

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345267</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/28/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>BLADEN EAST HEALTH AND REHAB, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>804 S POPLAR STREET</b> <b>ELIZABETHTOWN, NC 28337</b>	
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E 000	Initial Comments	E 000		
F 000	An unannounced Recertification survey was conducted on 10/25/2021 through 10/28/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #TR1N11.	F 000		
F 641 SS=D	INITIAL COMMENTS  A recertification and complaint investigation was conducted from 10/25/2021 through 10/28/2021. Event ID#TR1N11.  3 of the 27 complaint allegations were substantiated but did not result in a deficiency.  Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of level II Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident (Resident # 12) identified as PASRR Level II.  Findings included:  Resident #12 was admitted to the facility on 10/23/17 and most recently readmitted on 2/26/21 after hospitalization with multiple diagnoses that included schizophrenia, anxiety, depressive episodes, and psychosis.  Record review indicated Resident #12 had a	F 641	11/22/21	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE
Electronically Signed				11/12/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	Continued From page 1 Preadmission Screening and Resident Review (PASRR) Level II Determination Notification dated 5/02/19.  The annual MDS assessment dated 8/24/21 was left blank to question A1500 which asked if Resident #12 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or intellectual disability or a related condition.  An interview was conducted on 10/26/21 at 2:50 PM with the Director of Nursing and the Administrator regarding PASRR II documentation. The Administrator provide a copy of the Level II PASRR Review for Resident #12. The Administrator explained it was not coded correctly due to the previous staff not being thorough in documentation. The Administrator stated until new staff is trained, PASRR reviews will be done by Administration.  An interview was conducted with the Social Worker (SW) on 10/26/21 at 3:00 PM. She explained she has only been in her position a few weeks. She stated she is learning and had not been trained on the PASRR filing for the facility. She explained the Administrator was completing the task for PASRR until she completed her training.  An interview was conducted with the MDS Nurse on 10/27/21 at 9:36 AM. The MDS Nurse was not aware of the Level II PASRR for Resident #12. The MDS Nurse stated she was new in her position and was not informed Resident #12 had a Level II PASRR.	F 641	located under miscellaneous information. MDS coordinator educated by the administrator on 11/11/21 on location of PASRR information and importance of accurate PASRR coding on MDS assessments. Administrator or Director of Nursing will review MDS assessments prior to submission to ensure accurate coding of PASRR information x one month, then randomly review 10 MDS assessments per month x 2 months. 4. The Administrator or Director of Nursing will report results of their reviews to the facility's Performance Improvement Committee monthly x 3 months for review/recommendation.		
F 644 SS=E	Coordination of PASARR and Assessments	F 644		11/22/21	

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F 644	<p>Continued From page 2 CFR(s): 483.20(e)(1)(2)</p> <p>§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:</p> <p>§483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.</p> <p>§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 staff interview and record review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) for residents with an active diagnosis of a serious mental illness for 4 of 5 resident reviewed for PASRR (Resident #54, #46, #3 and #2)</p> <p>Findings included:</p> <p>Resident #54 was admitted to the facility on 11/20/2017. A review of the facility's Diagnosis Report revealed, Resident #54 had diagnoses including major depressive disorder dated 01/03/2019, and anxiety disorder dated 01/22/2019.</p>	F 644	<p>1. Resident #54 information submitted to NCMUST for PASRR review on 11/4/21 with Level II determination given. Resident #46 information submitted to NCMUST for PASRR review on 11/4/21 with Level II determination given. Resident #3 information submitted to NCMUST for PASRR review on 11/4/21 with Level II screening halted due to dementia diagnosis being primary for this resident. Resident #3 remains with Level I determination. Resident #2 information submitted to NCMUST for PASRR review on 11/4/21 with Level II determination given. MDS assessments completed for residents #2, # 46, and #54 to reflect</p>		

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F 644	<p>Continued From page 3</p> <p>The annual Minimum Data Set (MDS) dated 10/08/2021 had resident #54 coded as cognitively intact with diagnosis including</p> <p>The comprehensive care plan dated 10/03/2021 had focus' of uses antidepressant medication Cymbalta r/t Depression and Anxiety, a mood problem r/t Disease Process Anxiety Disorder, has depression r/t facility placement.</p> <p>A review of the North Carolina Department of Health and Human Services PASRR level I determination notification dated 11/20/2017 revealed the level I screen and PASRR number already exists for the above named individual. You may use the existing PASRR number until it expires. There was no expiration date.</p> <p>A review of Resident #54's Medication Administration Record (MAR) revealed an order for Cymbalta capsule delayed Release particles 30 mg. Give one (1) capsule by mouth one time a day related to major depressive disorder, single episode, unspecified.</p> <p>An interview with the Administrator was conducted on 10/26/2021 at 1:49 PM. The Administrator stated when there is a new mental health diagnosis, the resident should be screened for a PASRR level II. The Administrator also stated they have a new Social Worker (SW) that just started and did not know why the screening had not been completed but would handle the PASRR screenings until the SW is fully trained.</p> <p>An interview with the SW was conducted on 10/26/2021 at 3:00 PM. The SW stated she had only been at the facility for a short while, was learning her role as SW and had not been trained</p>	F 644	<p>correct PASRR information and care plans were updated with recommendations from the Level II determination. Resident #3 did not require MDS assessment or care plan revision as PASRR determination did not change.</p> <p>2. Audit completed by Administrator and MDS Coordinator for all current residents <input type="checkbox"/> PASRR determination and documentation of diagnoses of serious mental disorders, intellectual disabilities or related conditions. Residents identified with these diagnoses were then audited for Level II PASRR screenings. If no Level II screening was performed, information for these residents will be submitted to NCMUST for PASRR review prior to their next scheduled MDS assessment. Changes to PASRR Level I/II determinations will be reflected as appropriate on the MDS and care plans updated to reflect recommendations from the PASRR Level II determination. Newly admitted residents will be reviewed by the Social Worker or Admissions Coordinator for presence of diagnoses of serious mental disorders, intellectual disabilities or related conditions and Level II PASRR screening. If no Level II PASRR screening performed, resident information will be submitted to NCMUST for PASRR review upon admission. Current residents with new diagnoses of serious mental disorders, intellectual disabilities or related conditions during their stay will have information submitted to NCMUST for PASRR screening and care plans updated as appropriate.</p> <p>3. Education provided by the</p>		

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F 644	<p>Continued From page 4</p> <p>on the PASRR filing for the facility. She also explained the Administrator would be completing the task until she learns the process and was as not aware of the PASRR needed to be completed when there is a new mental health diagnosis.</p> <p>2. Resident #46 was admitted to the facility on 09/20/11 with last re-entry on 1/08/20 after hospitalization. Review of Resident #46's Quarterly Minimum Data Set (MDS) dated 10/04/21 revealed Resident #46 current diagnoses included, dementia, major depressive disorder, bipolar disorder, and generalized anxiety disorder.</p> <p>Review of the PASRR Level I Determination Notification letter dated 9/20/11 revealed that "no further PASRR screening is required unless a significant change occurs with the individual's status that suggest a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions."</p> <p>Review of Resident #46's medical record revealed mental health diagnoses added. These included a diagnosis of major depressive disorder on 1/07/13, a diagnosis of anxiety disorder on 2/14/17, and a diagnosis of bipolar disorder on 4/16/19.</p> <p>An interview with the Administrator was conducted on 10/26/21 at 1:49 PM. The Administrator stated when there is a new mental health diagnosis, the resident should be screened for a PASARR level II. The Administrator also stated they have a new Social Worker (SW) that</p>	F 644	<p>administrator to Social Worker, Admissions Coordinator, and MDS Coordinator on 11/11/21 on requirements for LEVEL II PASRR screenings, identification of diagnoses of serious mental disorders, intellectual disabilities or related conditions, and facility process for managing PASRR determinations for current and new residents. Administrator or designee will maintain log of residents referred for Level II PASRR reviews. Administrator or Director of Nursing will review MDS assessments prior to submission to ensure accurate coding of PASRR information x one month, then randomly review 10 MDS assessments per month x 2 months. Administrator or Director of Nursing will review newly admitted residents weekly x 4 weeks, then monthly x 2 months to ensure Level II PASRR screenings performed as appropriate.</p> <p>4. The Administrator or Director of Nursing will report results of their reviews to the facility's Performance Improvement Committee monthly x 3 months for review/recommendation.</p>		

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F 644	<p>Continued From page 5</p> <p>just started her employment with the facility, and she would not know why the screening had not been completed. The last Social Worker was no longer employed by the facility and the Administrator did not know why the previous Social Worker did not submit the screening for Resident #46. The Administrator stated she would handle the PASARR screening process until the new SW is fully trained.</p> <p>An interview with the Social Worker (SW), was conducted on 10/26/21 at 3:00 PM. The SW stated she had only been at the facility for a short while, was learning her role as SW and had not been trained on the PASRR filing process for the facility. She also explained the Administrator would be completing the task until she learns the process. She also stated she was not aware of the PASRR needing to be completed when there is a new mental health diagnosis or change in mental health treatments.</p> <p>3. Resident #3 was admitted to the facility on 8/28/2017 with diagnoses that included major depressive disorder.</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment dated 7/19/2021 indicated Resident #3 was not currently considered by the state Level II PASRR process to have a serious mental illness. Diagnoses included depression, non-Alzheimer's dementia, anxiety, and psychotic disorder.</p> <p>Resident #3's diagnosis/history sheet dated 10/26/2021 indicated Resident #3 was diagnosed with delusional disorders on 7/9/2019, generalized anxiety disorder on 1/10/2020 and unspecified dementia without behavioral</p>	F 644			

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F 644	<p>Continued From page 6 disturbance on 4/6/2020.</p> <p>An interview with the Administrator was conducted on 10/26/2021 at 1:49 PM. The Administrator stated when there was a new mental health diagnosis, the resident should be screened for a PASRR level II. The Administrator also stated they had a new Social Worker (SW) that just started and did not know why the screening had not been completed but would handle the PASRR screenings until the SW was fully trained.</p> <p>An interview with the SW was conducted on 10/26/2021 at 3:00 PM. The SW stated she had only been at the facility for a short while, was learning her role as SW and had not been trained on the PASRR filing for the facility. She also explained that the Administrator would be completing the task until she learned the process and was not aware of the PASRR needing to be completed when there was a new mental health diagnosis.</p> <p>4.Review of Resident #2's PASRR Level I Determination Notification dated 8/20/13 indicated that "No further PASARR screening is required unless a significant change occurs within the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a charge in treatment needs for these conditions."</p> <p>Resident #2 was admitted to the facility 8/29/13 with diagnoses that included schizophrenia, generalized anxiety disorder, and unspecified psychosis.</p>	F 644			

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F 644	<p>Continued From page 7</p> <p>Resident #2's quarterly Minimum Data Set (MDS) dated 10/21/21 indicated he was cognitively intact. The MDS included diagnoses of schizophrenia, dementia, and anxiety disorder and received antipsychotic medications daily. The questions "Has the resident been evaluated by Level II PASRR?" and "PASRR conditions" were unanswered.</p> <p>Resident #2's Comprehensive Care Plan (not dated) focused on mood problems related to schizophrenia and anxiety with goals to receive antipsychotic medications at lowest effective dose and improve mood state.</p> <p>Review of Resident #2's medical record indicated a new diagnosis of schizotypal disorder dated 5/6/20.</p> <p>An interview with the Administrator was conducted on 10/26/2021 at 1:49 PM. The Administrator stated when there was a new mental health diagnosis, the resident should be screened for a PASRR level II. The Administrator also stated they had a new Social Worker (SW) that just started and did not know why the screening had not been completed but would handle the PASRR screenings until the SW was fully trained.</p> <p>An interview with the SW was conducted on 10/26/2021 at 3:00 PM. The SW stated she had only been at the facility for a short while, was learning her role as SW and had not been trained on the PASRR filing for the facility. She also explained the Administrator would be completing the task until she learned the process and was as not aware of the PASRR needing to be completed when there is a new mental health diagnosis.</p>	F 644			



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F 761 SS=D	<p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove expired medications from 1 of 2 medication rooms (Medication Room #1).</p> <p>The findings included:</p> <p>Accompanied by Nurse #1, an observation of Medication Room #1 was conducted on 10/26/21 at 10:00 AM. The observation revealed two (2) boxes of Debrox Ear Wax Removal Aid with an</p>	F 761	<ol style="list-style-type: none"> <li>Expired Debrox Ear Wax Removal Aids were removed from Medication Room #1 on 10/26/21 and disposed of.</li> <li>Director of Nursing completed audit of Medication Rooms #1 and #2 on 10/27/21 with no additional expired medications identified.</li> <li>Director of Nursing or designee will audit Medication Rooms #1 and #2 for expired medications weekly x 4 weeks,</li> </ol>	11/22/21	

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F 761	<p>Continued From page 9</p> <p>expiration date of 07/21/21. Nurse #1 confirmed the expiration date.</p> <p>During an interview with Nurse #1 on 10/26/21 at 10:05 AM, Nurse #1 stated night shift nurses check the stock medications usually, but all nurses check them if they pull from the stock supplies.</p> <p>During an interview with the Director of Nursing (DON) and the Administrator on 10/26/21 at 2:50 PM, the DON stated there should have been no expired medications in any medication room. She explained the room had been recently checked by pharmacy and nursing. She stated the expired medication got overlooked in some kind of way; but should not have been left in any medication room. She also stated it was her expectation that all expired medications be removed and disposed per the facility protocols.</p>	F 761	<p>then monthly x 2 months. Medications identified as expired will be removed when found and disposed of appropriately.</p> <p>4. The Director of Nursing will report results of the audits to the facility's Performance Improvement Committee monthly x 3 months for review/recommendation.</p>		