STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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 with complaint investigation was conducted on 11/7/22 through 11/14/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #R7YS11.	E 000		
F 000	INITIAL COMMENTS A recertification survey with complaint investigation was conducted from 11/07/22 through 11/14/22. Event ID#: R7YS11 2 of the 8 complaint allegations were substantiated resulting in deficiency. The following intake #s were investigated: NC00188987, NC00191005, NC00191242, NC00192433, NC00193004 Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/10/22 and was removed on 11/11/22. An extended survey was conducted. The Statement of Deficiencies was amended on 12/28/22 at tags F689, F805 and F867.	F 000		
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	F 656		12/12/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/07/2022

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	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 656	Continued From page 1 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 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.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 656	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to develop a comprehensive care plan to address a resident's behavior of putting non-food items in his mouth for 1 of 13 (Resident #42) residents reviewed for comprehensive care plans. Findings included: Resident #42 was admitted to the facility on 11/5/21 with diagnoses that included dementia. A physician's order dated 4/28/22 for Resident #42 indicated "remove potentially dangerous objects from resident including drinking straws" every shift included directions "resident puts objects in his mouth and chews on them." Resident #42's annual Minimum Data Set (MDS) dated 8/8/22 indicated he had severe cognitive impairment. A nursing progress note dated 8/6/22 indicated Resident #42 was found in his room chewing on his bed sheet. A nursing progress note dated 8/9/22 indicated Resident #42 was found chewing on his oxygen tubing several times. A nursing progress note dated 8/28/22 indicated Resident #42 was found in his room with a piece of plastic in his mouth. A nursing progress note dated 9/21/22 indicated Resident #42 was observed in bed chewing on his hand brace.	F 656	F 656 What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Based on observations, record review, and staff interviews, the facility failed to develop a comprehensive care plan to address a resident's behavior of putting non-food items in his/her mouth for 1 of 13 (Resident #42) residents reviewed for comprehensive care plans. Resident #42's care plan has been updated to reflect behavioral care needs for putting non-food items in their mouth. No adverse outcomes were identified. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Element # 2 All residents have the potential to be affected by the deficient practice. The District Director of Clinical Services has provided 1:1 education with the Director of Nursing, MDS Coordinators, Social Service Director on 11/10/22 related to development and implementation of a comprehensive care plan. A full house care plan audit was conducted by the MDS Coordinator and/or designee to ensure all residents with behaviors of placing non-food items in their mouth have a comprehensive care plan in place. Updates to care plans were made as necessary. What measures will be put into place or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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

F 656

Continued From page 3

Review of Resident #42's care plan did not include any information related to the behavior of chewing on non-food items and/or placing non-food items in his mouth.

An observation was made on 11/10/22 at 9:10 AM of Resident #42 in bed with breakfast tray in front of him. He had a sandwich in his left hand and a plastic sandwich bag in his mouth with the open end out of his mouth 1 inch.

During an interview on 11/10/22 at 9:15 AM, Nurse Aide (NA) #1 revealed she had provided a sandwich on his breakfast tray wrapped in a plastic sandwich bag. NA #1 indicated she was new and was not aware of Resident #42 having an order to not leave potentially dangerous objects in his room. She indicated she would find this in the care plan.

During an interview on 11/10/22 at 10:25 AM, the MDS Nurse indicated that Resident #42's behavior of putting things in his mouth was care planned but "disappeared." The MDS nurse revealed it should have been care planned.

During an interview on 11/10/22 at 3:15 PM, the Director of Nursing (DON) revealed Resident #42's behavior of putting non-food items in his mouth should have been care planned. The care plan would communicate the resident's behavior to staff and the need for supervision.

During an interview on 11/10/22 at 3:20 PM, the Administrator revealed Resident #42's behavior of putting non-food items in his mouth should have been care planned. This would communicate the behavioral issue and the need

F 656

systematic changes made to ensure the deficient practice does not recur:
Element #3
Immediate education/intervention was provided to the MDS Nurse 11/10/2022 by the District Director of Clinical Services. Education for nursing department managers was initiated and completed on 11/10/2022 by the District Director of Clinical Services. Daily observation and education will be provided by the Administrator or Director of Nursing, as necessary, to maintain compliance.
How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place:
Element #4
To ensure ongoing compliance, the MDS Nurse Manager and/or designee will audit any resident noted with behaviors of placing non-food items in their mouth, to ensure a comprehensive care plan is implemented. This will be done daily Monday through Friday for 1 Month and once a week for 2 Months. The District Director of Clinical Services and/or designee will provide education on any areas of concern.
The results of the comprehensive care plan audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months.

Compliance Date: December 12, 2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 656	Continued From page 4 for supervision to nursing staff.	F 656		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide supervision to prevent a cognitively impaired resident with a history of putting non-food items in his mouth from placing a plastic sandwich bag in his mouth for 1 of 4 residents (Resident #42) reviewed for accidents. In addition, the facility had fall interventions in place that were not effective for a resident with severly impaired cognition and poor impulse control, did not complete a root cause analysis to assist with determining new fall interventions, and did not evaluate the effectiveness of fall interventions for 1 of 3 residents (Resident #501) reviewed for falls. There was a high likelihood of Resident #42 choking on the sandwich bag resulting in serious harm, hospitalization, and/or death. Resident #501 sustained a laceration to his scalp, abrasion to his elbow, and a wound to his ear from a fall. A day later, he sustained a closed fracture of the nasal bone. Immediate Jeopardy began on 11/10/22 when	F 689	F 689 What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Based on observations, staff interviews, and records review, the facility failed to provide supervision to prevent a cognitively impaired resident with a history of putting non-food items in his mouth from placing a plastic sandwich bag in his mouth for 1 or 4 residents (Resident #42) reviewed for accidents. In addition, the facility had fall interventions in place that were not effective for a resident with severely impaired cognition and poor impulse control, did not complete a root cause analysis to assist with determining new fall interventions, and did not evaluate the effectiveness of fall interventions for 1 of 3 residents	12/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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

F 689 Continued From page 5

Resident #42 was observed with a plastic sandwich bag in his mouth alone in his room. Resident #42 had a history of putting non-food items in his mouth. Immediate Jeopardy was removed on 11/11/22 when the facility implemented a credible allegation of Immediate Jeopardy removal. The Immediate Jeopardy was lowered in scope and severity to a G (actual harm that is not immediate jeopardy). Example #2 was cited at scope and severity of G.

Findings included:

1. Resident #42 was admitted to the facility on 11/5/21 with diagnoses that included dementia with dysphagia.

A physician's order dated 4/28/22 for "remove potentially dangerous objects from resident including drinking straws" every shift included directions "resident puts objects in his mouth and chews on them."

Resident #42's annual Minimum Data Set (MDS) dated 8/8/22 indicated he had severe cognitive impairment. He required extensive assistance with eating. Resident #42 did not exhibit any behaviors for the review period.

A Care Plan revised 9/6/22 focused on Activities of Daily Living (ADL) care included a goal for Resident #42 to improve current level of function in ADL through the review date. Interventions included Resident #42 required assistance by 1 staff member to eat.

A nursing progress note dated 8/6/22 indicated Resident #42 was found in his room chewing on his bed sheet.

F 689

(Resident #501) reviewed for falls.

The plastic-wrapped sandwich provided to Resident #42 at breakfast was removed from the resident's possession. The center immediately launched an investigation into the incident when notified of the incorrect diet consistency provided to Resident #42 enclosed in a sandwich bag. The Unit Manager assessed Resident #42 for possible complications of ingestion of the plastic wrapper. No adverse findings were noted upon assessment. The attending physician was notified by the Director of Nursing at 12:05pm on 11/10/22 regarding the incident. No new orders were received as a result of the notification. The resident□s representative was notified of the incident at 12:15pm on 11/10/22 by the Unit Manager. The center documented the incident in the medical record. Resident #42 was immediately provided with the correct diet consistency and supervised during eating by a Certified Nurse Aide. Speech Therapy evaluated Resident #42 with no changes in diet consistency on November 10, 2022. The center□s Medical Director evaluated Resident #42 on 11/10/22 with no adverse findings identified. Resident #42 remains on a Pureed Diet.

Resident #42's room was evaluated by the Administrator and Director of Nursing for any other potentially hazardous item the resident could place in his mouth on 11/10/22. At the lunch and dinner meals, Resident #42 was provided the correct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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

F 689

Continued From page 6

A nursing progress note dated 8/9/22 indicated Resident #42 was found chewing on his oxygen tubing several times.

A nursing progress note dated 8/28/22 indicated Resident #42 was found in his room with a piece of plastic in his mouth.

A nursing progress note dated 9/21/22 indicated Resident #42 was observed in bed chewing on his hand brace.

An observation was made on 11/10/22 at 9:10 AM of Resident #42 alone in bed with his breakfast tray in front of him. He had a sandwich in his left hand and a plastic sandwich bag in his mouth with the open end out of his mouth 1 inch. The surveyor immediately went into the hall to get a staff member. The medication aide was standing in the hallway two doors down from Resident #42's room. The surveyor immediately asked for the medication aide to assist Resident #42. The medication aide put on gloves and pulled the sandwich bag from his mouth revealing 3 inches covered in chewed food particles. She threw the plastic bag and gloves in the trash can.

During an interview on 11/10/22 at 9:11 AM, the Medication Aide revealed Resident #42 should not have been provided a sandwich on his diet and the sandwich bag should not have been in his room.

During an interview on 11/10/22 at 9:12 AM, the Director of Nursing (DON) revealed the sandwich bag should have been removed from Resident #42's room. Resident #42 should have supervision or assistance with meals. Resident

F 689

consistency diet and was supervised while eating by a Certified Nurse Aide to ensure the resident did not place inappropriate items that could cause choking in his mouth.

As a result of the incident, a root cause analysis was conducted by the center□s interdisciplinary team on 11/10/22. It was identified that the Certified Nurse Aide did read the tray ticket and went to the charge nurse to ask if Resident #42 was allowed to eat the sandwich on his tray. The Unit Manager was aware of Speech Therapy doing trial mechanical soft diet and thought the resident was allowed to eat the sandwich since she witnessed him eating a sandwich with Speech Therapy supervision. The sandwich was not fully unwrapped; therefore, the resident was able to ingest part of the sandwich prior to it being identified. Resident #42□s care plan was updated to include supervision at all meals, ensuring items that require unwrapping or opening have the wrapper removed, and room checks every shift and PRN to identify any items that could cause choking which may be within his/her reach.

The Director of Nursing and Assistant Director of Nursing began an audit of current residents on 11/10/22 to identify those who require supervision with meals and those who have special orders for monitoring during meals. The results of the audit did not identify other residents to have special monitoring orders during meals. Those residents who need

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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

F 689 Continued From page 7

#42 usually ate in his room due to communal dining restriction due to COVID-19.

During an interview on 11/10/22 at 9:15 AM, the Nurse Aide (#1) revealed the sandwich wrapped in the sandwich bag was on Resident #42's breakfast tray. She indicated she was new and was not aware Resident #42 had an order not to leave potentially dangerous items in his room. NA #1 indicated she would find this in the Care Guide on the computer kiosk on each hall. She was aware Resident #42 needed some assistance with meals but that day he was able to feed himself. She indicated she would check in throughout the meal period.

During an interview on 11/10/22 at 9:16 AM, the Charge Nurse indicated Resident #42 had a history of putting things in his mouth and required supervision for this.

During an interview on 11/10/22 at 10:10 AM, the Speech Language Pathologist (SLP) revealed Resident #42 was able to feed himself pureed foods, but staff should be checking in with him during the meal period. Resident #42 was at risk for choking due to his dysphagia.

During an interview on 11/10/22 at 10:25 AM, the MDS Nurse indicated that Resident #42 required supervision with meals and staff should be checking on him throughout the meal period. She indicated Resident #42's behavior of putting things in his mouth was Care Planned but "disappeared." The Care Plan carries over the NA Care Guide. The MDS Nurse revealed NA #1 was new and was not familiar with which residents required supervision with meals. She would find this on her Care Guide on the computer kiosk on

F 689

supervision with meals have been identified via the MDS and care planning is in place to meet their care needs.

Resident #501 no longer resides at the facility.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Element # 2

Residents at risk for placing non-food items in their mouth or who have an order for a pureed diet have the potential to be affected by the deficient practice. An audit of all residents at risk for placing non-food items in their mouth was completed 11/10/22 by Assistant Director of Nursing. None were found to be affected.

Residents at risk for falls have the potential to be affected by the deficient practice. A 90-day retrospective audit of all falls for appropriate care plan interventions was completed 12/2/22. None were found to be affected.

What measures will be put into place or systematic changes made to ensure the deficient practice does not recur:

Element #3

Resident #42 will have supervision by a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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

F 689

Continued From page 8

each hallway.

During an interview on 11/10/22 at 3:15 PM, the DON indicated that staff should check the tray card when they provide resident trays. Staff should provide supervision and assistance to residents as needed as indicated in the Care Plan and Care Guide.

During an interview on 11/10/22 at 3:20 PM, the Administrator revealed staff should be providing supervision as indicated on the Care Plan. Staff should not have left a potentially dangerous items in Resident #42's room.

The administrator was notified of the Immediate Jeopardy on 11/10/22 at 11:45 AM.

The facility provided the following credible allegation with a completion date of 11/11/22:

Identify those recipients who have suffered, or are likely to suffer a serious adverse outcome as a result of the noncompliance:

The plastic-wrapped sandwich provided to Resident #42 at breakfast was removed from the resident's possession. The center immediately launched an investigation into the incident when notified of the incorrect diet consistency provided to Resident #42 enclosed in a sandwich bag. The Unit Manager assessed Resident #42 for possible complications of ingestion of the plastic wrapper. No adverse findings were noted upon assessment. The attending physician was notified by the Director of Nursing at 12:05pm on 11/10/22 regarding the incident. No new orders were received as a result of the notification. The resident's representative was notified of the

F 689

Certified Nurse Aide during all meals as indicated by his/her care plan and/or physician orders to help ensure he/she does not place items in his/her mouth that could cause injury, harm, or death if ingested.

On 11/10/22, the District Director of Clinical Services educated the Administrator, Director of Nursing and interdisciplinary team regarding providing appropriate levels of supervision at meal times, following diet consistency orders, and that all food items provided to the resident according to their diet order are to be unwrapped/opened prior to providing them to a resident.

One-to-one education was provided to the Dietary Manager on 11/10/22 by the District Director of Food Service on following resident meal tickets and the potential for injury related to inaccurate consistencies being served to residents. This Dietary Manager was in training and is no longer working in the center after 11/10/22. One-to-one education was provided to Unit Manager on 11/10/22 by the Director of Nursing related to not authorizing staff to serve a peanut butter sandwich to a resident on a pureed diet, providing supervision for meals when required and/or care planned to reduce the potential for injury, and following the physician�s order for removing potentially hazardous items from Resident #42�s reach due to his/her tendency to place items in his/her mouth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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

F 689 Continued From page 9

incident at 12:15pm on 11/10/22 by the Unit Manager. The center documented the incident in the medical record. Resident #42 was immediately provided with the correct diet consistency and supervised during eating by the Certified Nurse Aide. Speech Therapy evaluated Resident #42 with no changes in diet consistency on November 10, 2022. The center's Medical Director evaluated Resident #42 on 11/10/22 with no adverse findings identified. Resident #42 remains on a Pureed Diet.

Resident #42's room was evaluated by the Administrator and Director of Nursing for any other potentially hazardous item the resident could place in his mouth on 11/10/22. At the lunch and dinner meals,

Resident #42 was provided the correct consistency diet and was supervised while eating by a Certified Nurse Aide to ensure the resident did not place inappropriate items that could cause choking in his mouth.

As a result of the incident, root cause analysis was conducted by the center's interdisciplinary team on 11/10/22. It was identified that the NA #1 did read the tray ticket and went to the charge nurse to ask if Resident #42 was allowed to eat the sandwich on his tray. The Charge Nurse was aware of Speech Therapy doing trial mechanical soft diet and thought the resident was allowed to eat the sandwich since he witnessed him eating a sandwich with Speech Therapy supervision. The sandwich was not fully unwrapped; therefore, the resident was able to ingest part of the sandwich prior to it being identified. Resident #42's care plan was updated to include supervision at all meals, ensuring items that require unwrapping or

F 689 (Provider's Plan of Correction)

Education for nursing staff, including full time, part time, PRN and agency licensed nurses and Certified Nurse Aides, began on 11/10/22 by the Director of Nursing and Assistant Director of Nursing regarding the provision of appropriate levels of supervision at meal times to prevent incidents and/or injuries based on physician orders and care plan interventions, following diet consistency orders, accurately reading residents meal delivery tickets, following physician order related to removal of objects that could be considered hazardous to residents, and that all food items provided to a resident based on their ordered diet will be opened/unwrapped for resident consumption prior to providing the item to the resident. No nursing staff will be allowed to work until they have completed the education. Newly hired nursing staff will be educated on this process during orientation.

Beginning 11/10/22, random meal trays will be checked for accuracy against the meal delivery card by the Dietary Manager or assigned dietary staff member prior to leaving the kitchen and then again by a Certified Nurse Aide and/or charge nurse prior to providing to residents. Certified Nurse Aides and/or licensed nurses will provide appropriate levels of supervision during meals to each resident as indicated by their care plan to reduce the potential for injury. Daily room checks will be completed by Director of Nursing and/or designee to check for any items in room within reach of the resident that they may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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

F 689 Continued From page 10

opening have the wrapper removed, and room checks every shift and PRN to identify any items that could cause choking which may be within his/her reach.

The Director of Nursing and Assistant Director of Nursing began an audit of current residents on 11/10/22 to identify those who require supervision with meals and those who have special orders for monitoring during meals. The results of the audit did not identify other residents to have special monitoring orders during meals. Those residents who need supervision with meals have been identified via the MDS and care planning is in place to meet their care needs. The center's Medical Director was notified of the Immediate Jeopardy findings at 12:05pm on 11/10/22 by the Director of Nursing.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

Resident #42 will have supervision by a Certified Nurse Aide during all meals as indicated by his/her care plan and/or physician orders to help ensure he/she does not place items in his/her mouth that could cause injury, harm, or death if ingested.

The District Director of Clinical Services educated the Administrator, Director of Nursing and interdisciplinary team on 11/10/22 regarding providing appropriate levels of supervision at meal times, following diet consistency orders, and that all food items provided to the resident per their diet order are to be unwrapped/opened prior to providing them to a resident.

F 689

cause choking.

Mandatory education on policies and procedures related to the fall management system, which includes all nursing staff, social work, therapy, and activates will be completed by 12/12/22 by the Assistant Director of Nursing.

How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place:

Element #4

Incident or accident involving residents are monitored during Morning Clinical Meeting. If a resident is involved in an incident or accident the Clinical Management Team will ensure that proper documentation is complete per facility policy. The clinical management team will also ensure that appropriate interventions are reflected on the resident□s care plan.

The Director of Nursing and/or designee will check resident #42 room daily to ensure items that may cause choking are not within reach. To ensure ongoing compliance, the Dietary manager and/or designee will audit all mechanically altered diet trays once a day for one month then, three times per week for two months against the meal delivery card prior to leaving the kitchen. The Certified Nurse Aide and/or person passing meal tray will check the meal ticket versus the meal tray for accuracy prior to providing the meal to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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

F 689 Continued From page 11

One-to-one education was provided to the Dietary Manager on 11/10/22 by the District Director of Food Service on following resident meal tickets and the potential for injury related to inaccurate consistencies being served to residents. This Dietary Manager was in training and is no longer working in the center after 11/10/22. One-to-One education was provided to Unit Manager on 11/10/22 by the Director of Nursing related to not authorizing staff to serve a peanut butter sandwich to a resident on pureed diet, providing supervision for meals when required and/or care planned to reduce the potential for injury, and following the physician's order for removing potentially hazardous items from Resident #42's reach due to his/her tendency to place items in his/her mouth.

Education for nursing staff, including full time, part time, PRN and agency licensed nurses and Certified Nurse Aides, began on 11/10/22 by the Director of Nursing and Assistant Director of Nursing regarding the provision of appropriate levels of supervision at meal times to prevent incidents and/or injuries based on physician orders and care plan interventions, following diet consistency orders, accurately reading residents' meal delivery tickets, following physician order related to removal of objects that could be considered hazardous to residents, and that all food items provided to a resident based on their ordered diet will be opened/unwrapped for resident consumption prior to providing the item to the resident. No nursing staff will be allowed to work until they have completed the education. Newly hired nursing staff will be educated on this process during orientation.

F 689

the residents. Certified Nurse Aides and/or licensed nurses will provide appropriate levels of supervision during meals to each resident as indicated by their care plan to reduce the potential for injury.

The Director of Nursing and/or designee will complete an audit of resident falls for the last 90 days to ensure all resident□s have appropriate interventions in place. To ensure ongoing compliance the Director of Nursing and/or designee with audit daily, Monday through Friday, for 3 months, any falls to verify appropriate and effective interventions are being care planned and the IDT Post-Fall Review (UDA) is being completed. Weekly At-Risk meetings are being held with IDT to further ensure that interventions are in place and appropriate.

Compliance Date: 12/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 689	Continued From page 12 Beginning 11/10/22, all meal trays will be checked for accuracy against the meal delivery card by the Dietary Manager or assigned dietary staff member prior to leaving the kitchen and then again by a Certified Nurse Aide and/or charge nurse prior to providing to residents. Certified Nurse Aides and/or licensed nurses will provide appropriate levels of supervision during meals to each resident as indicated by their care plan to reduce the potential for injury Alleged date of immediate jeopardy removal: 11/11/22. An onsite validation was completed on 11/14/22 through staff interviews, observations, and record review. Staff were interviewed to validate in-service completion of resident supervision at meals, tray card review. Observations were made of the lunch meal on all halls with no issues observed. Documentations of Care Plan and Tray Card Audits were reviewed. The facility's credible allegation of immediate jeopardy removal was validated to be completed on 11/11/22. 2. Resident #501 was admitted to the facility on 01/26/2022 with diagnoses that inluded anxiety disorder,dementia with behavioral disturbance,osteophyte vertebrae, arthritis and cerebrovascular accident. His significant change Minimum data Set(MDS) dated 06/28/2022 indicated his cognition was severely impaired and he required extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. His MDS indicated the resident was frequently incontinent. No behaviors were noted.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 689	Continued From page 13	F 689		

Care plan initiated 02/19/2022 and updated 03/07/2022 focused on the resident had impaired cognitive function/dementia or impaired thought processes due to dementia and cognitive communication deficit. Goals included resident will improve current level of cognitive function. Interventions included engage the resident in simple, structured activities that avoid overly demanding tasks.

Fall Care plan initiated 01/28/2022 indicated the resident was at risk for falls due to sick sinus syndrome, atrial fibrillation with Cardiac Pacemaker. Goals included resident risks and injury potential will be minimized. The intervention included the following:

-assist to out of room activities of choice during waking hours as he will allow,

-be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance updated 01/28/22

-The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night, handrails on walls, personal items within reach) updated 01/28/22

-Ensure that the resident is wearing appropriate footwear or non-skid socks when ambulating or mobilizing in wheelchair. He also needs non-skid socks on when he goes to bed due to impulsiveness to stand and walk without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 689	Continued From page 14 assistance for safety updated 02/02/22 -Resident likes to get out bed early - Between 5-7 AM assist him to bathe and get dressed as he desires/will allow updated 03/10/22. Resident education to ask for assistance with care and transfers for fall prevention updated 03/16/22 -Check frequently to ensure resident's call light and urinal in within reach and encourage to use, -Ensure all frequently used items are within resident's reach updated 06/09/2022 -Ensure bed is in low position when resident is in bed updated 06/09/22 The following fall investigations from 03/27/2022 through 07/08/2022 for Resident #501 were reviewed with circumstances, and interventions: -03/27/2022- Resident #501 went in the bathroom without his walker. He was rushing and fell. The resident stated that he did not have time to wait. The report further revealed the resident had no socks or shoes on. he did not put call bell on before getting up. He had skin tear and bruise on left arm. Abrasion over right ear. It also indicated the resident landed in an almost sitting position and his briefs was wet. Treatment was provided and the physician was notified. The intervention included to remind resident to use call light and wear appropriate footwear -04/07/2022-Resident #501 attempted to transfer self to bed from wheelchair (WC) and scooted onto buttocks onto floor. No injuries noted. Resident denied pain. The physician was notified. The interventions included check frequently to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 689	Continued From page 15	F 689		

ensure resident call light and urinal within reach -

-05/12/2022-Resident #501 was found on his knees by his bed. He had no shoes or socks on. He said he had to use the bathroom. he did not call for help after he fell. the nurse was coming down the hall and saw him. The report indicated the resident had cognitive decline and he was non-compliant with wearing footwear and calling for help. Intervention included Sign by bed with" Call for help"

-05/28/2022- staff Nurse Aide (NA) #2 who was also Activity Director found resident sitting on buttocks on floor. Resident #501 said that walker had gotten away from him. Body assessment did not reveal any bruising, discoloration, swelling, open areas nor any other form of distress currently. Resident #501 did state that his lower back was little sore. The physician was notified - No new interventions put in place

-06/06/2022- Resident #501 found on floor in bedroom lying on left side beside wheelchair and discovered by NA#2. Resident #501 reports and confirm that he hit his head and that it hurts 8 out of a 10 on a 0-10 pain scale. The resident was sent out to the Emergency room and the physician was notified- interventions put in place was assist to out of room (OOR) activities of choice during waking hours as he will allow.

Review of the hospital report revealed Resident #501 was readmitted back to the facility on 06/06/2022.

Review of Resident #501 hospital discharge record dated 06/06/2022 revealed a Computer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 689	Continued From page 16	F 689		

Tomography (CT) scan was completed at the hospital. It revealed the following impression:
- No acute intracranial abnormality identified. No acute intracranial hemorrhage
- Mild posterior scalp soft tissue swelling and contusive changes. No underlying skull fractures.

-06/08/2022- Resident #501 was found lying on the floor in his room. was sitting on his bottom, holding the walker. Resident#501 stated that he was trying to walk and fell. Received skin tear on left hand, no other injuries observed at this time. The physician was notified. Interventions put in place was ensure bed is in low position when resident is in bed.

06/10/2022- Resident #501 noted on floor beside bed. The resident indicated he was coming from the bathroom-interventions placed was
-Reeducate on using call for assistance.

06/12/2022- Noted on floor in middle of room on left side-No new intervention put in place

07/02/2022- Resident #501 lost his balance and fell on his knees in the bathroom by the toilet. He has a large bruise on his right arm and has several skin tears. He had socks on with pants that were dragging the floor. First aide provided and the physician was notified. The intervention indicated was assess for possible toileting program.

07/08/2022-Resident #501 was found lying on his back on the floor under side table, 2centimenters (cm) laceration noted to right parietal scalp above right ear, 5cm skin tear to right forearm noted. The resident was assessed for injuries, first aid rendered, Emergency services was called, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 689	Continued From page 17	F 689		

the resident was transported to the Emergency department for further evaluation. The physician was notified. No new intervention put in place.

Review of the Emergency Room (ER) report dated 07/08/2022 revealed the following diagnosis: Laceration of scalp, abrasion of right elbow, open wound of right ear. The treatment included 1 suture and 4x4 sterile gauze.

Nurse note dated 07/09/2022 indicated the resident was on floor outside resident bathroom. Blood coming from nose and mouth. Dentures on floor broke in half. Called physician and obtained order to send to ER.

Review of the Emergency Room (ER) report dated 07/09/2022 revealed the anterior maxillary sinus process or the inferior nasal spine appears fragmented baby fracture. There was a question of a non-displaced left nasal bone fracture. Soft tissue swelling overlying the nose. The impression indicated anterior maxillary sinus or anterior nasal spine appears fracture. Nondisplaced left nasal bone fracture, soft tissue swelling overlying the nasal bone. ER reported indicated the diagnosis of closed fracture of nasal bone.

Observation of the resident was not completed due to the resident was no longer residing at the facility.

An interview was conducted with MDS nurse #1 on 11/09/2022 at 10:20AM. MDS nurse #1 stated after the fall on 07/02/2022, they provided the resident with a highchair toilet seat to make it easier for the resident to come in and out of the bathroom. She reported the facility did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 689	Continued From page 18	F 689		

document toileting program for Resident #501.

An interview was conducted with Charge Nurse (CN) #1 on 11/09/2022 at 11:51 AM. CN#1 indicated she was familiar with Resident #501 and the resident was on her regular facility assignment. CN #1 reported the resident was a challenge to care for due to his falls risk and the frequency of the resident's falls. CN 1 indicated she felt the resident needed constant supervision to ensure her safety is maintained. She stated the resident was confused and did not ask for assistant to use the bathroom even after he was reminded to ask for help.

An interview was conducted with Nurse #3 on 11/09/2108 at 11:56 AM. Nurse #3 indicated she was regularly assigned to Resident #501. She indicated the Nurse Aides (NAs) observed the resident closely and attempted to toilet him every 2 hours. Nurse #3 indicated the resident was always determined to use the bathroom and did not ask for help. She indicated the resident was very confused especially during the last 2 weeks before his discharge from the facility. Nurse #3 indicated the resident did not remember to ask for help and to use the call light.

An interview was conducted with the Director of Nursing (DON) on 11/10/2022 at 12:40 PM. The DON stated she was very familiar with Resident #501 and his continued falls. The DON reported the nursing staff were in serviced on falls and interventions. She stated that they did discuss resident falls in the morning meetings but currently did not have resident at risk meetings. DON added she was planning to start having resident at risk meetings soon. The DON stated the staff tried their best to prevent the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 689	Continued From page 19	F 689		

from falls, but the resident was found on the floor frequently. She reported they did not evaluate Resident #501's fall interventions for effectiveness and moving forward the plan was for at the resident at risk meetings, they will start evaluating interventions for its effectiveness. The DON stated currently there was a daily clinical meeting, and the falls were discussed with interventions reviewed. DON stated she could not present any documentation about discussion of Resident #501's falls at the morning meetings. The DON indicated the interventions should consistently be put in place. The DON acknowledged that resident was cognitively impaired and the interventions that indicated to remind the resident to use the call light and ask to use the bathroom should not have been put in place. DON reported that she did not have documentation for the toileting program assessment for Resident #501. The DON reported the expectation was for the staff to provide adequate supervision for residents and to implement appropriate interventions.

An interview was conducted with the Administrator on 11/10/2022 at 01:32 PM. The Administrator reported she was aware of Resident #501 and his continued falls. She indicated the staff made all the effort to prevent Resident #501 from falling. She indicated the expectation was to put interventions in place after each fall and to provide adequate supervision for the residents in the facility. The Administrator also indicated they will review the interventions put in place for residents at the facility to make sure they were appropriate.

During a phone interview on 11/14/2022 at 1:30PM, Nursing Assistant (NA) #2 who was also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ____ B. WING ____	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 689	Continued From page 20 the Activity Director indicated she cared for Resident #501 while he was residing at the facility. NA #2 stated she was aware of the resident's continued falls. NA # 2 indicated she observed the resident closely but sometimes she could not prevent the resident from falling because he was confused, and he tried to get to the bathroom constantly without asking for assistance.	F 689		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to staff Registered Nurse (RN) coverage for at least 8 consecutive hours a day for six (6) of the past 38 consecutive days reviewed (10/01/22, 10/02/22, 10/15/22, 10/16/22, 10/29/22, and 10/30/22). Findings included: A review of 10/01/22 through 11/07/22 staff	F 727	F 727 RN Coverage What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Based on record review and staff interviews, the facility failed to staff	12/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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

F 727

Continued From page 21

assignment sheet was conducted on 11/07/22. The assignment sheets for 10/01/22, 10/02/22, 10/15/22, 10/16/22, 10/29/22, and 10/30/22 did not indicate a registered nurse was on duty.

The daily staff posting sheets for 10/01/22, 10/02/22, 10/15/22, 10/16/22, 10/29/22, and 10/30/22 indicated no data (zero) for the RNs on duty.

An interview was conducted with the Scheduler on 11/08/22 at 1:30 PM. The Scheduler explained the staff posting sheets were correct and there was no RN coverage on 10/01/22, 10/02/22, 10/15/22, 10/16/22, 10/29/22, and 10/30/22 due to staff shortages. The Scheduler explained if she did not have enough staff to cover the call roster people would be called. The call roster included the treatment nurse (Licensed Practical Nurse (LPN), the Assistant Director of Nursing (ADON), the Director of Nursing, and the Unit Manager (an LPN). The Scheduler stated the on-call staff would come help to get pass the crisis. She was not sure if the on-call staff stayed eight consecutive hours. The Scheduler explained she had no knowledge of any RN coverage that was not noted on the daily staff posting sheets.

An interview was conducted on 11/08/22 at 2:32 PM with the Director of Nursing (DON). The Director of Nursing explained the Scheduler posted the schedules, as well as the posted staffing. The DON also explained if there were shortages, the staff tried to cover and when they do not have enough then, the on-call staff may be used. She also explained she did not remember coming to the facility for 8 consecutive hours on the dates of 10/01/22, 10/02/22, 10/15/22,

F 727

registered nurse (RN) coverage for at least 8 consecutive hours a day for six (6) of the past 38 consecutive days reviewed (10/01/22, 10/02/22, 10/15/22, 10/16/22, 10/29/22, and 10/30/22). No adverse outcomes were identified. The facility management will monitor RN coverage on a daily basis to assure that at least 8 hours of RN coverage each day.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Element # 2

All residents have the potential to be affected by the deficient practice. The District Director of Clinical Services has provided 1:1 education with the Director of Nursing, Administrator and scheduler on 11/14/22 related to ensuring 8 consecutive hours of RN Coverage is provided each day. An audit will be conducted by the Administrator and/or designee every day to ensure 8 hours of consecutive coverage is in place going forward.

What measures will be put into place or systematic changes made to ensure the deficient practice does not recur:

Element #3

The Nursing Department managers, the Administrator and the scheduler were provided mandatory education by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 727	Continued From page 22 10/16/22, 10/29/22, and 10/30/22. The DON stated moving forward she expected the regulation be followed for the RN coverage. An interview was conducted with Administrator on 11/09/22 at 4:18 PM. The Administrator stated she was aware there were some days a RN was not staffed at the facility, and they did not have a waiver for the daily RN staffing. The Administrator explained there were on-call nurses to cover the facility if needed for call outs or weekends. The Administrator stated she expected the RN position to be covered on weekends, and the facility had plans going forward for coverage with the new hires, the Assistant Director of Nursing, and/or the Director of Nursing would cover the gaps.	F 727	District Director of Clinical Services on 11/14/2022 regarding the policies and procedures related to the requirement to maintain 8 consecutive hours of RN coverage each day Ongoing observation and education will also be provided to maintain compliance, as necessary. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the Administrator and/or designee will audit daily, staffing schedules to ensure 8 consecutive hours of RN coverage is provided Monday through Friday for 3 months. On the weekends or during the week, the staff are to alert the Director of Nursing and/or the Assistant Director of Nursing in the event that there is no RN in the center. The Director of Nursing and/or the Assistant Director of Nursing will then come to the center to provide 8 hours of RN coverage. The District Director of Clinical Services and/or designee will provide education on any areas of concern. The Administrator will identify any trends of more than two days a week without RN coverage and share that trend with the Quality Assurance Performance Committee ("QAPI") during the monthly meeting or on an ad hoc basis. Compliance Date: 12/12/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 805	Continued From page 23	F 805		
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide Resident #42 with a pureed diet as ordered by the physician due to a history of difficulty swallowing when a peanut butter and jelly sandwich was served to the resident by Nurse Aide (NA) #1 and the failed to provide pureed ham of a smooth consistency for 11 of 11 residents on a pureed diet. Findings included: 1. Review of the facility's recipe for Baked Ham included instructions to prepare the ham according to the regular recipe, measure out desired number of servings into the food processor and blend until smooth using milk or broth to thin as needed. An observation occurred on 11/9/22 at 11:40 AM of the lunch meal with the regional dietary manager present. He indicated the foods on the tray line were ready for service. The pureed ham on the tray line had a chunky consistency with visible pieces of ham. The regional dietary manager confirmed it was the pureed ham. During an interview at 11/9/22 at 11:40 AM, the Regional Dietary Manager indicated that pureed	F 805	F 805 Food and Drink What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Based on observations, record review, and staff interviews, the facility failed to provide Resident #42 with a pureed diet as ordered by the physician due to a history of difficulty swallowing when a peanut butter and jelly sandwich was served to the resident by Nurse Aide (NA) #1 and the facility failed to provide pureed ham of a smooth consistency for 11 of 11 residents on a pureed diet. No Adverse outcomes were identified. The sandwich provided to Resident #42 was removed at the time of identification with no adverse outcomes as a result. No adverse outcomes were identified for the 11 residents identified as having received the pureed ham. How will you identify other residents having the potential to be affected by the same deficient practice and what	12/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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

F 805 Continued From page 24

foods should have a smooth consistency with no chunks. He revealed the ham was not fully pureed and should be returned to the food processor.

During an interview on 11/09/22 at 11:45 AM, the Dietary Manager revealed he usually checked the foods on the steam table prior to service but on that day he was busy. He indicated pureed foods should be smooth without chunks.

During an interview at 11/9/22 at 11:50 AM, the Cook indicated the pureed ham was ready for service when she placed it on the steamtable. She revealed the pureed meats usually had some chunks but she tries to get it as smooth as she can. She revealed the dietitian, dietary manager, speech therapist reviewed the mechanically altered foods occasionally and had not reported any issues to her.

During an interview on 11/9/22 at 3:25 PM, the Administrator revealed she expected the Dietary Manager to ensure foods were appropriate consistencies for mechanically altered diets.

2. Resident #42 was admitted to the facility on 11/5/21 with diagnoses that included dementia with dysphagia.

A physician's order dated 4/11/22 indicated Resident #42 was prescribed a dysphagia pureed diet.

Resident #42's annual Minimum Data Set (MDS) dated 8/8/22 indicated he had severe cognitive impairment. He required extensive assistance with eating. He had a swallow disorder including coughing or choking during meals or when

F 805

corrective action will be taken:

Element # 2

All residents on a pureed specialty diet have the potential to be affected by the deficient practice. The District Director of Dietary Services provided one-to-one education with the Dietary Staff on 11/10/22 related to ensuring pureed diet orders are followed and pureed ham texture is the proper smooth consistency.

What measures will be put into place or systematic changes made to ensure the deficient practice does not recur:

Element #3

Mandatory education for dietary and nursing staff on policies and procedures related to following of pureed diet orders and diet textures are of proper smooth consistency was completed by the District Director of Dietary Services and the Assistant Director of Nursing (ADON) on 11/10/22. Immediate education/intervention was provided to the Dietary Manager in Training (who is no longer in the building) on 11/10/2022 by the District Director of Dietary Services. Education for all dietary staff was initiated and completed on 11/10/2022 by the District Director of Dietary Services. Education for all nursing staff was completed 11/10/22 by the Assistant Director of Nursing. Daily ongoing observation and education will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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

F 805

Continued From page 25

swallowing medications. He required a mechanically altered diet.

A Care Plan dated 8/9/22 focused on nutrition risk due to dysphagia, dementia, and mechanically altered diet. Goals included Resident #42 will have no weight fluctuations through the review period. Interventions included diet per physician's order, speech to evaluate and treat as ordered, and refer to dietitian as needed.

A Speech Therapy note dated 10/23/22 indicated Resident #42 had worked with the Speech Language Pathologist (SLP) with trials of mechanical soft texture trials. The SLP recommend a Fiberoptic Endoscopic Evaluation of Swallowing (FEES) (a swallowing test involving a small camera) referral for potential diet upgrade.

A FEES report dated 10/25/22 recommended a pureed texture diet with continued trials of mechanical soft meals.

An observation was made on 11/10/22 at 9:10 AM of Resident #42 alone in bed with his breakfast tray in front of him. He had a peanut butter and jelly sandwich in his hand with 1/3 consumed. Resident #42's tray card indicated he was on a pureed diet. The tray card did not indicate Resident #42 could have mechanical soft items. The surveyor immediately went into the hall to get a staff member. A medication aide was in the hallway two doors down from Resident #42's room. The surveyor immediately requested assistance for Resident #42. Resident #42 was not in distress and did not appear to have difficulty eating the sandwich. No coughing or choking was noted. The medication aide did not

F 805

provided by the Dietary Manager, Administrator, and/or Director of Nursing or designees as necessary to maintain compliance.

How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place:

Element #4

To ensure ongoing compliance, the Dietary manager and/or designee will audit all mechanically altered diet trays once a day for one month then, three times per week for two months to ensure proper dietary textures and diet orders are followed. The Director of Nursing and/or designee will audit the mechanically altered trays once a day for one month and then three times a week for two months. The District Director of Clinical Services and/or designee will provide education as necessary on any areas of concern.

Compliance Date: 12/12/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 805	Continued From page 26	F 805		

remove the sandwich from Resident #42's hand. The medication aide and surveyor left the room and walked approximately fifteen feet to the nurse's station then ten feet to the Director of Nursing's (DON) office. She consulted her DON if the sandwich should be removed from Resident #42's room. The DON, medication aide, and surveyor returned to Resident #42's room. Time between the medication aide arriving to the room to the DON arriving at the room was two minutes. Resident #42 had finished the sandwich. No signs of coughing or choking were noted.

During an interview on 11/10/22 at 9:10 AM, the Medication Aide revealed that Resident #42 was on a pureed diet and should not have been given a sandwich. She indicated his tray card revealed a pureed diet.

During an interview on 11/10/22 at 9:12 AM, the DON indicated Resident #42 was on a pureed diet and should not have been provided a sandwich.

During an interview on 11/10/22 at 9:14 AM, the Dietary Manager revealed the kitchen had not put the sandwich on Resident #42's tray. He stated another resident on the hall gets a sandwich and it may have gotten mixed up.

During an interview on 11/10/22 at 9:16 AM, Nurse Aide (NA) #1 revealed the sandwich came on Resident #42's breakfast tray. She revealed she saw his tray card indicated a pureed diet with a sandwich on his tray. She asked the charge nurse if Resident #42 could have the sandwich before bringing the tray into the room. The charge nurse approved the sandwich.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 805	Continued From page 27	F 805		

During an interview on 11/10/22 at 9:17 AM, the Charge Nurse revealed she had approved the sandwich for Resident #42 because he had had a swallow evaluation a few weeks prior and the SLP said he could tolerate mechanical soft textures. Nurse #1 revealed there was not an order for a mechanical soft diet.

During an interview on 11/10/22 at 10:10 AM, the SLP revealed she had been working with Resident #42 on trials of a mechanical soft diet, but he was not ready to have his diet advanced. The SLP indicated she had not made recommendations for the diet to be changed. She revealed Resident #42 should not have been provided a sandwich due to his history of dysphagia and high risk of choking.

During an interview on 11/10/22 at 3:15 PM, the DON revealed Resident #42 should not have been provided a sandwich on his pureed diet. Staff should be checking the diet order and Care Plan before providing snacks. The diet order was on the residents' tray cards and in the Care Guide. The Care Guide was found on the computer kiosks on each hall.

During an interview on 11/10/22 at 3:20 PM, the Administrator revealed the kitchen should be providing foods appropriate for the resident's diet. Staff feeding the residents should make sure the foods were allowed on their diet by checking their tray card.

During an interview on 11/14/22 at 12:40 PM, the Cook revealed the Regional Dietary Manager had placed the sandwich on the wrong tray. Resident #42 should not have been provided a sandwich on a pureed diet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 805	Continued From page 28 The regional dietary manager was not available for interview.	F 805		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, failed to date leftover food stored for use in one of one (300 hall) nourishment room refrigerator. This had the potential to affect food served to residents. Findings included: A tour was conducted on 11/7/22 at 10:15 AM of the facility's nourishment room with Dietary Aid #1. The refrigerator revealed a to-go box of food	F 812	F 812 Food Procurement What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Based on observation, staff interviews, and record review, the facility failed to assure that leftover food stored for use in	12/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 812	Continued From page 29 with a resident's name and no date, a plastic lidded container with a resident's name and no date, a plastic to-go container with a resident's name and no date, and a gallon jug of tea with no date. During an interview on 11/7/22 at 10:17 AM, Dietary Aid #1 revealed she checked the refrigerator daily and discards foods with no name or date. She revealed she had checked the refrigerator that morning. During an interview on 11/8/22 at 1:45 PM, the Dietary Manager revealed the dietary aids checked the refrigerators daily and should discard food with no name or date. He indicated he checked the refrigerators most days as well. During an interview on 11/9/22 at 3:25 PM, the Administrator revealed she expected dietary staff to monitor the nourishment room refrigerator and discarding foods with no date. Nursing staff should be labeling foods with the resident's name and date when they put the food in the refrigerator.	F 812	1 of 1 (300 hall) nourishment room refrigerator was labeled and dated. This had the potential to affect food served to residents. Any food that was not labeled or dated on the 300 hall in the nourishment room refrigerator was immediately discarded. All other resident refrigerators were observed to assure unlabeled and undated food was not identified or, if it was, it was discarded. No adverse outcomes were identified. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Element # 2 All residents have the potential to be affected by the deficient practice. The District Director of Dietary Services provided 1:1 education with the dietary staff on 11/10/22 related to ensuring all food placed in the nourishment room refrigerators are labeled with a name and a date. An audit is being completed by the dietary manager or designee once daily to ensure all items in the nourishment room refrigerator are labeled with a name and date. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 812	Continued From page 30	F 812	The Assistant Director of Nursing conducted mandatory education with dietary and nursing staff related to policies and procedures regarding labeling and dating food items placed in the nourishment room refrigerator. The District Director of Dietary Services provided additional education on 12/6/2022 for all dietary staff. Daily ongoing observation and education will be provided also to maintain compliance, as necessary. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the dietary manager and/or designee will audit the nourishment room refrigerator daily for 3 months to ensure proper labeling and dating of food items is followed. The Administrator and/or designee will audit the nourishment room refrigerator 3 times a week for 1 month, 2 times a week for 2 months, and then randomly thereafter. The District Director of Dietary Services and/or designee will provide education on any areas of concern, as necessary. Compliance Date: 12/12/2022	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		12/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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

F 867 Continued From page 31 F 867

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee must:
(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 3/19/21 recertification and complaint investigation survey and the 8/18/21 focused infection control and complaint investigation survey. This was for a recited deficiency on the current recertification survey in the area of infection control. The continued failure during three federal surveys shows a pattern of the facility's inability to sustain an effective QAA program.

Findings included:

This tag is cross referenced to:
F880: Based on observation and record review, the facility failed to implement a Legionella prevention program. This had the potential to effect 51 residents.

During the recertification and complaint investigation survey of 3/19/21, the facility was cited for failing to implement their procedures for Personal Protective Equipment (PPE) and hand hygiene.

During a focused infection control and complaint investigation survey of 8/18/21, the facility was

F 867

What corrective action will be accomplished for those residents found to have be affected by the deficient practice:

Element #1

Based on staff interviews and record review, the facility's Quality Assessment Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 3/19/21 recertification and complaint investigation survey and the 8/18/21 focused infection control and complaint investigation survey. Based on observation and record review, the facility failed to implement a Legionella prevention program. This had the potential to effect 51 residents. No adverse outcomes were identified.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Element # 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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
F 867	Continued From page 32 cited for failing to implement their infection control policy related to screening employees prior to entering the building and utilizing PPE. During an interview on 11/10/22 at 5:10 PM, the Administrator revealed the QAA committee meets monthly to discuss identified issues in the facility. She indicated Infection Control was discussed at every meeting. She was not aware Legionella surveillance was required for infection control.	F 867	All residents have the potential to be affected by the deficient practice. An ad hoc QAPI meeting was held with the Director of Nursing, Maintenance Director, District Director of Clinical Services, Division Vice President of Clinical Services, Division Vice President of Operations, Chief Nursing Officer, and Division Director of Facility Services to review the water safety plan and procedures on 12/6/22. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 The Water Safety Plan was completed 1/27/2022 by Special Pathogens Laboratory. The Comprehensive Emergency Management Plan (CEMP) was updated 3/9/22 and the CMS Long Term Care Facility Self-Assessment was completed 3/7/22. The Water Safety Plan is reviewed monthly during QAPI meetings. Mandatory education on policies and procedures related to the Water Safety Plan with the Administrator, Director of Nursing and Maintenance Director was completed as part of the ad hoc QAPI meeting on 12/6/22 by the Senior Director of Facility Engineering. The Water Safety Plan committee will continue to meet monthly during the QAPI meeting and will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 867	Continued From page 33	F 867	review the monitoring logs, any corrective actions, reviews of validation results, and review of any necessary changes to plan. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the District Director of Operations and/or designee will review the facility□s QAPI meeting minutes, as needed, to ensure the Committee is monitoring compliance with its Water Safety Plan and will ensure the facility takes the appropriate action for any identified concern. Compliance Date: 12/12/22	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		12/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 880	Continued From page 34	F 880		

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(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

F 880 Continued From page 35

(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation and record review, the facility failed to implement a Legionella prevention program. This had the potential to effect 51 residents.

Findings included:
Review of the Emergency Preparedness and Infection Control Programs revealed the facility did not have a procedure or program for water safety management for Legionella.

Review of the facility water safety plan policy dated 01/27/2022 revealed the following:
Water Safety Team shall meet regularly to review water safety program including
- Review of monitoring logs
- Review of any corrective actions
- Review validation results
- Review if any changes to plan is required.

In an interview on 11/10/2022 at 10:45AM, the Maintenance Supervisor (MS) revealed he had

F 880

F 880

What corrective action will be accomplished for those residents found to have be affected by the deficient practice:

Element #1

No specific residents were identified as having been affected in the alleged deficient practice. Review of the Emergency Preparedness and Infection Control Programs revealed the facility management lacked a functional understanding of the procedure or program for water safety management for Legionella.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET KENANSVILLE, NC 28349**

(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
F 880	Continued From page 36 not conducted a Legionella risk assessment of the facility water system. MS stated he will only conduct the risk assessment if there was an outbreak of Legionella at the facility. In an interview on 11/10/22 at 10:50 AM, the Administrator revealed the facility had not conducted a risk assessment for Legionella. She believed assessment was optional unless there was an outbreak of Legionella.	F 880	Element # 2 All residents have the potential to be affected by the deficient practice. An ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held with Director of Nursing, Administrator, District Director of Clinical Services, Maintenance Director, Chief Nursing Officer, Divisional Vice President of Clinical, Vice President of Operations, and Senior Director of Facility Engineering to review water plan and procedures on 12/6/22. The Water Safety Plan is implemented and routinely monitors areas of risk for Legionella. If concerns are identified, the plan specifies the necessary risk mitigation actions. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 The Water Safety Plan was completed 1/27/2022 by Special Pathogens Laboratory. The Comprehensive Emergency Management Plan (CEMP) was updated 3/9/22 and the CMS Long Term Care Facility Self-Assessment was completed 3/7/22. The Water Safety Plan is reviewed monthly during QAPI meetings. Mandatory education on policies and procedures related to the Water Safety Plan was completed with the Administrator, Director of Nursing and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET** **KENANSVILLE, NC 28349**

(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
F 880	Continued From page 37	F 880	Maintenance Director as part of the ad hoc QAPI meeting on 12/6/22 by the Senior Director of Facility Engineering. The Water Safety Plan committee will continue to meet monthly during the QAPI meeting to review the monitoring logs, any corrective actions, reviews of validation results, and review of any necessary changes to plan. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the District Director of Operations and/or designee will review the facility’s QAPI meeting minutes as needed to ensure it includes review of the Water Safety Plan and will ensure the facility takes the appropriate action for any identified concern. Compliance Date: 12/12/22	