STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

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E 000	Initial Comments An unannounced Recertification survey was conducted on 12/12/2022 through 12/15/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #MTNR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 12/12/2022 through 12/15/2022. Event ID#MTNR11. 1 of the 3 complaint allegations was substantiated but did not result in a deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of Preadmission Screening and Resident Review (PASRR) Level II for 2 of 2 residents (Resident #19 and Resident # 38) reviewed for PASRR. Findings included: 1. Resident #19 was admitted to the facility on 09/20/2011 with multiple diagnoses that included anxiety disorder, bipolar disorder, and major depressive disorder. Record review indicated Resident #19 had a Preadmission Screening and Resident Review	F 641	1. Residents #19 and #38 most recent comprehensive assessments were corrected on 12/27/22 to reflect accurate Level II PASRR coding. 2. Residents residing in the facility have the potential to be affected by stated deficiency. Administrator and Director of Nursing completed an audit on 12/26/22 of all current residents most recent comprehensive MDS assessment to validate accurate coding of resident s PASRR status. Residents identified with inaccurate coding of PASRR status on the most recent comprehensive MDS assessment had corrections completed by the Administrator, MDS Coordinator,	1/6/23

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

Electronically Signed | 12/28/2022

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F 641	Continued From page 1 (PASRR) Level II Determination Notification dated 11/10/2021. The Annual Minimum Data Set (MDS) assessment dated 11/18/2022 was answered "No" to question A1500 which asked if Resident #19 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or intellectual disability or a related condition. The Minimum Data Set Nurse responsible for completion was not available for an interview during the survey. During an interview on 12/15/2022 at 11:32 AM, Administrator stated she was responsible for completing the PASRR for the residents at the facility. She indicated Resident#19 had PASRR level II since 11/10/2021 and the MDS should have been coded. The Administrator indicated the MDS nurse failed to code the Annual MDS dated 11/18/2022 to reflect Resident#19 had PASRR level II. She stated she did not know the reason the MDS nurse failed to code the MDS. 2. Resident #38 was admitted to the facility on 5/16/22 with multiple diagnoses that included anxiety disorder, bipolar disorder, and major depressive disorder. Record review indicated Resident #38 had a Preadmission Screening and Resident Review (PASRR) Level II Determination Notification dated 6/20/22. The significant change Minimum Data Set (MDS) assessment dated 9/20/22 was answered "No" to question A1500 which asked if Resident #38 had been evaluated by a level II PASRR and	F 641	and/or Assistant Director of Nursing to correct MDS inaccuracies. The nurses completing MDS assessments will be educated by the Administrator on 12/29 and 12/30 on the importance of accurate coding of PASRR status on comprehensive MDS assessments as well as the new process of auditing all comprehensive MDS assessments prior to submission to the state database. 3. The Administrator and/or Director of Nursing will maintain an on-going audit of all comprehensive MDS assessments completed to validate accurate coding of the resident□s PASRR status. Assessments will be validated prior to submission to the state database. Inaccuracies will be identified by the Administrator and/or Director of Nursing and corrected by the MDS nurse prior to submission. These audits will continue for no less than 12 months to ensure all current residents will be reviewed. 4. The Administrator and/or Director of Nursing will inform the QAPI Committee monthly of the audit results including any inaccuracies that were identified. The QAPI Committee will review audit findings for a minimum of 12 months to ensure all current residents have a comprehensive MDS assessment that has been reviewed.	

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F 641	Continued From page 2 determined to have a serious mental illness and/or intellectual disability or a related condition. The Minimum Data Set Nurse responsible for completion was not available for an interview during the survey. An interview was conducted on 12/13/22 at 12:24 PM with the Administrator. The Administrator explained she completed the PASRR for the residents at the facility; however, the MDS nurse had failed to complete the coding on the Significant Change MDS dated 9/20/22. The Administrator stated the MDS coding should have been completed for Resident #38 PASRR Level II and she did not know why it was not done.	F 641		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and	F 867		1/6/23

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F 867	Continued From page 3	F 867		

information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness

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of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's

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F 867	Continued From page 5 governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. 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 10/28/2021 recertification survey. This was for a recited deficiency on the current recertification survey in accuracy of assessments. The continued failure during two federal surveys shows a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross referenced to: F641: Based on record review and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in Preadmission Screening and Resident Review (PASRR) Level II for 2 of 2 residents (Resident #19 and Resident # 38) reviewed for PASRR. During the recertification survey of 10/28/2021, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of	F 867	1. The facility QAPI plan has been reviewed and revised to ensure that the QAPI Committee has sufficient time to effectively review, offer feedback, and identify potential problems with the new process of reviewing MDS coding accuracy for resident PASRR status. 2. Residents residing in the facility have the potential to be affected. The QAPI Committee members will be educated on or before 12/30/22 by the administrator on the QAPI plan and revision to allow sufficient time to effectively review, offer feedback, and identify potential problems with the new process of reviewing MDS coding accuracy for resident PASRR status. 3. The Administrator will ensure the QAPI Committee reviews monthly the on-going audits of comprehensive MDS assessments to ensure accurate coding of the resident□s PASRR status and offers feedback as needed to ensure compliance is met and maintained. 4. The QAPI Committee will continue to	

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F 867	Continued From page 6 level II Preadmission Screening and Resident Review (PASRR). During an interview on 12/15/22 at 11:10 AM, the Administrator revealed the QAA committee meets monthly to discuss identified issues in the facility. She indicated PASRR level II was not discussed recently in the QAA meetings since she was not aware that the facility had concerns with coding PASRR level II accurately in the MDS.	F 867	review the accuracy of MDS PASRR coding at least monthly for a period of no less than 12 months to ensure continued compliance.	