STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING _____ B. WING _____	C 10/28/2021

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GRANTSBROOK NURSING AND REHABILITATION CENTER	290 KEEL ROAD GRANTSBORO, NC 28529

(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 and complaint investigation was conducted on 10/10/21 through 10/13/21. Additional information was obtained offsite on 10/27/21 and 10/28/21. Therefore, the exit date was changed to 10/28/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZD8V11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/10/21 through 10/13/21. Additional information was obtained offsite on 10/27/21 and 10/28/21. Therefore, the exit date was changed to 10/28/21. Event ID# ZD8V11 One of the 6 complaint allegations was substantiated resulting in deficiencies.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral	F 622		11/27/21

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

Electronically Signed | 11/12/2021

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F 622	Continued From page 1	F 622		

status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:

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F 622	Continued From page 2 (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff and responsible party interviews, and record review the facility failed to allow a resident with exit seeking and aggressive behaviors to remain in the facility and failed to provide written documentation which specified the resident's needs the facility could not meet as well as the attempts made by the facility to meet	F 622	1.Other Residents: a.100% audit of all transfer and discharged residents from October 1st, 2021 through November 1st, 2021 to ensure all documentation requirements for Transfer and Discharges were met. No issues or concerns were identified.	

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F 622	Continued From page 3 those needs for 1 of 1 resident reviewed for facility initiated discharge (Resident #124). The findings included: Resident #124 was admitted to the facility on 3/1/21 with diagnoses that included dementia and emotional lability (unstable emotions). Resident #124's minimum data set assessment (MDS), a quarterly assessment dated 7/13/21, revealed severe cognitive impairment. He had delusions. Resident #124 had daily behaviors not directed towards others, rejection of care 1-3 days, and daily wandering. He required extensive assistance with two or more person assist for bed mobility and transfers. He required supervision from one person for walking and locomotion. Resident #124 received antipsychotic medication on 7 of 7 days. Resident #124's care plan, last reviewed on 6/16/21, revealed the following problem areas: - Use of psychotropic drugs related to anxiety/aggressive behaviors. This area was initiated on 3/29/21. The goal area indicated Resident #124 would show improvement in mood/behavior through the next review. The interventions, also implemented on 3/29/21 included, in part to administer medications according to physician orders. - Acts characterized by ineffective coping such as wandering and risk for unsupervised exits from the facility related to cognitive impairment and restlessness. This area was initiated on 6/14/21. The goal area indicated Resident #124 was to have no episodes of unsupervised exits from the facility through the next review. The interventions, also implemented on 6/14/21,	F 622	2.Systemic Changes: a.100% Inservice of Care Plan team members on Transfer and Discharge requirements was conducted on November 11, 2021 by Nursing Consultant. b.When a transfer or discharge may be potentially necessary, the Care Plan team, including the Medical Director, will meet to determine if the transfer or discharge is necessary for the resident□s welfare and if the resident□s needs cannot be met in the facility. c.After all transfer or discharge requirements have been met and proper documentation is in place regarding facility efforts to meet resident□s needs, a Care Plan meeting will be scheduled with the Resident and/or Resident Representative in order to discuss alternative placement. 3.Quality Assurance Monitoring: a.100% audit of all transfer and discharges from the facility will be completed by the Medical Records Manager weekly x 4 weeks and monthly x 1 month utilizing the Transfer and Discharge Audit Tool. This audit is to ensure all transfer or discharge requirements have been met per CFR (s): 483.15. b.The Administrator will review and initial the Transfer and Discharge Audit Tools to ensure completion and all areas of issues and/or concerns have been addressed. The Administrator will forward the Transfer and Discharge Audit Tool to the	

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F 622	Continued From page 4 included allow resident to wander on the unit and wander guard alarm bracelet to right ankle. A social work progress note dated 7/20/21 revealed a phone call with Resident #124's Responsible Party (RP) which discussed Resident #124's diagnoses and medical conditions and the type of facility that would be the appropriate placement for him. The RP was informed Resident #124 required a more structured environment for safety issues and quality of life. She was informed a facility with a secure unit had extended an offer of acceptance. The RP declined the alternative placement. Record review revealed a letter dated 7/21/21 that stated Resident #124 was going to discharged on 8/21/21 because of the inability of the facility to meet his needs as he needed a locked unit. The letter further stated Resident #124's responsible party was notified by telephone. A social work progress note dated 7/21/21 revealed a phone call was made to Resident #124's RP to inform her the resident required a more structured environment and another facility had extended an offer of acceptance. The RP declined the alternative placement. Record review revealed Resident #124 discharged home with his responsible party on 7/26/21. Review of Resident #124's record revealed no documentation by the Physician of specific needs the facility could not meet or facility efforts to meet those needs.	F 622	Executive QA Committee monthly x 2 months. The Executive QA Committee will review the Transfer and Discharge Audit Tools monthly x 2 months to determine trends and/or issues that may need further interventions put into place and to determine for further and/or frequency of monitoring.	

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F 622	Continued From page 5 During an interview with the social worker on 10/11/21 at 3:06 PM he stated he found placement for Resident #124 in another facility with a locked unit and Resident #124's responsible party stated rather than allow him to transfer to another facility she would take him back to his home. He stated he had not known Resident #124's RP's reasons for rejecting the alternative placement. The social worker further stated he had discussed Resident #124's behaviors with Resident #124's RP prior to 7/20/21 but had not documented those discussions in the record. An interview was conducted with Resident #124's RP on 10/28/21 at 8:20 AM. She reported she was unaware that Resident #124 was in danger of being discharged from the facility until she was contacted about the alternate placement found by the social worker on 7/21/21. She stated the alternative facility found by the social worker was not local and would have prevented her from being able to visit as she does not drive. The RP reported Resident #124 cared for Resident #124 when he returned to the home and all his needs were met. An interview was conducted with the Administrator on 10/13/21 at 10:00 AM in which she stated Resident #124's record should have reflected the facility's efforts to meet Resident #124's needs and the needs the facility were unable to meet as required by regulation.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		11/27/21

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Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility

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F 623	Continued From page 8 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and Ombudsman interviews the facility failed to include a resident's appeal rights and the Regional Ombudsman contact information on the written notice of discharge provided to the resident's responsible party and also failed to provide written notification of discharge to the Ombudsman for 1 of 2 residents reviewed for discharge (Resident #124). The findings included: Resident #124 was admitted to the facility on 3/1/21 with diagnoses that included dementia. His Minimum Data Set assessment (MDS) completed 3/8/21, an admission assessment revealed severe cognitive impairment. Record review revealed a letter dated 7/21/21 that stated Resident #124 was going to be discharged on 8/21/21 because of the inability of the facility to meet his needs as he needed a locked unit. The letter further stated Resident #124's responsible party was notified by	F 623	1.Affected Residents: a.The Regional Ombudsman was notified of the Transfer/Discharge of Resident #124. 2.Other Residents: a.100% audit was conducted of all transfer and discharged residents from October 1st, 2021, through November 1st, 2021 will be completed by the Medical Records Manager to ensure a Notice of Transfer and Discharge was provided to the resident and/or responsible party and to ensure the notice included the Resident□s Appeal Rights; the Regional Ombudsman contact information and that written notification of discharge was provided to the Regional Ombudsman. Any issues and/or concerns will be addressed. 3.Systemic Changes: a.An Inservice with the Social Services	

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telephone. The letter contained no mention of appeal rights to the discharge or the Ombudsman's contact information.

Resident #124 was discharged to his home on 7/26/21.

A phone interview was conducted with the ombudsman on 10/11/21 at 2:44PM who stated she was never notified by the facility of Resident #124's discharge. She reported she never received a copy of the letter sent to Resident #124's responsible party.

An interview was conducted with Resident #124 ' s RP on 10/28/21 at 8:20 AM. The RP stated she was not made aware of the right to appeal his discharge. She stated had she known she would have appealed the discharge. The RP stated she cared for Resident #124 when he returned home.

During an interview with the Social Worker on 10/11/21 at 3:06 PM he stated he sent the notice of discharge to the responsible party. He stated he was unaware that he should have included information regarding appeal rights to the discharge and the Ombudsman's contact information. He further indicated he was unaware a copy of the letter needed to be sent to the Ombudsman. The Social Worker stated he had found placement for Resident #124 in another facility with a locked unit and Resident #124's responsible party stated rather than allow him to transfer to another facility she would take him back to his home.

An interview was conducted with the Administrator on 10/13/21 at 10:00 AM who

Director, MDS Nurse, and Admissions Coordinator regarding Transfer and Discharge Notice requirements was conducted by the Administrator on November 5, 2021.
b.Social Services Director is now notifying the Regional Ombudsman of transfers/discharges as soon as possible after discharge or, at least, on a monthly basis.
c.Social Services Director will provide residents and/or responsible party the resident□s appeal rights, and the Regional Ombudsman contact information per the Notice of Transfer and Discharge Form.

4.Quality Assurance Monitoring:
a.100% audit of all Transfers and Discharges will be completed by the Medical Records Manager and Administrator weekly x 4 weeks and monthly x 1 month utilizing the Transfer and Discharge Audit Tool. This audit is to ensure notice requirements for all transfer or discharges have been met including written notification to Regional Ombudsman per CFR (s): 483.15.
b.The Administrator will review and initial the Transfer and Discharge Audit Tools to ensure completion and all areas of issues and/or concerns have been addressed. The Administrator will forward the Transfer and Discharge Audit Tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will review monthly x 2 months to determine trends and/or issues that may need further interventions put into place and to

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F 623	Continued From page 10 stated the Social Worker should have included all the required elements when composing the notice of discharge. The Administrator also indicated he should have notified the Ombudsman when he sent the notice of discharge. She indicated he was new in his position and was unaware of the requirements for a notice of discharge.	F 623	determine for further and/or frequency of monitoring.	
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 reviews and staff interviews the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of antipsychotic medication, diagnoses, and wander alarm for 4 of 21 assessment reviewed (Resident #35, Resident #50, Resident #16, and Resident #18). The findings included: 1. Resident #35 was admitted to the facility on 2/5/20 with diagnoses that included dementia. Her most recent Minimum Data Set (MDS) assessment dated 7/26/21 a quarterly assessment, revealed she received antipsychotic medication 7 of 7 days of the 7-day lookback period. Record review revealed Resident #35 did not receive antipsychotic medication during the 7-day lookback period. There was no physician order for a antipsychotic medication.	F 641	1.Affected Residents: a.Resident #35- most recent and completed MDS was corrected by removing the antipsychotic medication and resubmitted on October 12th 2021 by the MDS Nurse. b.Residents #50 and #18 □ most recent and completed MDS was corrected and coded for wander/elopement alarm in section P and resubmitted on October 12th, 2021 by MDS Nurse. c.Resident #16 -MDS corrected for medical diagnoses and resubmitted on November 11th, 2021 by the MDS Nurse. 2.Other Residents: a.100% audit of section N on the most recent completed MDS by the MDS Consultant and MDS Nurse to ensure accuracy of coding of residents receiving antipsychotic medications. b.100% audit of all residents by the MDS Consultant and MDS Nurse with	11/27/21

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F 641	Continued From page 11 An interview was conducted with the MDS Nurse on 10/12/21 at 2:00 PM who stated she coded antipsychotic medication for Resident #35 in error. During an interview with the Director of Nursing on 10/21/21 at 2:30 PM she stated that Resident #35's MDS assessment should have accurately reflected her medications. 2. Resident #50 was admitted to the facility on 3/01/21 with diagnoses which included hypertension and Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 8/27/21 indicated Resident #50 had severe cognitive impairment and was coded as extensive assistance or total dependence for most activities of daily living. Further review revealed Resident #50 was not coded for wander/elopement alarm in the Restraints and Alarms section of the MDS. Observation with the Director of Nursing (DON) on 10/13/21 at 9:31 AM of Resident #50 revealed she was wearing a wander/elopement alarm on her right ankle. An interview on 10/13/21 at 8:12 AM with the MDS Nurse revealed she was responsible for entering the MDS data. She stated she was told to never code a wander/elopement alarm in the P Section of the MDS. An interview on 10/13/21 at 2:06 PM with the DON revealed the wander/elopement alarm should have been coded on the MDS and she did not know why it had not been done. An interview with the Administrator on 10/13/21 at	F 641	wander/elopement alarms to ensure accuracy of coding in Section P. Any identified issues were corrected. c.100% audit by the MDS Consultant and MDS Coordinator of all admissions for the last 30 days to ensure medical diagnoses were coded accurately in section I. Any identified issues corrected. 3.Systemic Changes: a.Reeducation and additional one-on-one training by MDS Consultant with MDS Nurse with specific focus on Sections I, N and P of the Minimum Data Set. 4.Quality Assurance Monitoring: a.The MDS Nurse will audit 10% of recent and completed MDS Assessments, weekly for 4 weeks then monthly x 1 month utilizing the Section N Audit Tool to ensure accurate coding of antipsychotic medications. b.The MDS Nurse will audit 10% of the most recent and completed MDS Assessments, weekly x 4 weeks then monthly x 1 month, utilizing a Resident Wandering and Monitoring Tool to ensure any resident who has a wander/elopement alarm has been coded accurately in Section P. c.The MDS Nurse will monitor 10% of the most recent and completed MDS Assessments weekly by 4 weeks then monthly x 1 month to ensure accurate coding of medical diagnoses in Section I. This will be done utilizing the Section I Audit Tool. d.The Director of Nursing will review and initial the Section N Audit Tool, Resident	

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F 641	Continued From page 12 2:06 PM revealed Resident #50 should have been coded for a wander elopement guard on her MDS. 3. Resident #16 was admitted to the facility on 7/12/21 with diagnoses which included hypertension, depression, and hypothyroidism. The 5-day admission Minimum Data Set (MDS) dated 7/19/21 indicated Resident #16 was cognitively intact and was total dependence for most activities of daily living. Further review revealed Resident #16 was not coded for hypertension, depression, or hypothyroidism in the Active Diagnoses section of the MDS. Review of Resident #16's hospital discharge summary dated 7/12/21 revealed discharge diagnoses which included hypertension and depression. The discharge summary also contained discharge medications which included medications for hypothyroidism, hypertension, and depression. Review of Resident #16's hospital physician progress notes read in part that resident had hypertension and to continue lisinopril and hydralazine for high blood pressure. It further read that resident had depression and was on quetiapine, Wellbutrin and Lexapro. It also read that resident hypothyroidism and to continue Levoxyl. Review of Resident #16's physician orders dated 7/12/21 indicated he was prescribed the medications as recommended by the hospital discharge summary which included medications for hypertension, depression, and hypothyroidism.	F 641	Wandering and Monitoring Audit Tool, and Section I Audit Tool to ensure completion and all areas of issues and/or concerns have been addressed. The Director of Nursing will forward the Section N Audit Tool, Resident Wandering and Monitoring Audit Tool, and Section I Audit Tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will review monthly x 2 months to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or increased frequency of monitoring.	

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F 641	Continued From page 13	F 641		

An interview on 10/13/21 at 8:12 AM with the MDS Nurse revealed she was responsible for entering the MDS data. She stated she just missed the diagnoses and did not know why they had been missed. She stated the MDS should have been coded with the diagnoses.

An interview on 10/13/21 at 2:06 PM with the DON revealed Resident #16's MDS should have been coded accurately to reflect the resident's diagnoses and she did not know why it had not been done.

An interview with the Administrator on 10/13/21 at 2:06 PM revealed Resident #16's MDS should have been coded with the correct medical diagnoses.

4. Resident #18 was admitted to the facility on 12/9/2020 with diagnoses that included type 2 Diabetes Mellitus and peripheral vascular disease.

The Minimum Data Set (MDS) dated 7/9/2021 revealed Resident #18 was severely cognitively impaired and required extensive assistance with bed mobility and transfers. It indicated he used a wheelchair as a mobile device. Per the MDS the resident did not use a wanderguard.

A care plan initiated on 1/23/2021 and reviewed on 7/23/2021 focused on ineffective coping characterized by wandering and at risk for unsupervised exits from the facility. The interventions included wander guard to right lower extremity and allow to wander on the unit.

A wandering risk evaluation dated 7/23/2021 revealed Resident #18 was disoriented most of the time and wandered without the intent to leave

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F 641	Continued From page 14 the facility. It indicated he was ambulatory or self-mobile per wheelchair. The evaluation indicated Resident #18 was at risk for wandering. There were no comments in the follow up or action taken section. An observation on 10/12/2021 at 10:00 am revealed Resident #18 was resting on the bed with his leg propped up. A wander guard was on his right ankle. During an interview on 10/13/2021 at 9:52 am with the MDS Nurse she stated did not put the wanderguard on Resident #18's MDS because she thought it was only coded if it was a restraint. She stated the wanderguard should have been coded on the MDS. The Director of Nursing stated during an interview on 10/13/2021 at 11:24 am the wanderguard should have been reflected on Resident #18's MDS. She then stated the MDS Nurse was new, and she didn't know if she was aware the wanderguard needed to be coded.	F 641		
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	F 644		11/27/21

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F 644	Continued From page 15 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 interviews the facility failed to refer a resident with a diagnosis of mental illness for a Preadmission Screening and Resident Review (PASARR) evaluation for 2 of 3 residents reviewed for PASARR (Resident #35 and Resident #36). Findings included: 1. Resident #35 was admitted to the facility on 6/27/19 with diagnoses that included depressive disorder. Resident #36's medical record revealed her last referral for a PASARR screen was dated 6/25/2019 which was completed by a local hospital. A physician progress note revealed Resident #35 was diagnosed with delusional disorder on 7/23/20. Resident #35's Minimum Data Set (MDS) assessment dated 10/9/21, a quarterly assessment she was assessed as cognitively intact. She was assessed as having behavioral symptoms not directed towards others and rejection of care 1-3 days of the 7-day lookback period.	F 644	1.Affected Residents a.A PASRR was completed and submitted on November 12th, 2021 for both residents #35 and #36. 2.Other Residents: a.100% of all current residents with new physician orders that include a new diagnosis of mental illness, from October 1st, 2021 through November 1st, 2021 will be reviewed. This audit is to ensure a Preadmission Screening and Resident Review (PASRR) was completed by the Social Worker for any new mental illness diagnoses. All identified issues were corrected by the Social Worker with oversight by the Director of Nursing. 3.Systemic Changes: a.The Administrator conducted an inservice with Social Worker, MDS Nurse, and Admissions Coordinator, and Director of Nursing on November 12th, 2021 on requirements for PASRR screening. 4.Quality Assurance Monitoring: a.10% of Residents with a newly evident or possible serious mental disorder, intellectual disability, or related condition	

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F 644	Continued From page 16 A review of Resident #35's care plan last reviewed 9/21/21 revealed she was care planned for behaviors related to mental illness. The interventions included behavior management and psychiatric consult as needed. Resident #36's medical record revealed her last referral for a PASARR screen was dated 6/25/2019 which was completed by a local hospital. An interview with Social Worker #1 on 10/12/21 at 3:42 PM was conducted. He stated he was not aware that a new psychiatric diagnosis required a new referral for a PASSAR evaluation. During an interview on 10/13/21 at 11:00 AM the Administrator indicated if a new psychiatric diagnosis required a new referral to NC MUST (North Carolina Medicaid Uniform Screening Tool) then Social Worker #1 should have followed the correct referral process. 2. Resident #36 was admitted to the facility on 1/18/18 with diagnoses that included dementia. Resident #36's medical record revealed her last referral for a PASARR screen was dated 1/18/2018 which was completed by a local hospital. A review of Resident #36's diagnoses revealed on 1/1/19 she was diagnosed with delusional disorder. Resident #36's Minimum Data Set (MDS) assessment dated 7/14/21, a significant change assessment, revealed she was assessed as	F 644	to include change in mental health status will be monitored by the Director of Nursing utilizing the PASRR Audit Tool weekly x 4 weeks and then monthly x 1 month. This is to ensure that the facility submits and coordinates with the appropriate, State-designated authority, to ensure individuals with a mental disorder, intellectual disability, or a related condition to include change in mental health status receives care and service in the most integration setting appropriate to their needs. Any identified areas of concerns will be corrected during the audit by the Social Worker with oversight from the Director of Nursing to include completing a Preadmission Screening and Resident Review (PASRR). The Administrator will review and initial the PASRR Audit Tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. b.The Administrator will forward the results of the PASRR Audit tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months to review the PASRR Audit tool 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.	

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F 644	Continued From page 17 having severe cognitive impairment. She was assessed as having no behaviors during the 7-day lookback period. A review of Resident #36's care plan last reviewed 8/9/21 revealed she was care planned for psychotropic use related to depression. The interventions included to administer psychotropic medications as ordered by the physician and monitor for effectiveness of antidepressant use. An interview with Social Worker #1 on 10/12/21 at 3:42 PM was conducted. He stated he was not aware that a new psychiatric diagnosis required a new referral for a PASSAR evaluation. During an interview on 10/13/21 at 11:00 AM the Administrator indicated if a new psychiatric diagnosis required a new referral to NC MUST (North Carolina Medicaid Uniform Screening Tool) then Social Worker #1 should have followed the correct referral process.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,	F 645		11/27/21

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F 645	Continued From page 18 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified,	F 645		

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F 645	Continued From page 19 before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to initiate a screening for a level II Pre-Admission Screening Resident Review (PASRR) for 1 of 3 residents reviewed for PASSR (Resident #45). The findings included: Resident #45 was admitted to the facility 3/12/20 with diagnoses that included major depressive disorder. Review of Resident #45's level II Pre-Admission Screening Resident Review revealed an expiration date of 5/17/20. Resident #45's minimum data set (MDS) assessment dated 8/13/21 revealed Resident #45 was assessed as cognitively intact. An interview with Social Worker #1 on 10/12/21 at 3:42 PM was conducted. He stated he was	F 645	1.Affected Residents a.A Level II PASRR was completed and submitted on 10/24/2021 for Resident #45. 2.Other Residents: a.100% audit of all current residents with Level II PASRRS was conducted on 10/7/2021 by the Social Service Director to determine if resident□s had PASRRs that were expiring. This audit was to ensure residents requiring a Level II PASRR are up to date and current. An additional audit of PASSR□s was conducted on 11/12/21. All identified issues were addressed by Social Services Director. 3.Systemic Changes: a.The Administrator conducted an inservice with Social Service Director, MDS Nurse, Admissions Coordinator, and Director of Nursing on November 12th,	

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F 645	Continued From page 20 aware that Resident #45 ' s PASSR had expired prior to his employment and was working to get expired PASSRs caught up. Social Worker #1 stated he had not sent in a request for Resident #45 for a screening. During an interview with the Administrator on 10/13/20 at 11:00 AM she indicated Resident #45's level II PASSR should have been initiated prior to the expiration date with the results present in his record.	F 645	2021 on requirements for PASRR screening. 4.Quality Assurance Monitoring: a.10% audit of all residents with PASSRs will be conducted by the Social Worker to ensure that they are current and up to date by utilizing the PASRR Expiration Audit Tool, weekly x 4 weeks and then monthly x 1 month. Any identified areas of concerns will be corrected during the audit by the Social Services Director with oversight from the Administrator. The Administrator will review and initial the PASRR Expiration Audit Tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. b.The Administrator will forward the results of the PASRR Expiration Audit tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months to review the PASRR Expiration Audit tool 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 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		11/27/21

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F 655	Continued From page 21 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to complete a	F 655	1.Affected Residents: a.Resident #16□s baseline care plan was	

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F 655	Continued From page 22 baseline care plan and failed to provide a resident and/or their responsible party (RP) with a written summary of the baseline care plan for 2 of 4 residents (Resident #16 and Resident #22) reviewed for baseline care plans. Findings included: 1. Resident #16 was admitted to the facility on 7/12/21 with diagnoses which included hypertension, depression, and hypothyroidism. Review of Resident #16's hospital discharge summary dated 7/12/21 revealed discharge medications which included medications for Diabetes Mellitus and hypertension. Review of Resident #16's baseline care plan initiated 7/13/21 revealed no focus, goals, or interventions for monitoring the medical conditions of Diabetes Mellitus or hypertension. An interview on 10/12/21 11:19 AM revealed the MDS nurse she was responsible for initiation of the baseline care plan. She also stated she had not entered the medical monitoring interventions for Resident #16's medical diagnoses because she had overlooked them. A joint interview on 10/13/21 at 2:13 PM with the Director of Nursing (DON) and Administrator revealed they were unaware that Resident #16's baseline care plan had not included monitoring for his medical conditions and stated they must have gotten missed. 2. Resident #22 was admitted to the facility on 4/14/21 with diagnoses which included non-Alzheimer's dementia and cerebrovascular	F 655	updated to include medical monitoring interventions for medical diagnoses. b.Resident #22 was provided with a written copy of baseline care plan. 2.Other Residents: a.On 11/12/21, 100% audit of all admissions and/or readmissions for the past 30 days was conducted by the Social Services Director. This audit is to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and that the resident and/or resident representative was provided a copy of the care plan. All areas of concerns were immediately addressed by the Director of Nursing. 3.Systemic Changes: a.On November 12th, 2021, 100% in-service was initiated by the Administrator with all nurses, MDS Coordinator, and MDS nurse in regard to Baseline Care Plans. Emphasis includes guidelines to develop and implement a baseline care plan for each new admission and/or readmission within 48hrs that includes instructions needed to provide effective and person-centered care of the resident, minimum healthcare information necessary to properly care for a resident, and that the facility must provide the resident and their resident representative with a summary of the	

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F 655	Continued From page 23 disease. Review of the electronic medical record revealed no evidence a copy of the baseline care plan was provided to the resident and/or the RP. An interview on 10/10/21 at 2:50 PM with Resident #22 revealed she had never been provided a copy of her baseline care plan. An interview on 10/12/21 at 10:52 AM with the Social Worker (SW) revealed was he responsible for ensuring the baseline care plan was completed and a copy provided to the family. He stated he did not know he was supposed to provide a copy of the baseline care plan to the resident or the RP. He also stated he had never mailed a care plan to an RP but would provide a copy if the RP was in the facility. A joint interview on 10/13/21 at 2:13 PM with the Director of Nursing (DON) and Administrator revealed they were unaware that Resident #22's baseline care plan had not been provided to the responsible party or the resident.	F 655	baseline care plan. All newly hired will be in-serviced in regard to Baseline Care Plans during orientation. 4.Quality Assurance Monitoring: a.10% audit of all admissions and/or readmissions will be completed by the Social Worker utilizing the Baseline Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and that the resident and/or resident representative was provided a copy of the care plan. All areas of concerns will be immediately addressed by the Social Worker to include retraining of staff as indicated. The Director of Nursing will review and initial the Baseline Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns have been addressed. b.The Director of Nursing will forward the results of Baseline Care Plan Audit Tool to the Executive Quality Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Baseline Care Plan Audit Tool 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.	

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F 656	Continued From page 24	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		11/27/21

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F 656	Continued From page 25 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive, individualized care plan that addressed the areas of medications and monitoring for Diabetes Mellitus (DM), potential seizures, and hypertension (Resident #16) for 1 of 5 residents reviewed for unnecessary medications and failed to update an expired Preadmission Screening and Resident Review (PASARR) (Resident #45) for 1 of 1 residents reviewed for PASARR. Findings included: 1. Resident #16 was admitted to the facility on 7/12/21 with diagnoses which included Diabetes Mellitus (DM), post evacuation subdural hematoma, and hypertension. The 5-day admission Minimum Data Set (MDS) dated 7/19/21 indicated Resident #16 was cognitively intact and was total dependence for most activities of daily living. Review of Resident #16's hospital discharge summary dated 7/12/21 revealed discharge diagnoses which included Diabetes Mellitus, hypertension, and subdural hematoma. His discharge medications included insulin and blood sugar checks. Review of Resident #16's hospital physician progress notes read in part that resident had	F 656	1.Affected Residents: a.Resident #16 is no longer in the facility. 2.Other Residents: a.100% audit of all care plans for residents with a diagnosis for Diabetes Mellitus (DM), post evacuation subdural hematoma, and hypertension was initiated by the Director of Nursing, MDS Nurse, QI Nurse, and Unit Manager. Any care plans with areas of concerns related to medical diagnoses will be updated by the MDS Nurse with oversight from the Director of Nursing. 3.Systemic Changes: a.An inservice will be completed by the MDS Consultant and Director of Nursing with the interdisciplinary care plan team members and hall nurses: Minimum Data Set (MDS) Coordinator, Dietary Manager (DM), Social Worker (SW), Staff Facilitator, Quality Improvement Nurse, Activities Director and 100% of nurses on the requirements for completing a comprehensive care plan for each resident and to review and revise the care plan for each resident change as needed. b.The MDS Nurse was inserviced by the MDS Consultant on 11/11/21 regarding the importance of ensuring all medications are accurately coded on all MDS	

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F 656	Continued From page 26 hypertension and to continue lisinopril and hydralazine medications for high blood pressure. It also read that the resident recently had a subdural hematoma and was prescribed Keppra for seizures prophylaxis. Review of Resident #16's physician orders dated 7/12/21 indicated he was prescribed the medications as recommended by the hospital discharge summary which included medications for hypertension, DM, and seizure prophylaxis. Review of the comprehensive care plan for Resident #16 last revised on 7/21/21 revealed no care plans that addressed DM, hypertension, or potential for seizures. An interview on 10/13/21 at 8:12 AM with the MDS Nurse revealed she was responsible for entering the care plan information. She stated she just missed the diagnoses and did not know why they had been missed. She stated the care plan should have included monitoring for DM, hypertension and potential for seizures. A joint interview on 10/13/21 at 2:13 PM with the Director of Nursing (DON) and Administrator revealed they were unaware that Resident #16's comprehensive care plan had not included monitoring for his medical conditions and stated they must have gotten missed. 2. Resident #45 was admitted to the facility 3/12/20 with diagnoses that included major depressive disorder. Resident #45's minimum data set (MDS) assessment dated 8/13/21 revealed Resident #45	F 656	assessments.so that medical diagnoses are included in the resident care plan. 4.Quality Assurance Monitoring: a.10% audit of all resident□s care plans with a diagnosis for Diabetes Mellitus (DM), post evacuation subdural hematoma, and hypertension by the Director of Nursing to ensure that the care plans accurately reflect the residents utilizing the Care Plan Audit Tool. The interdisciplinary care plan team members or hall nurses will be retrained, and the care plan will be revised immediately by DON for any identified areas of concern. The Administrator will review and initial the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. b.The Director of Nursing will present the findings of the Care Plan Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Care Plan Audit Tool 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 656	Continued From page 27 was assessed as cognitively intact. Record review revealed Resident #45 had been seen by a mental health nurse practitioner and a psychologist thirty-four times since admission to the facility with the last visit being on 9/30/21. Review of the comprehensive care plan for Resident #45 which was updated 8/12/21 revealed no mention of his mental health visits with the mental health nurse practitioner and psychologist. An interview was conducted with the MDS Nurse on 10/12/21 at 3:42 PM who stated she was unaware mental health services provided to a resident by a contracted provider needed to be included on the care plan. During an interview on 10/13/21 at 11:00 AM the Administrator indicated all relevant services should be included on the comprehensive care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		11/27/21

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F 657	Continued From page 28 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, and record review the facility failed to update a care plan for allergies for 1 of 1 resident (Resident #69) reviewed for pain management. Findings included: Resident #69 was originally admitted on 7/15/2016 and readmitted on 11/30/2020 with diagnoses that included fracture of the left femur with routine healing. A nursing note written by Nurse #1 dated 8/11/2020 was to discontinue Tylenol and non-steroidal anti-inflammatory drug (NSAIDS). A review of allergies in the electronic record revealed Tylenol and NSAIDS were marked resolved. The careplan initiated on 12/14/2020 and reviewed on 9/14/2021 focused on allergies to tetracycline, Tylenol, Non-steroidal	F 657	1.Other Residents: a.100% audit was initiated of all current resident care plans with listed allergies by the Director of Nursing (DON). Any identified areas of concerns will be corrected by the MDS Nurse and Unit Manager during the audit. 2.Systemic Changes: a.An in-service will be conducted by the MDS Consultant with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Staff Facilitator, Social Worker, MDS nurses and hall nurses in regard to developing, implementing and revising a comprehensive care plan that reflects accurate and current allergies. Any newly hired DON, ADON, Unit Manager, SW, MDS Nurse or hall nurse will be educated by the Staff Facilitator during orientation in regard to developing, implementing and	

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F 657	Continued From page 29 anti-inflammatory drugs (NSAIDS), and steroids. The interventions included administer medications as prescribed and observe for signs and symptoms of allergic reactions. A Minimum Data Set (MDS) dated 9/11/2021 revealed Resident #69 was mildly cognitively impaired. During an interview with Resident #69 on 10/12/2021 at 10:00 am he stated he was not allergic to Tylenol or ibuprofen. He then stated that he took ibuprofen daily and it helped his pain. A review of Resident #69's Medication Administration Record revealed he took an as needed NSAID (ibuprofen) daily for pain. On 10/13/2021 at 9:52 am during an interview the MDS Nurse stated she was unaware the Tylenol and NSAID allergies were resolved. She stated the nurses could have updated the careplan to reflect the changes. The MDS Nurse then stated the careplan should have been updated. During an interview with the Director of Nursing on 10/13/2021 at 11:24 am she stated the careplan should have been updated to reflect the resolution of the Tylenol and NSAID allergies. The Administrator stated on 10/13/2021 at 12:00 pm during an interview the MDS Nurse should have looked at Resident #69's careplan to make sure it was updated.	F 657	revising a comprehensive care plan that reflects accurate and current allergies. Completion date of in-service will be November 17th, 2021. 3.Quality Assurance Monitoring: a.10% of residents care plans will be audited to ensure the resident has a comprehensive care plan that reflects accurate and current allergies utilizing a Care plan audit tool by the MDS Nurse and Unit Manager weekly X 4 weeks then monthly X 1 month. Any identified areas of concerns will be corrected by the Director of Nursing during the audit. The Director of Nursing will review and initial the Care plan Audit Tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. b.The Director of Nursing will forward the results of the Care Plan Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the Care Plan Audit Tool 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 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration.	F 835		11/27/21

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F 835	Continued From page 30 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have effective processes and systems in place for training of a new social work employee. Findings included: A. Cross refer to F622: Based on staff and responsible party interviews, and record review the facility failed to allow a resident with exit seeking and aggressive behaviors to remain in the facility and failed to provide written documentation which specified the resident's needs the facility could not meet as well as the attempts made by the facility to meet those needs for 1 of 1 resident reviewed for facility initiated discharge (Resident #124). B. Cross refer to F623: Based on record reviews, staff, and Ombudsman interviews the facility failed to include a resident's appeal rights and the Regional Ombudsman contact information on the written notice of discharge provided to the resident's responsible party and also failed to provide written notification of discharge to the Ombudsman for 1 of 2 residents reviewed for discharge (Resident #124). C. Cross refer to F661: Based on record reviews and staff interviews the facility failed to complete a recapitulation of stay for 1 of 1 resident reviewed for a planned discharge to the	F 835	The current Social Services Director is being retrained and will receive ongoing training on Social Services duties and responsibilities from experienced Social Service Director. Focus on training will be on Transfer/Discharges, PASARRs, and Care Plan regulations. The current Social Service Director is currently in the midst of switching employee roles in facility. The Social Service Director position will be listed on Indeed once position becomes available. A comprehensive training program will be initiated for newly-hired Social Service Director. The comprehensive training program will include oversight from Regional Nursing Consultant.	

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F 835	Continued From page 31 community (Resident #124). During an interview with the Director of Nursing (DON) on 10/21/21 at 2:30 PM she stated the facility social worker was new to his position and she had tried to assist him as she was available. She reported the Staff Development Coordinator and the Minimum Data Set Nurse were also new in their positions and she was also training those staff as well. The DON stated it was difficult to assist all three staff in learning their positions. An interview was conducted with the Administrator on 10/13/21 at 10:00 AM who stated the Social Worker was new in his position and was still learning how to complete his assigned duties. The Administrator stated she had resigned her position and would be working with a new company with a more comprehensive staff training program.	F 835		