STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345072	A. BUILDING ______ B. WING ______	C 08/16/2024

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CAROLINA RIVERS NURSING AND REHABILITATION CENTER	**1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/13/24 through 08/16/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 81EX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/13/24 through 08/16/24. Event ID# 8IEX11. The following intakes were investigated NC00221010, NC00220787, NC00220661, NC00219831 NC00219455, and NC00218120. 8 of the 8 complaint allegations did not result in deficiency.	F 000		
F 641 SS=B	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 record review, observation, and staff interview the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of level 2 Pre-Admission Screening and Resident Review (PASRR) for 2 out of 20 residents (Residents #9 and Resident #13) reviewed for accuracy in assessments. The findings included: 1. Resident #9 was admitted into the facility on 6/8/2015 and readmitted on 12/15/2020 with diagnoses of unspecified psychosis and	F 641	F641 Accuracy of Assessments On 8/15/24, the Minimum Data Set (MDS) Coordinator completed a modification of assessment dated 3/25/24 comprehensive assessment for Resident # 9 to reflect accurate coding for Level II PASRR. On 8/15/24, the Minimum Data Set (MDS) Coordinator completed a modification of assessment dated 2/11/24 comprehensive	9/4/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/03/2024

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 641 Continued From page 1
depression.

A review of Resident #9's North Carolina PASRR application indicated that he had a mental health diagnosis of major depression.

A review of Resident #9's medical records included a PASSR Level 2 Determination Notification letter dated 2/7/2024.

A review of Resident #9's annual MDS dated 3/25/24 did not indicate he was currently considered by the state level 2 PASRR process to have a serious mental illness.

An interview with the Administrator on 8/15/24 at 8:35 AM indicated that Resident #9's MDS assessments was coded incorrectly regarding the PASRR question on his annual MDS. He further indicated that the annual MDS should be reviewed for accuracy prior to transmitting it.

An interview with the MDS Coordinator on 8/15/24 at 9:10 AM revealed the MDS was not coded correctly for both Resident #9 and Resident #13 regarding the level 2 PASRR. She further stated that her process was to check the miscellaneous tab in the electronic medical record for a PASSR letter, if the resident had not had one in a while she would check the demographics for a PASSR number and if she had any concerns or questions would speak with Social Services.

2. Resident #13 was admitted into the facility on 3/21/17 and readmitted on 3/16/22 with diagnoses of schizoaffective disorder, depression, and anxiety.

F 641

assessment for Resident # 13 to reflect accurate coding for Level II PASRR.

On 8/15/24, the MDS Coordinator under the oversight of the Director of Nursing initiated an audit of the most recent comprehensive, significant change assessments and/or quarterly MDS assessment section A for all residents to include resident # 9 and resident # 13 to ensure all MDS□s assessments completed are coded accurately for Level II PASRR. The DON will address all concerns identified during the audit to include updating assessment when indicated. The audit will be completed by 9/3/24.

On 8/30/24, the MDS Consultant completed an in-service on MDS Assessments and Coding with all MDS nurses and MDS Coordinator regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately for Level II PASRR, falls risk and hospice services/significant change. All newly hired MDS Coordinator or MDS nurses will be in-service regarding MDS Assessments and Coding during orientation.

The Assistant Director of Nursing (ADON) and/or Quality Assurance Nurse (QA) will review10% of newly completed MDS assessments, to include assessments for resident # 9, and resident # 13 utilizing the MDS Accuracy Audit Tool weekly x 4

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F 641	Continued From page 2 A review of Resident #13's North Carolina PASRR application indicated that she had a mental health diagnosis of anxiety, depression, and schizoaffective disorder. A review of Resident #13's medical records included a PASRR Level 2 Determination Notification letter dated 11/18/2019. A review of Resident #13's annual MDS dated 2/11/24 did not indicate she was currently considered by the state level 2 PASRR process to have a serious mental illness. An interview with the Administrator on 8/15/24 at 8:35 AM indicated that both Resident #9 and Resident #13's MDS assessments were coded incorrectly regarding the PASRR question on their annual MDS. He further indicated that the annual MDS should be reviewed for accuracy prior to transmitting it. An interview with the MDS Coordinator on 8/15/24 at 9:10 AM revealed the MDS was not coded correctly for both Resident #9 and Resident #13 regarding the level 2 PASRR. She further stated that her process was to check the miscellaneous tab in the electronic medical record for a PASSR letter, if the resident had not had one in a while she would check the demographics for a PASSR number and if she had any concerns or questions would speak with Social Services.	F 641	weeks then monthly x 1 month to ensure accurate coding of the MDS assessment for Level II PASRR. All identified areas of concern will be addressed immediately by the ADON or QA nurse to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review the MDS Accuracy Audit Tool weekly x 4 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The Quality Assurance Nurse (QA) nurse will forward the results of MDS Accuracy Audit Tool to the QA Committee monthly x 4 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
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	F 644		9/4/24

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F 644	Continued From page 3 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: Based on observation, staff interview, and medical record review, the facility failed to refer a resident with newly evident diagnoses of serious mental illnesses for Pre-Admission Screening and Annual Resident Review (PASRR) Level II screen for 1 of 4 sampled residents reviewed for PASRR (Resident #33). The findings included: Resident #33 was admitted to the facility on 01/12/2023 with diagnoses including unspecified other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, and depression. The comprehensive admission Minimum Data Set (MDS) assessment dated 12/21/2023 had Resident #33 coded as cognitively intact and was not currently considered by the state level II	F 644	F 644 Coordination of PASARR and Assessments On 8/15/24, resident # 33 was referred for evaluation of PASRR. New PASRR level received on 8/21/24 with the following: the individual screened does not meet criteria for a mental illness. On 8/14/24, the Director of Nursing and Minimum Data Set Nurse (MDS) initiated an audit of all residents with evident or possible serious mental disorder, intellectual disability, or a related diagnosis condition for a level II resident review. This audit is to identify any resident with a newly added Level II PASRR qualifying diagnosis to ensure the resident was assessed for the need to re-submit PASRR for evaluation. The	

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F 644	Continued From page 4 PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #33s had the diagnosis of anxiety disorder added to his diagnosis list on 06/14/2023. A review of the North Carolina PASRR level I screen dated 04/12/2024 revealed no mental health diagnoses were selected for the screen Resident #33. The care plan dated 08/07/2024 for Resident #33 revealed focus of resident had anxiety/depression/insomnia and was at risk for feelings of sadness, emptiness, anxiety, uneasiness, depression related to: Loss of function, decline in condition, and loss of independence. An interview with the Social Worker (SW) was conducted on 08/14/2024 at 2:00 PM. The SW stated she had worked at the facility for over a year and was responsible for completing the screens for PASRRs. An audit for residents who may need PASRRs were completed, and it was found that Resident #33 had mental health diagnoses including psychoactive substance abuse with psychoactive substance-induced psychotic disorder, depression, and anxiety. The SW also stated she marked "no," on the screen tool for mental health diagnosis and should have selected "yes," and checked all mental health diagnoses. The SW also stated she was trying to catchup with her audits, and it was an oversite. An interview was conducted with the Director of Nursing (DON) on 08/14/2024 at 2:00 PM. The DON stated he was very familiar with the	F 644	Social Worker, MDS nurse and/or Director of Nursing will address all concerns identified during the audit to include submission of Level II PASRR evaluation/re-evaluation. The audit will be completed by 9/3/24. On 8/15/24 an in-service on Level II PASRRs was initiated by the Administrator with the Admission Director, Social Worker, Minimum Data Set Nurse (MDS), Director of Nursing with emphasis on referral for evaluation/re-evaluation of PASRR following changes in mental health status or newly Level II qualifying diagnosis. All newly hired Admission Director, Social Worker, Minimum Data Set Nurse (MDS), and Director of Nursing will be in-serviced during orientation on PASRRs in regards to referral for re-evaluation following changes in mental health status. In-service will be completed by 9/3/24. All newly hired Admission Director, Social Worker, Minimum Data Set Nurse (MDS), Director of Nursing will be educated by the Staff Development Coordinator during orientation. The Minimum Data Set Nurse (MDS) and/or Unit Managers will review all new admissions/readmission and all residents with a newly evident or possible serious mental disorder, intellectual disability, or a related diagnosis condition for a level II resident review 5 times a week x 4 weeks then monthly x 1 month utilizing the PASRR Audit Tool. This audit is to ensure any resident with a newly written PASRR qualifying diagnosis is reviewed to	

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F 644	Continued From page 5 regulations related to PASRRs and he expected the regulations to be followed in reference to completing a PASRR screening for a newly identified mental illness diagnosis. He added the SW was responsible for referring residents with a new psychiatric diagnosis. An interview with the Administrator was conducted on 08/14/2024 at 2:10 PM. The Administrator stated when completing the screen for PASRRs, all the diagnoses should be included in the screen to get the accurate determination for proper placement of residents. The SW missed this due to an oversite and she was educated.	F 644	determine the need for re-submission of PASRR information. The Unit Manager, Social Worker and/or MDS nurse will address all concerns identified during the audit to include completing a new PASRR review. The Director of Nursing (DON) will review and initial the PASRR Audit Tool weekly for 4 weeks then monthly for 1 month for completion and to ensure all areas of concern were addressed. The Quality Assurance Performance Improvement (QAPI) Nurse will forward the results of the PASRR Audit Tool to the QAPI Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		9/4/24

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F 758	Continued From page 6 psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to ensure a Physicians order for an as needed (PRN) psychotropic medication, Ativan, was time limited in time duration for 1 of 5 resident reviewed for unnecessary medications (Resident #34).	F 758	F758 Free of Unnecessary Psychotropic Meds/PRN use On 8/6/24, the assigned nurse discontinued the PRN psychotropic medication Ativan per physician orders for	

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The findings included:

Resident #34 was admitted to the facility on 02/08/2024. The resident's cumulative diagnoses included chronic obstructive pulmonary disease, and anxiety disorder.

The quarterly MDS dated 06/28/2024 revealed Resident #34 was cognitively intact and on an antianxiety medication two out of seven days of the look back period.

A PRN physicians order for Ativan 0.5 milligrams (mg) for anxiety dated 06/20/2024 to 08/06/2024 did not have a stop date with a two-week period.

The June Medication Administration Record (MAR) review revealed an order for Ativan 0.5 mg as needed 06/20/2024 and discontinue 08/06/2024. The medication was administered on 06/20/2024 and 06/24/2024.

A review of the summary of Medication Regimen Review by the Pharmacy Consultant (PC) dated 07/02/2024 revealed PRN psych meds must have a stop date and rationale per Centers for Medicare and Medicaid Services (CMS) regulations. Some discrepancies found and notified Director of Nursing (DON).

A review of the summary of Medication Regimen Review by PC dated 08/02/2024 revealed PRN Psych meds must have a stop date and rationale per CMS regulations. Some discrepancies found and notified DON.

The July MAR review revealed an order for Ativan 0.5 mg as needed 06/20/2024 and discontinue

F 758

resident # 34.

On 8/15/24, an audit of PRN psychotropic medications was initiated by the Pharmacy Consultant to ensure PRN psychotropic medications for all residents to include resident # 34 were limited to a duration of 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time in the medical record and indicated the specific duration. The Director of Nursing, Unit Manager and Quality Assurance Nurse (QA) will address all areas of concern identified during the audit to include notification of the attending physician or prescribing practitioner for further orders. The audit will be completed by 9/3/24.

On 8/16/24 an in-service was initiated by the Staff Development nurse with all nurses and medical providers regarding PRN Psychoactive Medication Monitoring with emphasis on limiting the duration of PRN psychotropic medication use to a duration of 14 days unless the attending physician or prescribing practitioner documents the rational for the extended time in the medical record and indicates the specific duration. In-service will be completed by 9/3/24. After 9/3/24, any nurse or provider who has All newly hired nurses and/or medical providers will be in-serviced by the Staff Development Coordinator during orientation regarding PRN Psychoactive Medication Monitoring.

The Assistant Director of Nursing (ADON)

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08/06/2024. The medication was administered on 07/12/2024 and 07/25/2024.

The August MAR review revealed an order for Ativan 0.5 mg as needed 06/20/2024 and discontinue 08/06/2024. The medication was administered on 08/03/2024.

The care plan dated 08/12/2024 had a focus of problematic way resident acts characterized by ineffective coping due to anxiety.
An interview was conducted with the PC on 08/16/2024 at 9:53 AM. The PC stated she performed monthly medication reviews on Resident #34 and was aware of the Ativan 0.5 mg PRN order and had sent the facility the summaries from June and July to make them aware that the drug needed a 14 day stop date.

An interview was conducted with the Director of Nursing (DON) on 08/16/2024 at 12:05 PM. The DON stated he was aware of Resident #34 having Ativan 0.5 mg PRN from 06/20/2024 to 08/06/2024. He explained it did not have a 14 day stop date and realized it should have had a stop date and the medication was discontinued on 08/06/2024. He also stated he did have summaries from the pharmacy consultants, and it was missed due to an oversite. They have an audit for all medications to avoid this from happening again.

A telephone interview with Nurse Practitioner (NP) was conducted on 08/16/2024 at 12:28 PM. The NP stated she tried to give a 14 day stop date for all psychotropic medications. The order slipper through the cracks and in the future, she would create a template with all the residents PRN psychotropic medication orders to make

F 758

and/or the Quality Assurance (QA) nurse will audit 10% of all residents to include resident # 34 with new orders for PRN psychotropic medications weekly x 4 weeks then monthly x 1 month utilizing a Psychoactive Medication Audit Tool . This audit is to ensure that the duration of the psychotropic medication is limited to 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time in the medical records. The QA nurse, and/or Assistant Director of Nursing (ADON) will obtain a clarification order from the physician and retrain the nurse for any identified areas of concerns during the audit.

The DON will present the findings of the Psychoactive Medication Audit Tool to the Quality Assurance (QA) committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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F 758	Continued From page 9 sure their orders had 14 day stop dates. An interview with the Administrator was conducted on 08/16/2024 at 12:53 PM. The Administrator stated he was made aware that Resident #34 had a PRN medication without a stop date of 14 days. He stated he wanted his staff to follow the regulations and make sure if there is a PRN medication to have a stop dated within 14 days.	F 758		