively impaired residents were observed near the unlocked medication cart. At 2:36 PM Nurse #1 returned to the unlocked medication cart. During an interview on 1/8/24 at 2:37 PM Nurse #1 stated medication carts were to be locked when unattended and she should have locked the medication cart prior to taking medications to a resident. During an interview on 1/9/24 at 8:42 AM the Director of Nursing stated medication carts were to be locked when unattended for resident safety.	F 761	¿ Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Licensed Nurse immediately locked the medication cart when returning to the area. ¿ Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. ¿ Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 1-9-2024, the Clinical Competency Coordinator and/or Nurse Managers began education for all Licensed Nurses regarding locking of medication carts	

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F 761	Continued From page 6	F 761	when not in visual sight of the carts. Any Licensed Nurse not educated by 2-1-2024, will be educated on locking of the medication cart prior to their next scheduled shift. Education regarding locking medication carts will be provided to all newly hired Licensed Nurses during their general orientation. The Director of Nursing and/or Nurse Managers are conducting rounds daily for five days then weekly for four weeks then monthly thereafter to identify the security of all medications via locking of medication cart. ¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Nursing will track, trend, and analyze the rounding tools for locking of the medication carts monthly and will present the findings to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then quarterly. ¿ Include dates when corrective action will be completed. 2-2-2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		2/2/24

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F 812	Continued From page 7 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and date resident's personal food items stored in a nursing unit nourishment refrigerator. This was for 1 of 2 nursing unit nourishment refrigerators (First-Floor) observed. Findings included: On 1/10/24 at 11:24 AM an observation of the First-Floor nursing unit nourishment refrigerator with Nurse #2 revealed the following: a. two unlabeled and undated cardboard pizza boxes containing pizza. b. an unlabeled and undated brown paper bag containing tortilla chips and an unlabeled and undated cup of red liquid. c. an unlabeled and undated plastic food storage container of fried chicken, collard greens, and macaroni and cheese.	F 812	¿ Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The residents unlabeled personal food items were discarded by the Certified Nursing Assistant on 1/10/24. ¿ Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. ¿ Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 1-25-2024, the Clinical Competency	

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F 812	Continued From page 8	F 812		

d. an unlabeled and undated plastic food storage container containing corn bread and black-eyed peas.

e. an unlabeled and undated plastic food storage container of green beans and black-eyed peas.

In an interview at the time of the observation, Nurse #2 stated she was sure the unlabeled and undated food items in the refrigerator belonged to residents. She stated she had not placed the food items in the refrigerator, and she did not know who had. She went on to say she was not sure how long the items had been in there. She further indicated residents and family members were unable to place items in this refrigerator as it was behind the nurses station. Nurse #2 stated food items had to be given to a staff member. Nurse #2 stated staff were supposed to label items with the resident's name or room number and the date when items were placed in the refrigerator. Nurse #2 stated everyone tried to keep up with this. She went on to say she would need to discard the items because they were not labeled, she was not sure who they belonged to, and she did not know how long they had been in there.

On 1/10/24 at 2:46 PM an interview with the Director of Nursing indicated Nurse Aide (NA) #2 was responsible for checking this refrigerator daily Monday through Friday and discarding any items that were not labeled and dated. She stated any staff member who placed an item in this refrigerator should be labeling the item with the resident's name and the date the item was put in the refrigerator.

On 1/10/24 at 2:51 PM an interview with NA #2

Coordinator and/or Nurse Managers began education for all Staff regarding the labeling of resident food items prior to placing the resident nourishment refrigerator. Any Staff member not educated by 1-31-24, will be educated on the labeling of resident food items prior to placing the resident nourishment refrigerator prior to their next scheduled shift. The education regarding the labeling of resident food items prior to placing the resident nourishment refrigerator will be provided to all newly hired Staff during their general orientation.

The Director of Nursing and/or Nurse Managers will validate (review) the labeling and dating of resident food items within the nourishment refrigerator daily for five days then weekly for four weeks then monthly thereafter to validate that all resident food items placed in the refrigerator are labeled and dated appropriately.

¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

The Director of Nursing will track, trend and analyze the labeling and dating review monthly and will present the findings to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then quarterly.

¿ Include dates when corrective action will be completed. 2-2-2024

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F 812	Continued From page 9 indicated she was responsible for checking the First-Floor nursing unit nourishment refrigerator daily Monday through Friday to be sure all food items were labeled and dated. She stated she normally checked the refrigerator in the morning when she came in and, in the evening, before she left for the day. She went on to say she had checked the refrigerator on 1/9/24. She further indicated any item that was not labeled and dated was to be discarded. NA #2 stated she had not checked the refrigerator yet on 1/10/24, as she had been out of the facility on a transportation appointment.	F 812		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345371	MULTIPLE CONSTRUCTION A. BUILDING: B. WING	DATE SURVEY COMPLETE: 1/11/2024
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments

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 staff interviews and record review the facility failed to accurately code the Preadmission Screening Resident Review (PASRR) status of a resident on a Minimum Data Set assessment for 1 of 2 residents reviewed for PASRR. (Resident #50)

Findings included:

Resident #50 was admitted to the facility on 9/19/18. His active diagnoses included other sequelae of nontraumatic intracerebral hemorrhage, psychotic disorder with delusions due to known physiological condition, disorder of brain (unspecified), personal history of other mental and behavioral disorders, and paranoid personality disorder.

Review of a PASRR Level II Determination Notification letter for Resident #50 dated 7/2/19 revealed Resident #50 was assessed to be a level II PASRR and his PASRR number ended in the letter C which meant Resident #50's Level II PASRR had no end date.

Resident #50's most recent comprehensive Minimum Data Set assessment dated 5/16/23 revealed he was coded to not be a level II PASRR.

Resident #50's care plan dated 10/16/23 Resident #50's Level II PASRR related to delusional disorders, psychotic disorder with delusions due to known physiological condition, major depressive order. The interventions included specialized interventions from Level II PASRR, follow-up psychiatric services by a psychiatrist, psych services as needed/ordered, update PASRR screens as needed, and provide medications as ordered.

During an interview on 1/10/24 at 8:57 AM the MDS Coordinator stated Resident #50 was a level II PASRR during the time of the 5/16/23 annual assessment and it should have been captured on the minimum data set assessment. She concluded the staff member who completed the MDS was not working for the facility anymore and she could not speak to why it was inaccurate and believed it must have been an oversite.

During an interview on 1/10/24 at 9:08 AM the Administrator stated she and the facility were aware of minimum data set assessment issues and they had been slowly working on the issue since September 2023. She further stated PASRR status should be accurately captured on the minimum data set assessments.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345371	MULTIPLE CONSTRUCTION A. BUILDING: B. WING	DATE SURVEY COMPLETE: 1/11/2024
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 867	Continued From Page 1
F 867	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. §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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345371	A. BUILDING: ______ B. WING ______	1/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	**836 HOSPITAL DRIVE NEW BERN, NC**

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

(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 record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint surveys of 11/3/21 and 12/8/22. This was for a recited deficiency in the area of Accuracy of Assessments (F641). The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.

The findings included:

This tag is cross referenced to:

F641: Based on staff interviews and record review the facility failed to accurately code the Preadmission Screening and Resident Review (PASSR) status of a resident on a Minimum Data Set assessment for 1 of 2 residents (Resident #50) reviewed for accurate assessments.

During the recertification and complaint survey of 11/3/21 the facility failed to accurately code the MDS in

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345371	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 1/11/2024
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the areas of alarms, Pre-Admission Screening Resident Review, and speech.

During the recertification and complaint investigation survey of 12/8/22 the facility failed to accurately code the Minimum Data Set (MDS) for Preadmission Screening and Resident Review, oxygen use, and vision.

In an interview with the Administrator on 1/11/24 at 11:22 AM she indicated she felt the continued inaccuracy of assessments was because the prior MDS nurse focused more on case-mix (reimbursement method), worked on the floor passing medications and frequently was involved in other facility programs, such as the activities program. She indicated that the facility hired two new MDS nurses in July of 2023 to focus solely on MDS completion. She further stated that both new MDS nurses did not have prior MDS experience and had to learn the position and felt that further contributed to the failure to complete MDS's accurately. The Administrator stated the facility would review its process and put corrective action in place to address these issues.