PRINTED: 09/09/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 5012511				С
		345472	B. WING_			08/	/08/2019
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COLITHING	OOD NURSING AND RET	FIDEME		18	80 SOUTHWOOD DRIVE BOX 708		
SOUTHWO	DOD NORSING AND RE	IREME	CLINTON, NC 28328		LINTON, NC 28328		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	conducted on 08/05/1	certification survey was	E	000			
F 000	facility was found in c requirement CFR 483 Preparedness. Even INITIAL COMMENTS	3.73, Emergency t ID #JEP511.	F (000			
F 641		•	F	641			8/23/19
SS=D	CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status.						
	interviews the facility information correctly (Resident #8) whose assessments were reassessments were reassessment was admounted to the findings included Resident #8 was admounted to the findings included Resident #8 was admounted for the findings included Resident #8 was admounted for the findings included Resident #8 was admounted findings included for the findings included for	i:			F641 Accuracy of Assessments For resident #8, a corrective action was obtained on 08/07/19. The specific deficiency was corrected of 08/07/19 by modifying the Minimum Dasset assessment with an ARD of 04/19/in order to correct the coding for H0100 (presence of indwelling catheter) in order to accurately reflect that the resident dinot have an indwelling catheter at during the Assessment Reference Date lookbase period. This was completed by Minimum Data Set Nurse. Corrected Minimum Data Set assessments was re-submitted to State Database in	on ata 19 OA ler d ng ack m	
LABORATORY	resident was coded a	s having an indwelling			Batch #1336 on 08/07/19.		(X6) DATE

Electronically Signed 08/23/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345472	B. WING _				08/2019
	ROVIDER OR SUPPLIER	TIREME		18	TREET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHWOOD DRIVE BOX 708 LINTON, NC 28328	1 00/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	revealed that the resindwelling catheter. During an interview wo 08/07/19 at 9:00 AM, coding error and that an indwelling cathete During an interview wo 08/08/19 at 10:00 expectation that the Model of the object of the objec	n on 08/07/19 at 9:00 AM dent did not have an with the MDS Coordinator on stated that she made a the Resident #8 never had	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 the question H0100A (presence of indwelling catheter) was accurately coded. Any Massessment noted with inaccurate coding of H0100A was modified and corrected Audit results: 85 of 85 residents reviewed were noted with accurate coding of H0100A. O of 85 residents reviewed were noted with inaccurate coding of H0100A. Audit was completed by the facility Minimum Data Set Nurse on 08/22/201 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 in the standard orientation training for new Minimum Data Set Coordinators.	at ng DS ng	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345472	B. WING		C
	ROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328	08/08/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 641	Continued From pag	e 2	F 64	The monitoring procedure to ensure the the plan of correction is effective and to specific deficiency cited remains corrected and/or in compliance with the regulator requirements. On 08/26/19, the Director of Nursing of designated Nurse Manager will begin auditing Minimum Data Set assessment 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 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 compliance with the regulatory requirements. Reports will be presented to the weekl Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns initiated as appropriate. The weekly Quality Assurance Meeting is attended the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, He Information Manager, Dietary Manage and the Activity Director. The title of the person responsible for implementing the acceptable plan of	hat cted ry r nts for i in y e is I by

PRINTED: 09/09/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345472	B. WING				C 08/2019
	ROVIDER OR SUPPLIER DOD NURSING AND RET	[IREME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page			641	correction; Administrator and /or Director of Nursing. Date of Compliance: 08/23/19		
F 644 SS=D	Coordination of PASA CFR(s): 483.20(e)(1)(ARR and Assessments (2)	F	644			8/23/19
	pre-admission screen (PASARR) program u of this part to the max avoid duplicative testi includes: §483.20(e)(1)Incorpor from the PASARR lev PASARR evaluation r assessment, care pla care. §483.20(e)(2) Referrinal residents with new	nate assessments with the ning and resident review under Medicaid in subpart C kimum extent practicable to ing and effort. Coordination wrating the recommendations well II determination and the report into a resident's unning, and transitions of all level II residents and why evident or possible					
	related condition for le a significant change in	ler, intellectual disability, or a evel II resident review upon n status assessment. is not met as evidenced					
	Based on record revifacility failed to make after a change in mer sampled residents rescreening and Reside	iew and staff interview, the a referral for re-evaluation ntal health status for 2 of 3 eviewed for Preadmission ent Review(PASARR).			F644 Coordination of PASRR and Assessments Corrective actions for Resident #7 and Resident #16		
	(Resident # 7 and 16) Findings included:	,			Specific deficiency for Resident #7 was resolved on 08/08/19 by the facility Soc Services Director who submitted a new request for review via NCMUST.	cial	
	1. Resident #7 was ac 11/30/2018. Residen	dmitted to the facility on it # 7's neurological			Specific deficiency for Resident #16 wa	is	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345472	B. WING _				C / 08/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	700/2010
COLITHIAN	OOD NURSING AND RET	IDEME		18	0 SOUTHWOOD DRIVE BOX 708		
3001HW	DOD NUKSING AND RE	IKENIE		CL	INTON, NC 28328		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 644	Continued From page	e 4	F 6	644			
	and she had a level I	of admission was dementia Pre-Admission Screening SARR) dated 11/27/2018.			resolved on 08/08/19 by the facility Soc Services Director who submitted a new request for review via NCMUST.		
	assessment dated 4/	ge Minimum Data Set (MDS) 16/2019 indicated Resident everely impaired. Her active nxiety and psychotic			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.		
	new diagnosis of anx An observation was of	7 medical record revealed a liety was added on 4/4/2019. conducted of Resident # 7 on There were no observed ed.			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 ord to validate that the State Mental Health Authority was notified and a new residereview request was sent through the	der 1	
	(SW) on 8/8/18 at 11: Resident # 7 had a le 7's 4/16/2019 MDS a active diagnoses of a	ducted with Social Worker 40 AM. SW confirmed that vel I PASARR. Resident # ssessment that indicated the nxiety and psychotic ed with SW. SW confirmed			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		
	Resident # 7 was not the diagnoses of anxi She revealed she had	admitted to the facility with ety and psychotic disorder. I not referred Resident # 7 ority for a re-evaluation			having had a new request for PASARF review sent to State Mental Health Authority via NCMUST will have this completed immediately.		
	on 8/8 /19 at 1:44 PM not aware that when a diagnosed with a seri not present on admis	ous mental illness that was sion that the resident I for evaluation for level II added that SW was			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 have had new diagnosis of severe merillness or intellectual disability/mental retardation.	d to	

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		345472	B. WING			C 8/ 08/2019	
NAME OF P	ROVIDER OR SUPPLIER	0.0.1.2	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		0/00/2019	
NAME OF T	TO VIDER OR OUT FEEL			180 SOUTHWOOD DRIVE BOX 708	_		
SOUTHW	OOD NURSING AND RE	TIREME		CLINTON, NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 644	Continued From pag	ne 5	F 64	14			
	Nursing on 8/8/19 at she was not very fan related to PASARR, regulations to be follow	RR for a newly identified		9 of 18 residents who had nev of severe mental illness or intendisability/mental retardation D evidence of having been refermental health authority for new screening via NCMUST. 9 of 18 residents who had nev	ellectual ID have rred to state w PASARR		
	5/1/2018. Resident at the time of admiss	as admitted to the facility on # 16's neurological diagnosis sion was dementia and she mission Screening Resident lated 4/23/2018.		of severe mental illness or into disability/mental retardation D have evidence of having beer state mental health authority f PASARR screening via NCMU	ellectual ID NOT I referred to for new JST.		
	#16's cognition was active diagnoses inc disorder. Further it in was given antipsychoeek. Review of Resident:	m Data Set (MDS) /9/2019 indicated Resident severely impaired. Her luded anxiety and psychotic ndicated the Resident # 16 otic medication 7 times in a # 16's medical record nosis of anxiety was added		9 of 18 residents who had new of severe mental illness or into disability/mental retardation a have evidence of having beer state mental health authority f PASARR screening via NCMU new request for PASARR leves sent via NCMUST. This was by the facility Social Services 08/22/2019.	ellectual nd DID NOT n referred to for new JST had el review completed		
	on 8/7/2019 at 10:30 observed behavioral An interview was cor (SW) on 8/8/18 at 11 Resident # 16 had a confirmed also that F admitted to the facility anxiety disorder. Sh	nducted with Social Worker 1:40 AM. SW confirmed that a level I PASARR. SW Resident # 16 was not ty with the diagnoses of the revealed she had not 16 to the PASARR authority		Systemic Changes All residents who receive a dia Serious Mental Illness or Intel Disabilities/Mental Retardation potential to be impacted. On 08/26/2019, the Regional Data Set Consultant complete in-service training for the facil Services Director and Minimu Coordinator that included the of thoroughly reviewing each	Minimum ed an ity Social m Data Set importance		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345472	B. WING				C 08/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2019	
				18	80 SOUTHWOOD DRIVE BOX 708			
SOUTHWO	OOD NURSING AND RET	TIREME		С	LINTON, NC 28328			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 644	on 8/8 /19 at 1:44 PM not aware that when diagnosed with a seri not present on admis needed to be referred PASARR. The MDS responsible for making An interview was con Nursing on 8/8/19 at she was not very fam related to PASARR, the regulations to be followed.	ducted with the MDS nurse I. She stated that she was a resident was newly ous mental illness that was sion that the resident d for evaluation for level II added that SW was ig this referral. ducted with the Director of 2:00 PM. She stated that illiar with the regulations out that she expected the lowed in reference to R for a newly identified	F6	344	medical record in order to identify whet 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 levia NCMUST of all residents who have newly received these diagnoses and/or these residents have a significant chan in status. This information has been integrated in 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 the specific deficiency cited remains correct and/or in compliance with the regulator requirements. On 08/26/19, the Director of Nursing or designated Nurse Manager will begin auditing residents who have a diagnost of a severe mental illness and/or intellectual disabilities/mental retardation to ensure that state mental health authority is notified via NCMUST syste anytime that they have a significant change in status or are newly diagnose with above diagnoses, using the quality assurance survey tool entitled PASARI Screening Audit Tool to ensure that the plan of correction is effective and that they have a significant change in status or are newly diagnose.	der vel rif nge nto w n at nat cted ry res on m ed y Res		
					anytime that they have a significant change in status or are newly diagnose with above diagnoses, using the quality assurance survey tool entitled PASARI Screening Audit Tool to ensure that the	ed y R		

A. BUILDING C	
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345472 B. WING 08/08	8/2019
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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644 Continued From page 7 F 644 Continued From page 7 F 645 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, Suppropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit 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 F 646 SS=D F 646 SS=D F 646 SS=D F 646 F 648 SS=D F 646 F 648	8/23/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345472	B. WING _				C /08/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2019
					80 SOUTHWOOD DRIVE BOX 708		
SOUTHWO	OOD NURSING AND RET	TIREME			CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 646	Continued From page	e 8	F 6	646			
	Pre-Admission Screening and Resident Review (PASRR). (Resident #60) Findings included:				Specific deficiency for Resident #60 waresolved on 08/7/19 by the facility Soci Services Director who submitted a new	al	
_					request for review via NCMUST.	•	
	4/12/18 had mental h Anxiety, Panic Disord Insomnia.	R level I screen dated ealth diagnoses including: ler, Delusional Disorder, and	creen dated noses including: conal Disorder, and deficient potential to deficient potential		Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have th potential to be affected by the alleged	e	
	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				deficient practice.		
					A 100 % audit of all residents who have	e a	
	mental health needs				mental illness and/or intellectual		
		ined the nursing facility			disability/mental retardation diagnosis	-	
	placement is appropr	iate for a 90-day period.			assigned to them AND have had a Significant Change in Condition MDS		
	A review of the PASR	R level 1 determination			Assessment completed during the past	t 6	
		7/18 read: PASRR number			months from 02/20/2019 08/20/2019		
	_	without an expiration date,			was completed in order to validate that		
		creening unless a significant			State Mental Health Authority was notif		
	•	ne individual's status which			and a new resident review request was	3	
		of mental illness or mental ent, suggests a change in			sent through the NCMUST.	ough the NCMUST.	
	treatment needs for the	RN MDS Coordinator on 08/21/2019.		/			
	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 have a diagnosis of a illness and/or intellecture retardation AND have				Audit results are:		
					11 of 85 residents reviewed were noted	d to	
					have a diagnosis of a serious mental		
					illness and/or intellectual disability/men		
			retardation AND have had a significant				
					change in status MDS assessment		
	A1700 and A1800 ha	d resident codes as reentry			completed during the past six months		
	from psychiatric hosp	ital.			02/20/19 🗆 08/20/19.		
		care plan dated 6/17/19 had #60 to receive Antipsychotic			2 of 11 residents reviewed who have of the above diagnoses and who have		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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NAME OF D	ON (IDED OD OUDDUIED	343472	B. WING _		ATREET ADDRESS SITV STATE 7/D SODE	08/	08/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHWO	OOD NURSING AND RE	TIREME			80 SOUTHWOOD DRIVE BOX 708		
				C	CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 646	Continued From page	ge 9	F	646			
	medication Olanzan	ine related to diagnosis of			a significant change MDS assessment		
		with risk for adverse side			completed during the past six months		
	effects.				WERE noted to have had a request for	r	
					new PASARR review sent via NCMUS		
	A review of the PAS	RR level I screen dated				• •	
		ealth diagnoses including:			9 of 11 residents reviewed who have o	ne	
		der, Bipolar Disorder,			of the above diagnoses and who have		
		Schizoaffective Disorder,			a significant change MDS assessment		
	Insomnia and Depre	ession.			completed during the past six months		
					were NOT noted to have had a reques	t for	
The 08/2019 Medication Administration Recor		ation Administration Record			new PASARR review sent via NCMUS	Т.	
	(MAR) has the follow	ving medication: Olanzapine					
Tablet disintegrating; 10 milligrams by mouth in			A request for new PASARR review was	S			
	the afternoon for sch	nizoaffective disorder/bipolar.			sent via NCMUST for all residents who		
					not have one completed upon complet		
	-	with the Social Worker (SW)			of significant change in condition MDS		
		AM, the SW stated Resident			assessment. This was completed by t	ne	
		evel II in 9/10/2018 ending in			facility Social Services Director on		
		f Delusional Disorder, she			08/22/2019.		
	-	s of schizoaffective Disorder					
		mitted on 3/5/19 and should			Overtonia Observa		
		ated for a PASRR level II due			Systemic Changes		
		ge in her mental health.			All regidents who have a diagnosis of	_	
		RR II screening done when noversight and audits are			All residents who have a diagnosis of a Serious Mental Illness or Intellectual	1	
		out the facility to check for			Disabilities/Mental Retardation have the	10	
		at would need to be screened			potential to be impacted.	.0	
		to avoid this oversight in the			potential to be impacted.		
	future.	to avoid this oversight in the			On 08/26/2019, the Regional Minimum	1	
					Data Set Consultant completed an		
	During an interview	with the Director of Nursing			in-service training for the facility Social		
	_	at 10:09 AM, the DON stated			Services Director and Minimum Data S		
		ital health significant change			Coordinator that included the importan		
		nould be re-evaluated for			of thoroughly reviewing each resident		
	PASARR II and it wasn't done. It was missed. Going forward we are auditing all residents to medical record in order to identify whether or not the resident has a diagnosis of a						
	•	, and the Social worker is			severe mental illness or intellectual		
	going to go over the	new diagnoses personally to			disability/mental retardation.		
	assure nothing is mi	ssed.					

F 646 Continued From page 10 F 646 Continued From page 10 F 646 Continued From page 10 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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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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	F 646	Continued From page	ge 10	F		importance of ensuring that the state mental health authority is notified in ord to request a new review of PASARR levia NCMUST of all residents who have any of these diagnoses any time that thave a significant change in status MD assessment completed. This information has been integrated in the standard orientation training for new Social Services Directors and Minimum Data Set Coordinators. The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements. On 08/26/19, the Director of Nursing or designated Nurse Manager will begin auditing residents who have a diagnose 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 compliance with the regulatory requirements. This will be done weekly x 4 weeks and	vel eney eney ens nto w n at hat cted ry r es on m	

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