STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	C 08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

(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 survey was conducted on 08/05/19 through 08/08/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #JEP511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 08/08/19. There was a total of 2 allegations and they were unsubstantiated.	F 000		
F 641 SS=D	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 interviews the facility failed to accurately code information correctly for 1 of 18 sampled resident (Resident #8) whose Minimum Data Set (MDS) assessments were reviewed. The findings included: Resident #8 was admitted to the facility on 04/28/16. Cumulative diagnoses included dependence of renal dialysis, adult failure to thrive, osteoporosis, peripheral vascular disease, gastroesophageal reflux disease and atrial fibrillation. Review of the Quarterly Minimum Data set (MDS) dated on 04/19/19 revealed that in section H the resident was coded as having an indwelling	F 641	F641 Accuracy of Assessments For resident #8, a corrective action was obtained on 08/07/19. The specific deficiency was corrected on 08/07/19 by modifying the Minimum Data Set assessment with an ARD of 04/19/19 in order to correct the coding for H0100A (presence of indwelling catheter) in order to accurately reflect that the resident did not have an indwelling catheter at during the Assessment Reference Date lookback period. This was completed by Minimum Data Set Nurse. Corrected Minimum Data Set assessment was re-submitted to State Database in Batch #1336 on 08/07/19.	8/23/19

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

Electronically Signed | 08/23/2019

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F 641	Continued From page 1 catheter. During an observation on 08/07/19 at 9:00 AM revealed that the resident did not have an indwelling catheter. During an interview with the MDS Coordinator on 08/07/19 at 9:00 AM, stated that she made a coding error and that the Resident #8 never had an indwelling catheter. During an interview with the Director of Nursing on 08/08/19 at 10:00 AM, she stated that it is her expectation that the MDS be coded accurately. During an interview with the Administrator on 08/08/19 at 10:15 AM, he stated that it is his expectation that the MDS be coded accurately.	F 641	Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents most recent MDS assessment was completed on 08/22/2019. Each assessment was reviewed to ensure that question H0100A (presence of indwelling catheter) was accurately coded. Any MDS assessment noted with inaccurate coding of H0100A was modified and corrected. Audit results: 85 of 85 residents reviewed were noted with accurate coding of H0100A. 0 of 85 residents reviewed were noted with inaccurate coding of H0100A. Audit was completed by the facility Minimum Data Set Nurse on 08/22/2019. Systemic Changes On 08/26/19, the Regional Minimum Data Set Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the following: This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.	

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F 641	Continued From page 2	F 641	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. On 08/26/19, the Director of Nursing or designated Nurse Manager will begin auditing Minimum Data Set assessments that have been completed in order to ensure that they have been accurately coded for Section H0100A (Indwelling Catheter) using the Quality Assurance Audit Tool with the title of MDS Coding Accuracy □ H0100A (Indwelling Catheters) Quality Assurance Tool. These audits will be completed weekly for one month, and then monthly for two months to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of	

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F 641	Continued From page 3	F 641	correction; Administrator and /or Director of Nursing. Date of Compliance: 08/23/19	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to make a referral for re-evaluation after a change in mental health status for 2 of 3 sampled residents reviewed for Preadmission Screening and Resident Review(PASARR). (Resident # 7 and 16) Findings included: 1. Resident #7 was admitted to the facility on 11/30/2018. Resident # 7's neurological	F 644	F644 Coordination of PASRR and Assessments Corrective actions for Resident #7 and Resident #16 Specific deficiency for Resident #7 was resolved on 08/08/19 by the facility Social Services Director who submitted a new request for review via NCMUST. Specific deficiency for Resident #16 was	8/23/19

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F 644	Continued From page 4 diagnosis at the time of admission was dementia and she had a level I Pre-Admission Screening Resident Review (PASARR) dated 11/27/2018. The Significant change Minimum Data Set (MDS) assessment dated 4/16/2019 indicated Resident #7's cognition was severely impaired. Her active diagnoses included anxiety and psychotic disorder. Review of Resident # 7 medical record revealed a new diagnosis of anxiety was added on 4/4/2019. An observation was conducted of Resident # 7 on 8/7/2019 at 11:30 AM. There were no observed behavioral issues noted. An interview was conducted with Social Worker (SW) on 8/8/18 at 11:40 AM. SW confirmed that Resident # 7 had a level I PASARR. Resident # 7's 4/16/2019 MDS assessment that indicated the active diagnoses of anxiety and psychotic disorder were reviewed with SW. SW confirmed Resident # 7 was not admitted to the facility with the diagnoses of anxiety and psychotic disorder. She revealed she had not referred Resident # 7 to the PASARR authority for a re-evaluation related to these new diagnoses. An interview was conducted with the MDS nurse on 8/8 /19 at 1:44 PM. She stated that she was not aware that when a resident was newly diagnosed with a serious mental illness that was not present on admission that the resident needed to be referred for evaluation for level II PASARR. The MDS added that SW was responsible for making this referral.	F 644	resolved on 08/08/19 by the facility Social Services Director who submitted a new request for review via NCMUST. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of all residents who have had a new mental illness diagnosis assigned to them in the past 6 months from 02/20/2019 to 08/20/2019 in order to validate that the State Mental Health Authority was notified and a new resident review request was sent through the NCMUST system for any resident who received a new diagnosis of Severe Mental Illness or Intellectual Disability/Mental Retardation. Any resident who is identified as not having had a new request for PASARR review sent to State Mental Health Authority via NCMUST will have this completed immediately. This audit was completed by the facility Social Services Director and was completed on 08/21/2019. Audit results are: 18 of 85 residents reviewed were noted to have had new diagnosis of severe mental illness or intellectual disability/mental retardation.	

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F 644	Continued From page 5 An interview was conducted with the Director of Nursing on 8/8/19 at 2:00 PM. She stated that she was not very familiar with the regulations related to PASARR, but that she expected the regulations to be followed in reference to completing a PASARR for a newly identified mental illness diagnosis. 2. Resident # 16 was admitted to the facility on 5/1/2018. Resident # 16's neurological diagnosis at the time of admission was dementia and she had a level I Pre-Admission Screening Resident Review (PASARR) dated 4/23/2018. The Annual Minimum Data Set (MDS) assessment dated 5/9/2019 indicated Resident #16's cognition was severely impaired. Her active diagnoses included anxiety and psychotic disorder. Further it indicated the Resident # 16 was given antipsychotic medication 7 times in a week. Review of Resident # 16's medical record revealed a new diagnosis of anxiety was added on 1/8/2019. An observation was conducted of Resident # 16 on 8/7/2019 at 10:30 AM. There were no observed behavioral issues noted. An interview was conducted with Social Worker (SW) on 8/8/18 at 11:40 AM. SW confirmed that Resident # 16 had a level I PASARR. SW confirmed also that Resident # 16 was not admitted to the facility with the diagnoses of anxiety disorder. She revealed she had not referred Resident # 16 to the PASARR authority for a re-evaluation related to these new	F 644	9 of 18 residents who had new diagnoses of severe mental illness or intellectual disability/mental retardation DID have evidence of having been referred to state mental health authority for new PASARR screening via NCMUST. 9 of 18 residents who had new diagnoses of severe mental illness or intellectual disability/mental retardation DID NOT have evidence of having been referred to state mental health authority for new PASARR screening via NCMUST. 9 of 18 residents who had new diagnoses of severe mental illness or intellectual disability/mental retardation and DID NOT have evidence of having been referred to state mental health authority for new PASARR screening via NCMUST had new request for PASARR level review sent via NCMUST. This was completed by the facility Social Services Director on 08/22/2019. Systemic Changes All residents who receive a diagnosis of a Serious Mental Illness or Intellectual Disabilities/Mental Retardation have the potential to be impacted. On 08/26/2019, the Regional Minimum Data Set Consultant completed an in-service training for the facility Social Services Director and Minimum Data Set Coordinator that included the importance of thoroughly reviewing each resident□s	

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F 644	Continued From page 6 diagnosis. An interview was conducted with the MDS nurse on 8/8 /19 at 1:44 PM. She stated that she was not aware that when a resident was newly diagnosed with a serious mental illness that was not present on admission that the resident needed to be referred for evaluation for level II PASARR. The MDS added that SW was responsible for making this referral. An interview was conducted with the Director of Nursing on 8/8/19 at 2:00 PM. She stated that she was not very familiar with the regulations related to PASARR, but that she expected the regulations to be followed in reference to completing a PASARR for a newly identified mental illness diagnosis.	F 644	medical record in order to identify whether or not the resident has a diagnosis of a severe mental illness or intellectual disability/mental retardation. The education also included the importance of ensuring that the state mental health authority is notified in order to request a new review of PASARR level via NCMUST of all residents who have newly received these diagnoses and/or if these residents have a significant change in status. This information has been integrated into the standard orientation training for new Social Services Directors and Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. On 08/26/19, the Director of Nursing or designated Nurse Manager will begin auditing residents who have a diagnoses of a severe mental illness and/or intellectual disabilities/mental retardation to ensure that state mental health authority is notified via NCMUST system anytime that they have a significant change in status or are newly diagnosed with above diagnoses, using the quality assurance survey tool entitled PASARR Screening Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 644	Continued From page 7	F 644	and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: 08/23/19	
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify the PASRR office for a resident who had a significant mental health change for 1 of 4 residents reviewed for	F 646	F646 PASARR Notification with Significant Change in Condition Corrective actions for Resident #60	8/23/19

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F 646	Continued From page 8 Pre-Admission Screening and Resident Review (PASRR). (Resident #60) Findings included: A review of the PASRR level I screen dated 4/12/18 had mental health diagnoses including: Anxiety, Panic Disorder, Delusional Disorder, and Insomnia. A review of the PASRR level II determination notification dated 9/10/18 with the PASRR number ending in an "F" read: the physical and mental health needs of the above-named individual had determined the nursing facility placement is appropriate for a 90-day period. A review of the PASRR level 1 determination notification dated 12/7/18 read: PASRR number ending in an "A" and without an expiration date, did not need further screening unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. Resident #60 was re-admitted to the facility 3/5/19 with diagnoses included Anxiety Disorder, Manic Depression (Bipolar Disorder) and Psychotic disorder (other than schizophrenia). The significant change Minimum Data Set (MDS) dated 3/12/19, sections 1500 is coded: no, for consideration by the state PASRR level II process to have serious mental illness and sections A1700 and A1800 had resident codes as reentry from psychiatric hospital. The comprehensive care plan dated 6/17/19 had focuses of Resident #60 to receive Antipsychotic	F 646	Specific deficiency for Resident #60 was resolved on 08/7/19 by the facility Social Services Director who submitted a new request for review via NCMUST. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of all residents who have a mental illness and/or intellectual disability/mental retardation diagnosis assigned to them AND have had a Significant Change in Condition MDS Assessment completed during the past 6 months from 02/20/2019 □ 08/20/2019 was completed in order to validate that the State Mental Health Authority was notified and a new resident review request was sent through the NCMUST. This audit was completed by the facility RN MDS Coordinator on 08/21/2019. Audit results are: 11 of 85 residents reviewed were noted to have a diagnosis of a serious mental illness and/or intellectual disability/mental retardation AND have had a significant change in status MDS assessment completed during the past six months 02/20/19 □ 08/20/19. 2 of 11 residents reviewed who have one of the above diagnoses and who have had	

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F 646	Continued From page 9 medication Olanzapine related to diagnosis of delusional agitation with risk for adverse side effects. A review of the PASRR level I screen dated 8/7/19 had mental health diagnoses including: Anxiety/Panic Disorder, Bipolar Disorder, Delusional Disorder, Schizoaffective Disorder, Insomnia and Depression. The 08/2019 Medication Administration Record (MAR) has the following medication: Olanzapine Tablet disintegrating; 10 milligrams by mouth in the afternoon for schizoaffective disorder/bipolar. During an interview with the Social Worker (SW) on 8/08/19 at 09:58 AM, the SW stated Resident #60 had a PASRR level II in 9/10/2018 ending in "F" for a diagnosis of Delusional Disorder, she had a new diagnosis of schizoaffective Disorder when she was re-admitted on 3/5/19 and should have been re-evaluated for a PASRR level II due to a significant change in her mental health. There wasn't a PASRR II screening done when until 8/7/19. It was an oversight and audits are being done throughout the facility to check for eligible diagnosis that would need to be screened for a PASRR level II to avoid this oversight in the future. During an interview with the Director of Nursing (DON) on 08/08/19 at 10:09 AM, the DON stated when there is a mental health significant change in a resident, they should be re-evaluated for PASARR II and it wasn't done. It was missed. Going forward we are auditing all residents to make sure it is done, and the Social worker is going to go over the new diagnoses personally to assure nothing is missed.	F 646	a significant change MDS assessment completed during the past six months WERE noted to have had a request for new PASARR review sent via NCMUST. 9 of 11 residents reviewed who have one of the above diagnoses and who have had a significant change MDS assessment completed during the past six months were NOT noted to have had a request for new PASARR review sent via NCMUST. A request for new PASARR review was sent via NCMUST for all residents who did not have one completed upon completion of significant change in condition MDS assessment. This was completed by the facility Social Services Director on 08/22/2019. Systemic Changes All residents who have a diagnosis of a Serious Mental Illness or Intellectual Disabilities/Mental Retardation have the potential to be impacted. On 08/26/2019, the Regional Minimum Data Set Consultant completed an in-service training for the facility Social Services Director and Minimum Data Set Coordinator that included the importance of thoroughly reviewing each resident□s medical record in order to identify whether or not the resident has a diagnosis of a severe mental illness or intellectual disability/mental retardation.	

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F 646	Continued From page 10	F 646		

The education also included the importance of ensuring that the state mental health authority is notified in order to request a new review of PASARR level via NCMUST of all residents who have any of these diagnoses any time that they have a significant change in status MDS assessment completed.

This information has been integrated into the standard orientation training for new Social Services Directors and Minimum Data Set Coordinators.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.

On 08/26/19, the Director of Nursing or designated Nurse Manager will begin auditing residents who have a diagnoses of a severe mental illness and/or intellectual disabilities/mental retardation to ensure that state mental health authority is notified via NCMUST system anytime that they have a significant change in status MDS assessment completed using the quality assurance survey tool entitled PASARR Screening Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements.

This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be

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F 646	Continued From page 11	F 646	presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: 08/23/19	