DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>). 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345150	B. WING			05	/12/2016
NAME OF P	ROVIDER OR SUPPLIER	I		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
KENANS	/ILLE HEALTH & REHAB	II ITATION CENTER		209	BEASLEY STREET		
				KE	NANSVILLE, NC 28349		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 278 SS=E	ACCURACY/COORE	SSMENT DINATION/CERTIFIED	F 2	278			6/8/16
	resident's status.						
	A registered nurse mi each assessment wit participation of health						
	A registered nurse mi assessment is compl	ust sign and certify that the eted.					
		completes a portion of the n and certify the accuracy of sessment.					
	willfully and knowingly false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingly to certify a material a	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each					
	Clinical disagreemen material and false sta	t does not constitute a tement.					
LABORATORY	by: Based on record rev facility failed to accur Minimum Data Set (M residents (Residents #3, #40 and #106). The findings included	is not met as evidenced iew and staff interview the ately assess section I on the IDS) for 8 of 16 sampled #32, #11, #57, #44,# 138, : SUPPLIER REPRESENTATIVE'S SIGNATURE	=		Section I of Minimum Data Set (MDS reviewed and amended for residents #11, #57, #44, #138, #3, #40, and #10 The modified MDS assessments were transmitted on 5/19/20.	#32, 16.	(X6) DATE

Electronically Signed

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.

05/23/2016

PRINTED: 05/24/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) D	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	A. BUILDING		
		345150	B. WING			05/12/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP (	CODE	
KENANSVILLE HEALTH & REHABILITATION CENTER				209 BEASLEY STREET KENANSVILLE, NC 28349		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 278	Example 1 Resident # 32 was a diagnoses of asthma disease (GERD), and A review of the most Data Set (MDS) date revealed for active di not have asthma, GE A review of her May administration record received Spiriva 18 r prescribed on 3/29/1 mcg every day presc Resident #32 receive for GERD prescribed Lipitor 10 milligrams on 3/29/16 for hypert On 5/12/16 10:20 AM Resident #32 was re active diagnoses of a hyperlipidemia. On 5/12/16 at 10:35 (DON) stated the ME The DON stated she and she was not awa active diagnoses we	dmitted on 3/29/16 with , gastroesophageal reflux d hyperlipidemia. recent admission Minimum d 4/12/16 under Section I agnoses Resident #32 did ERD or hyperlipidemia listed. 2016 medication I revealed Resident #32 nicro grams (mcg) every day 6 and received Proair 90 ribed on 3/29/16 for asthma. ed Protonix 40 mg every day on 3/29/16. She received (mg) at bed time prescribed ipidemia. I the pharmacist stated ceiving medications for the	F 278	<ul> <li>Section I of the most currereviewed by the Director of licensed RNs to ensure al diagnosis are listed on ME in-house residents. Any dilisted will be added by the Management Director(RCI assessments will be modified transmitted by 4/8/2016.</li> <li>On 5-19-2016 the Resident Management Director (RCI assessments) will be modified transmitted by 4/8/2016.</li> <li>On 5-19-2016 the Resident Management Director (RCI assessments) will be modified transmitted by 4/8/2016.</li> <li>On 5-19-2016 the Resident Management Director (RCI assessments) will be modified transmitted by 4/8/2016.</li> <li>Section I Section The Resident Care Management (DDCM active diagnosis in Section The Resident Care Manage (RCMD) will in-service Director of the section I by 5</li> <li>5 MDS will be randomly set section I review weekly times 4 wee monthly times 2 months.</li> <li>The Director of Nursing will of reviews to Quality Assurements.</li> </ul>	f Nursing and I active DS for all iagnosis not Resident Care MD). The MDS fied and at Care MD) was Director of I) on coding I. ement Director ector of Nursing ng active /23/16. elected for nes 4 weeks, ks, then II report findings rance &	
	that she had identified diagnoses were not a the MDS Coordinato that were in the disch	M the Administrator stated d that the reason the active under section I was because r only coded the diagnoses narge summary. Any ded a supporting diagnoses on I.		Performance Improvement committee monthly times 4 QAPI committee will evalu develop additional interver needed to ensure continue	ate results and months. The ate results and	
	The MDS Coordinate	or was unavailable for				

Facility ID: 923212

If continuation sheet Page 2 of 9

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY	
IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		CON	IPLETED	
	345150		B. WING		0	5/12/2016
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD	E	
KENANSVILLE HEALTH & REHABILITATION CENTER         (X4) ID         SUMMARY STATEMENT OF DEFICIENCIES				09 BEASLEY STREET ENANSVILLE, NC 28349		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
PREFIX TAG       (EACH DEFICIENCY I REGULATORY OR LS         F 278       Continued From page 2 Example 2 Resident #11 was adm diagnoses of hypertens hyperplasia (BPH) and disease (GERD).         A review of the most re Data Set (MDS) dated revealed for active diagnot not have hypertension, A review of Resident # administration record re 40 milligrams (mg) by r prescribed on 4/7/15 for received Flomax .4 mg mouth daily prescribed Resident #11 received capsule by mouth twice 8/5/15 for GERD.         On 5/12/16 at 10:35 AM (DON) stated the MDS The DON stated she di and she was not aware active diagnoses were MDS.         On 5/12/16 at 3:31 PM that she had identified diagnoses were not un- the MDS Coordinator of that were in the dischar		Imitted on 4/7/15 with Insion, benign prostatic ad gastroesophageal reflux recent annual Minimum d 2/24/16 under Section I agnoses Resident #11 did in, BPH or GERD listed. #11's May 2016 medication I revealed he received Lasix y mouth every day for hypertension. He ag extended release by ed on 4/7/15 for BPH. d Omeprazole 20 mg 1 ice a day prescribed on AM the Director of Nursing DS Coordinator was out sick. did not complete the MDS are that Resident #11 's re not under section I in the M the Administrator stated d that the reason the active under section I was because r only coded the diagnoses marge summary. Any ded a supporting diagnoses	F 278			
	The MDS Coordinate interview during the s	or was unavailable for survey process.				
	Example 3					

Facility ID: 923212

If continuation sheet Page 3 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345150	B. WING			05/	12/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
KENANS	/ILLE HEALTH & REHAB	ILITATION CENTER			09 BEASLEY STREET KENANSVILLE, NC 28349		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	3	F	278			
	(MDS) dated 4/16/16	ocument Resident #57 had					
	for the month of April Resident #57 receive	tion Administration Record 2016 documented that d Phenytoin (Dilantin) 100 lease capsule prescribed on					
	Administrator stated t	n 5/12/16 at 3:31 PM the hat the problem was that the y coded the diagnoses that summary.					
	The MDS Coordinato interview during the s						
	11/3/15 with a diagno Review of the Admiss (MDS) Assessment d recent Quarterly MDS (Active Diagnosis) did #44 had an active dia Review of the Medica for the month of May #44 received Atorvas taking one tablet by n for Hyperlipidemia. During an interview w on 05/12/2016 10:32 understanding that ar	mitted to the facility on sis of Hyperlipidemia. sion Minimum Data Set ated 11/20/15 and the most dated 4/20/16 Section I d not document Resident ignosis of Hyperlipidemia. tion Administration Record 2016 documented Resident tatin Calcium 20 milligrams nouth every night at bedtime with the Director of Nursing AM she stated that she was by medication or treatment a g needed to be listed under					

Facility ID: 923212

If continuation sheet Page 4 of 9

PRINTED: 05/24/2016

		MEDICAID SERVICES				0.0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345150	B. WING		05	5/12/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KENANS	/ILLE HEALTH & REHAB	ILITATION CENTER		209 BEASLEY STREET KENANSVILLE, NC 28349		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 278	the Active Diagnosis and realize this was mparticipate in the MDS During an interview of Administrator stated the MDS Coordinator only were in the discharge The MDS coordinator only were on the diagnose of the Admiss (MDS) Assessment of MDS dated 4/15/16 u Diagnoses) did not in GERD, Hypokalemia Review of the Medica for the month of Marc 2016 documented the given: Prilosec 20mil for GERD and Lovast at bedtime for hyperc 10millequivalents by the Hypokalemia. During an interview wo on 5/12/2016 10:32 A understanding that an	Section I. She stated she did ot being done as she did not S process. n 5/12/16 at 3:31 PM the hat the problem was that the y coded the diagnoses that summary. r was unavailable for urvey process. dmitted to the facility on es including eflux (GERD), Hypokalemia	F 27	8		

If continuation sheet Page 5 of 9

			0.00		OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345150	B. WING		05/12/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
KENANS	/ILLE HEALTH & REHAE	BILITATION CENTER		209 BEASLEY STREET KENANSVILLE, NC 28349	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 278	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL G REGULATORY OR LSC IDENTIFYING INFORMATION)		F 2		
	Administrator stated	on 5/12/16 at 3:31 PM the the problem was that the ly coded the diagnoses that			

Facility ID: 923212

If continuation sheet Page 6 of 9

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(12) 0 470	E SURVEY
	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	A. BUILDING		PLETED
		345150	B. WING		05	/12/2016
NAME OF P	ROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
KENANS	/ILLE HEALTH & REHAE	BILITATION CENTER		209 BEASLEY STREET KENANSVILLE, NC 28349		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 278	Continued From pag		F 278			
		e summary. Any medications rting diagnoses were not				
		et (MDS) Coordinator was view during the survey				
	Example #7					
	on 3/29/16, with diag Gastroesophageal D Hypertension and De Review of the 5 day 6 (MDS) dated 5/1/16 d Diagnoses) did not ir Gastroesophageal R Anemia, Hypertensio addition the Admissio dated 4/5/16 under S	isease (GERD), Anemia, epression. Quarterly Minimum Data Set under Section I, (Active aclude the diagnoses of eflux Disease (GERD), n and Depression. In on Minimum Data Set (MDS) ection I (Active Diagnoses) oesophageal reflux disease				
	Review of the Medication Administration Records (MAR) for April, 2016 and May, 2016, documented the following medications were given: Omeprazole 20mgs.,daily for Gastroesophageal Reflux Disease, prescribed on 4/25/16, Ferrous Sulfate 325 (65) mg tablet for Feosol 325 mgs., twice daily, for Anemia, prescribed on 4/25/16, Atenolol 25mg tablet for Tenormin, 0.5 tablet (12.5mg) daily, used for Hypertension, prescribed on 4/25/16, Amlopidine Besylate 5mg. tablet for Norvasc, daily, used for Hypertension, prescribed on 4/25/16 and					

If continuation sheet Page 7 of 9

S FOR MEDICARE &		0/0) 1/1		OMB NO. 093	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345150	B. WING		05/12/20	016
ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
/ILLE HEALTH & REHAB	BILITATION CENTER				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE CON	(X5) IPLETIO DATE
During an interview of Administrator stated if MDS Coordinator onl were in the discharge that needed a suppor under section I. The Minimum Data S not available for inter process. Example #8 Resident #106 was of facility on 3/24/16 wit Hypertension, Gastro (GERD), Hypokelemi Review of the Admiss (MDS) dated 3/31/16 Data Set (MDS) date (Active Diagnoses) di of Hypertension, Gas Disease (GERD), Hyp Review of the Medica (MAR) for April, 2016 documented the follo given: Potassium Chl K-dur, twice daily for 3/24/16, Mirtazapine coated, at bedtime fo 3/24/16, Omeprazole daily for Gastroesoph	n 5/12/16 at 3:31 PM the the problem was that the y coded the diagnoses that a summary. Any medications thing diagnoses were not the (MDS) Coordinator was view during the survey riginally admitted to the h diagnoses including besophageal Reflux Disease a and Insomnia. sion Minimum Data Set and the thirty day Minimal d 4/23/16 under Section I id not include the diagnoses troesophageal Reflux pokelemia and Insomnia. ation Administration Records and May, 2016, wing medications were loride 10 meq tablets for Hypokalemia, prescribed on 15mg. tablet for Remeron r insomnia, prescribed on 20mg. capsule for Prilosec, nageal Reflux Disease,	F 278			
	ROVIDER OR SUPPLIER /ILLE HEALTH & REHAE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page During an interview of Administrator stated f MDS Coordinator onl were in the discharge that needed a suppor under section I. The Minimum Data S not available for inter process. Example #8 Resident #106 was of facility on 3/24/16 witt Hypertension, Gastro (GERD), Hypokelemi Review of the Admiss (MDS) dated 3/31/16 Data Set (MDS) date (Active Diagnoses) d of Hypertension, Gas Disease (GERD), Hy Review of the Medica (MAR) for April, 2016 documented the follo given: Potassium Chi K-dur, twice daily for 3/24/16, Mirtazapine coated, at bedtime for 3/24/16, Omeprazole daily for Gastroesoph	OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         345150         ROVIDER OR SUPPLIER         //ILLE HEALTH & REHABILITATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 7         During an interview on 5/12/16 at 3:31 PM the Administrator stated the problem was that the MDS Coordinator only coded the diagnoses that were in the discharge summary. Any medications that needed a supporting diagnoses were not under section I.         The Minimum Data Set (MDS) Coordinator was not available for interview during the survey process.	OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE         CORRECTION       345150       8. WING         B. WING       345150       8. WING         ROVIDER OR SUPPLIER       345150       8. WING         //LLE HEALTH & REHABILITATION CENTER       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 7       F 278         During an interview on 5/12/16 at 3:31 PM the Administrator stated the problem was that the MDS Coordinator only coded the diagnoses that were in the discharge summary. Any medications that needed a supporting diagnoses were not under section I.       F 278         The Minimum Data Set (MDS) Coordinator was not available for interview during the survey process.       Example #8         Resident #106 was originally admitted to the facility on 3/24/16 with diagnoses including Hypertension, Gastroesophageal Reflux Disease (GERD), Hypokelemia and Insomnia.         Review of the Admission Minimum Data Set (MDS) dated 3/31/16 and the thirty day Minimal Data Set (MDS) dated 4/23/16 under Section 1 (Active Diagnoses) did not include the diagnoses of Hypertension, Gastroesophageal Reflux Disease (GERD), Hypokelemia and Insomnia.         Review of the Medication Administration Records (MAR) for April, 2016 and May, 2016, documented the following medications were given: Potassium Chloride 10 meq tablets for K-dur, twice daily for Hypokalemia, prescribed on 3/24/16, Mirtazapine 15mg. tablet for Remeron coated, at bedtime for insomnia, prescribed on 3/2	OP DEFICIENCIES       (X1) PROVIDERSUPPLIERCLA       (X2) MULTIPLE CONSTRUCTION         A BUILDING	primericances       (x1) PROVIDERSUPPLICELA DENTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A BULLING       (x2) MULTIPLE CONSTRUCTION BULLING       (x2) MULTIPLE CONSTRUCTION A BULLING       (x2) MULTIPLE CONSTRUCTION BULLING       (x2) MULTIPLE CONSTRUCTION BULLING BULLING       (x2) MULTIPLE CONSTRUCTION BULLING BULLING       (x2) MULTIPLE CONSTRUCTION BULLING BULLING       (x2) MULTIPLE CONSTRUCTION BULLING       (x2) MULTIPLE CONSTRUCTION BULLING<

If continuation sheet Page 8 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/24/2016 FORM APPROVED OMB NO. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345150	B. WING		05/12/2016
NAME OF PRO	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
KENANSVI	LLE HEALTH & REHAB	ILITATION CENTER		209 BEASLEY STREET KENANSVILLE, NC 28349	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
F 278	Continued From page	8	F 27	8	
	Administrator stated t MDS coordinator only were in the discharge that needed a suppor under section I. The Minimium Data S	n 5/12/16 at 3:31 PM the he problem was that the coded the diagnoses that summary. Any medications ting diagnoses were not aet (MDS) Coordinator was view during the survey			

Facility ID: 923212

If continuation sheet Page 9 of 9