STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING ______ B. WING ______	C 04/06/2023

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PREMIER LIVING AND REHAB CENTER	**106 CAMERON STREET LAKE WACCAMAW, NC 28450**

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E 000	Initial Comments An unannounced Complaint Investigation and Recertification survey was conducted from 04/03/2023 thruogh 04/06/2023. The facility was found in compliance with the requirement of CFR. 483.73 Emergency Preparedness. Event ID # 3DV611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/03/23 to 04/06/23. Event ID# 3DV611. The following intake was investigated NC00200075. 2 of the 2 allegations did not result in deficiency.	F 000		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.	F 636		4/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/27/2023

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

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F 636	Continued From page 1 (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 636	Resident #39 Comprehensive	

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Continued From page 2

facility failed to complete the annual Minimum Data Set (MDS) assessments within the required timeframe for 5 of 5 residents reviewed for annual MDS assessments (Resident #39, Resident #4, Resident #19, Resident #34 and Resident #7)

Findings included:

a. Resident #39 was admitted to the facility on 9/30/20. Resident #39's 2/28/23 annual Minimum Data Set (MDS) assessment was listed as "in process". Assessment was not completed.

b. Resident #4 was admitted to the facility on 11/4/04. Resident #4's 3/6/23 annual MDS assessment was listed as "in process". Assessment was not completed.

c. Resident #19 was admitted to the facility on 5/26/16. Resident #19's 2/1/23 annual MDS had a completion date of 3/10/23.

d. Resident #34 was admitted to the facility on 2/2/21. Resident #34's 2/11/23 annual MDS was completed on 3/23/23.

e. Resident #7 was admitted to the facility on 5/11/17. Resident #7's 1/21/23 annual MDS was completed on 3/7/23.

Interview with the Administrator on 4/04/23 at 11:41 AM revealed the MDS Nurse left several months ago, and since then the Director of Nursing (DON) was completing the MDS assessments. Administrator stated she was actively looking for an MDS nurse. Administrator stated the DON was doing the best she could. Administrator stated she was aware of the situation with MDS assessments not completed

F 636

Assessment was completed on 4/11/23 and transmitted/accepted on 4/11/23. Resident #4 Comprehensive Assessment was completed on 4/18/23 and Transmitted/Accepted on 4/19/23

All past due Comprehensive MDS Assessments have been completed and transmitted/accepted.

Since all assessments are at risk for being incomplete, all staff responsible for completing sections on the MDS have been scheduled for the state-offered MDS courses beginning on April 27, 2023

Interdisciplinary staff responsible for completing sections of the MDS were inserviced on the regulation related to "Resident Assessment" on 4/27/23.

All assessments "In Progress" will be audited on a weekly basis x's 4 weeks (M-F) by the DON or designee., then monthly x's 3 months by the Administrator or designee.

Audit results will be forwarded to the QAPI Committee for review for 2 quarters and further recommendations as necessary.

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F 636	Continued From page 3 within the regulatory timeframe and was looking for a solution. Interview with the DON on 4/05/23 at 10:51 AM revealed the MDS Nurse left several months ago and since then she was responsible for the completion of the MDS assessments on all residents. DON stated things were left incomplete when the MDS Nurse left, and she was trying to catch up but did not have enough time with her other duties in the facility. DON stated she was aware of the MDS process and the timelines for completion of assessments.	F 636		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly assessments within the required 14-day timeframe for 6 of 6 residents reviewed for MDS assessments. (Resident #15, Resident #21, Resident #10, Resident #40, Resident #35, and Resident #17). Findings included: a. Resident #15 was admitted to the facility on 9/29/17. Resident #15's 2/13/23 quarterly MDS assessment was completed on 3/9/23. b. Resident #21 was admitted to the facility on 7/19/19. Resident #21's 2/22/23 quarterly MDS	F 638	All past due Quarterly MDS Assessments have been completed for Residents: #15, #10, #35 and #21 on 4/3/23. Resident #40 completed 4/11/23. All past due Quarterly MDS Assessments have been completed and transmitted/accepted as of 4/19/23. Since all assessments are at risk for being past due, all staff responsible for completing sections on the MDS have been scheduled for the state-offered MDS course beginning on April 27, 2023.	4/27/23

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F 638	Continued From page 4 was completed on 3/16/23. c. Resident #10 was admitted to the facility on 12/19/20. Resident #10's 2/18/23 quarterly MDS was completed on 3/9/23. d. Resident #40 was admitted to the facility on 11/16/21. Resident #40's 2/24/23 quarterly MDS was completed on 3/27/23. e. Resident #35 was admitted to the facility on 8/27/21. Resident #35's 2/12/23 quarterly MDS was completed on 3/9/23. f. Resident #17 was admitted to the facility on 12/17/19. Resident #17's 1/31/23 quarterly MDS was completed on 2/22/23. Interview with the Administrator on 4/04/23 at 11:41 AM revealed the MDS Nurse left several months ago, and since then the Director of Nursing (DON) was completing the MDS assessments. Administrator stated she was actively trying to hire an MDS Nurse. Administrator stated the DON was doing the best she could. Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and was looking for a solution. Interview with the DON on 4/05/23 at 10:51 AM revealed the MDS Nurse left several months ago and since then she was responsible for the completion of the MDS assessments on all residents. DON stated things were left incomplete when the MDS Nurse left, and she was trying to catch up but did not have enough time with her other duties in the facility. DON stated she was aware of the MDS process and the timelines for	F 638	An MDS nurse has been hired to ensure MDS assessments are completed accurately and timely every 3 months. Interdisciplinary staff responsible for completing sections of the MDS were inserviced on the regulation related to "Resident Assessment" on 4/27/23. All assessments "In Progress" will be audited on a weekly basis x's 4 weeks (M-F) by the DON or designee., then monthly x's 3 months by the Administrator or designee. Audit results will be forwarded to the QAPI Committee for review for 2 quarters and further recommendations as necessary.	

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F 638	Continued From page 5 completion of assessments.	F 638		
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 interview the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of Level II Preadmission Screening and Resident Review (PASARR) for 3 of 3 residents (Resident #15, Resident #7, and Resident #3) reviewed for PASARR. Findings included: 1. Resident #15 was admitted to the facility 9/29/17 with diagnoses which included major depressive disorder and anxiety. Record review indicated Resident #15 had a level II Preadmission Screening and Resident Review (PASARR), indicating serious mental illness evaluation on 8/16/18. Resident #15's 11/13/22 annual Minimum Data Set (MDS) indicated a "No" response to the question which asked if Resident #15 had been evaluated by a Level II PASARR and determined to have serious mental illness and/or intellectual disability or a related condition. Interview with the Director of Nursing (DON) on 4/05/23 at 2:57 PM revealed she was responsible for completing the MDS assessments for all	F 641	CORRECTIVE ACTION: - The Minimum Data Sets (MDS) that were inadvertently miscoded to reflect erroneous PASARR status of Residents #15 (4/5/23), #3 (4/11/23) and #7 (4/5/23) were modified to reflect appropriate Level II PASARR Status and transmitted to the state MDS database. OTHERS WITH POTENTIAL TO BE AFFECTED: - Most recent MDS assessment for all residents with Level II PASARR status were audited to ensure accurate coding. MEASURES AND SYSTEMIC CHANGES: Current process for coding the A1500 section of the MDS was reassigned to the Social Services Director since management of the PASARR process is their responsibility. The DON and Social Services Director reviewed the RAI Manual jointly related to coding Section A1500 on 4/11/23.	4/27/23

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residents since the MDS Nurse left several months ago. The DON stated some of the questions in the MDS are prepopulated from other parts of the computer system or from the previous full assessment. She verified Resident #15 was a Level II PASARR and should have been listed as such on the 11/13/22 annual MDS Assessment. The DON confirmed the MDS was coded inaccurately.

2. Resident #7 was admitted to the facility 9/29/17 with diagnoses which included major depressive disorder, anxiety, schizoaffective, paranoid personality, and borderline personality disorders.

Record review indicated Resident #7 had a level II PASARR evaluation on 5/21/17.

Resident #7's 1/21/23 annual MDS indicated a "No" response to the question which asked if Resident #7 had been evaluated by a Level II PASARR and determined to have serious mental illness and/or intellectual disability or a related condition.

Interview with the Director of Nursing (DON) on 4/05/23 at 2:57 PM revealed some of the questions on the MDS are prepopulated from other parts of the computer system or from the previous full assessment. DON verified Resident #7 was a Level II PASARR and should have been listed as such on the 1/21/23 annual MDS Assessment. DON confirmed the MDS was coded inaccurately.

3. Resident #3 was admitted to the facility 05/19/15 with diagnoses which included

F 641

All staff responsible for completing sections of the MDS are scheduled for the state-offered inservices beginning on 4/27/23.

PERFORMANCE MONITORING:

- The MDS Coordinator will audit all Comprehensive Assessments weekly x's 4 weeks for accuracy of A1500., then 50% of all Comprehensive Assessments weekly x's 4 weeks, then 50% monthly until the next QAPI meeting.

- Audit results will be forwarded to QAPI Committee for review and further recommendations as necessary.

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F 641	Continued From page 7 encephalopathy, bi-polar disorder, major depression with psychotic features, severe dementia, and anxiety. Record review indicated Resident 3 had a level II Preadmission Screening and Resident Review (PASARR), indicating serious mental illness evaluation on 01/15/20. Resident #3's 03/20/23 quarterly Minimum Data Set (MDS) indicated a "No" response to the question which asked if Resident #3 had been evaluated by a Level II PASARR and determined to have serious mental illness and/or intellectual disability or a related condition. Interview with the Director of Nursing (DON) on 4/05/23 at 2:57 PM revealed she was responsible for completing the MDS assessments for all residents since the MDS Nurse left several months ago. The DON stated some of the questions in the MDS are prepopulated from other parts of the computer system or from the previous full assessment. She verified Resident #3 was a Level II PASARR and should have been listed as such on the 03/20/23 quarterly MDS Assessment. The DON confirmed the MDS was coded inaccurately.	F 641		
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	F 727		4/27/23

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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 have a Registered Nurse (RN) scheduled for 8 consecutive hours a day for 3 of 92 days (08/07/22, 09/03/22, and 09/04/22) reviewed for staffing. This failure had the potential to affect all residents in the facility.

Findings included.

Review of the facility's Payroll Based Journal (PBJ) staffing data report for Quarter 4 of 2022 (July 1 - September 30, 2022) revealed 7 infraction dates of 07/09/22, 07/10/22, 08/07/22, 08/28/22, 09/03/22, 09/04/22, and 09/25/22 when there was no RN coverage in the facility.

During an interview on 04/05/23 at 09:00 AM the Administrator stated of the 7 infraction dates listed on the PBJ report she could verify through timecard reports that there was an RN on duty for 8 consecutive hours on 07/09/22, 07/10/22, 08/28/22, and 09/25/22 but stated she could not confirm RN coverage for 8 hours on the infraction dates of 08/07/22, 09/03/22, and 09/04/22.

A review of the facility Timecard Report revealed on 07/09/22, 07/10/22, 08/28/22, and 09/25/22 there was RN coverage in the facility for 8 consecutive hours.

F 727

The quarterly PBJ Staffing Data Report (Casper Report 1705D) was pulled on 4/10/2023 and indicates no areas of concern were triggered for the FY Quarter 1, 2022 (October 1 - December 31). The FY Quarter 2, 2022 (January 1 - March 31) has not been issued yet, however, an audit of the daily data that has been uploaded in the system indicates no areas of concern related to "No RN Hours" should trigger for FY Quarter 2 2022.

Since the survey, 4 RN's have been hired and interviews are ongoing to hire additional staff to ensure compliance with the staffing rule/regulation.

The Director of Nursing and Nursing Department Scheduler are aware of the requirement for 8 hours of continuous RN coverage on a daily basis and RN staff will be scheduled accordingly to ensure the deficient practice does not recur.

Scheduler and DON has been inserviced on the regulation related to 8 hours of continuous RN coverage on 4/27/23 and that all staffing needs/challenges and vacant positions or additional coverage needs should be communicated to the

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F 727	Continued From page 9 An interview on 04/06/23 at 10:00 AM with the Director of Nursing revealed she was also in charge of scheduling. She stated no RN coverage for the infraction dates for that time period was due to low staffing but indicated she was not aware that there was no RN in the facility on those dates. She stated they were actively trying to hire more RN's to cover shifts, but they had not had much success in finding RN's to work. She indicated that currently there were enough RN's in the facility to ensure there was RN coverage each day. During an interview on 04/06/23 at 11:00 AM with the Administrator she stated the PBJ Staffing report data was submitted from information received from the facility payroll company, and stated she was not aware that there was no RN coverage on the dates listed on the PBJ report. She stated they were continuously trying to hire more staff, but it was hard to find nurses to work, and they had hired nine RN's over the last two years, but some were no longer employed. She stated they were continuing to try to hire RN's and were using different platforms such as online websites and social media for recruitment and stated they were also keeping the census capped until more nursing staff were hired.	F 727	Administrator and Payroll Administrative Assistant for review of current applications and advertising open positions through recruiters, agencies, media platforms, etc. PBJ Reports and nursing RN schedules will be monitored monthly by Administrator for 3 months and as necessary to ensure 8 hours of RN coverage are scheduled to meet current regulatory requirements. Concerns and audit results will be brought before the QAPI Committee for further review and monitored for 2 quarters with recommendations as necessary.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		4/27/23

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except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-

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(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 842	Continued From page 11 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately document on the Medication Administration Record (MAR) for 1 of 19 residents (Resident # 34). Findings included: Resident #34 was admitted to the facility on 02/02/2021 with diagnoses to include hypertension (HTN) and bradycardia (heart rate that is too slow; less than 60 beats per minute). Review of the electronic medical record (EMR) for Resident #34 revealed a physician's order dated 04/03/2021 to give amlodipine besylate tablet 10 milligrams (mg) by mouth one time a day for HTN, hold for Systolic blood pressure of less than 100 or heart rate less than 60.	F 842	The inaccurate information for resident #34 (1 out of 19 records reviewed) was corrected on the Medication Administration Record (MAR). Since all records are at risk for inaccurate documentation, all clinical staff responsible for documenting medication administration on the MAR have been instructed to complete the eMAR training module in the facility eMAR software, PointClickCare (PCC) "Smartzone" until 100% compliance is achieved with module training. Smartzone training on accurate documentation will be added to new hire orientation and annual compentency checklist ongoing.	

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F 842 Continued From page 12

1. Review of Resident #34's Medication Administration Record (MAR) for February 2023 revealed:

a. 2/9/23 Medication Aide (MA) #1's initials, and a check mark (indicating the amlodipine medication was given) and the resident's pulse was recorded as 56 beats per minute.

b. 2/10/23 MA#1's initials, a check mark (indicating the amlodipine medication was given) and the resident's pulse was recorded as 54 beats per minute.

An interview was conducted with MA#1 on 04/05/2023 at 1:08 P.M. MA#1 confirmed that her MAR initials were documented on 2/9/23 and 2/10/23. She further stated that she knew she would not have given the amlodipine medication if a resident's pulse was that low. MA#1 indicated that she was going to be more careful and not just click "given" down the columns. She further stated that if she had a question about a medication or if a resident's pulse or blood pressure was too low, she would tell the nurse.

Review of Resident #34's Medication Administration Record (MAR) for March 2023 revealed:

c. 3/22/23 MA#2's initials, a check mark (indicating amlodipine medication was given) and the resident's pulse was recorded as 57 beats per minute.

An interview was completed with MA #2 on 04/05/2023 at 1:00 P.M. MA#2 stated that the initials documented on 3/22/23 were hers. She further stated she had not administered the

F 842

To ensure the effectiveness of these corrective measures, Medication Administration documentation audits will be observed on all staff randomly over a 2 week span, then randomly for 2 weeks, then monthly until next scheduled Quality Assurance/Performance Improvement (QAPI) meeting.

Results will be brought before the QAPI committee for review and to determine ongoing recommendations as necessary.

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F 842	Continued From page 13 amlodipine medication that day. MA#2 stated that she would not give the amlodipine medication if the pulse or blood pressure was too low. MA#2 indicated that she must have clicked the wrong button, but she was sure she had not given the medication. An interview was conducted with the Director of Nursing (DON) on 04/05/2023 at 1:57 P.M. The DON stated she had been unaware of the inaccurate documentation on Resident #34's February 2023 and March 2023 MAR. She further stated MA#1 and MA#2 should have documented a a code for not given instead of the checkmark for given. The DON indicated she usually handled documentation errors one-on-one with the nurse or medication aide. She stated she would usually re-educate or counsel them on the importance of correct documentation and how to correct errors.	F 842		
F 867 SS=D	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.	F 867		4/27/23

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§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and 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

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F 867	Continued From page 15	F 867		

level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness 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.

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F 867	Continued From page 16 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's 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 record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitoring interventions the committee put into place following a COVID-19 Focused Infection Control survey and complaint investigation survey on 01/06/2021. The failure was for one deficiency that was cited for Resident Assessment (F641) and was subsequently recited on the current recertification and complaint investigation survey of 04/06/2023. The repeat deficiency during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referenced to F 641: Based on record review and staff interview the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of	F 867	The 2023 facility QAPI Evaluation Plan was reviewed and revised on 4/27/23 to include Minimum Data Set (MDS) assessment accuracy as a priority for the facility, to include Level II PASARR coding in section A1500 of the MDS, as well as, overall assessment accuracy. All assessments for residents found to be incorrectly coded, have been corrected/modified and resubmitted to the state database. A new system has been initiated 4/11/23 for ensuring the MDS is coded correctly to include the Social Services Director coding this item since the responsibility is assigned to this position for ensuring the Level II PASARR is completed for each resident that triggers for this screening. All staff responsible for coding the MDS	

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F 867	Continued From page 17 Level II Preadmission Screening and Resident Review (PASARR) for 3 of 3 residents (Resident #15, Resident #7, and Resident #3) reviewed for PASARR. During the COVID-19 Focused Infection Control Survey and Complaint investigation on 01/06/2021 the facility failed to code the Minimum Data Set (MDS) assessment accurately to reflect deep tissue injuries on 1 of 3 residents reviewed for pressure ulcers. An interview was conducted with the Administrator on 04/06/2023 at 01:55 P.M. The Administrator stated that she thought the facility had a good QA committee and that they had done a great job. She further stated that she felt the reason for the repeated deficiency was due to the facility continuing to have a shortage of nurses. The Administrator indicated that the Director of Nursing was completing the MDS assessments and was also currently the Infection Control Preventionist for the facility. She stated that the facility had been trying to hire nurses for these positions since August and the nurses she had hired had either quit or declined the position before starting. The Administrator further stated that the facility had offered to pay for current staff members to attend nursing school for a work contract but that no one had accepted the offer. She stated that the facility currently had ads for hiring nurses on job sites online and had reached out to other resources in the community for nursing applicants.	F 867	assessments are participating in the state-offered training for MDS coding beginning on 4/27/23. MDS Assessment accuracy related to PASARR coding compliance audits will be performed by the MDS Coordinator prior to transmittal to ensure the deficient practice does not recur. The Director of Nursing or designee will randomly audit 1 completed MDS prior to transmission on a weekly basis x 4 weeks to ensure appropriate coding that accurately reflects the total resident's conditions/needs. For any areas of inaccuracy noted, a Performance Improvement Plan, (PIP) will be initiated and monitored to ensure an effective system change has occurred. All PIP's will be brought to the quarterly QAPI meetings. These principles will be applied to all areas/departments of the facility to ensure an on-going, effective QAPI/QAA Improvement Activity Program. Audits will be forwarded for 2 quarters to the QAPI Committee for review and further recommendations as necessary.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		4/27/23

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immunizations
§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

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F 883	Continued From page 19 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to administer the influenza vaccine during the 2022-2023 season after informed consent was obtained for 2 of 5 residents reviewed for influenza vaccinations (Resident #248 and Resident #44) and failed to administer the pneumococcal vaccination after obtaining informed consent for 1 of 5 residents reviewed for pneumococcal vaccinations (Resident #248). Findings included: 1.Resident #248 was admitted on to the facility on 3/13/23. A review of Resident #248's medical record revealed the 2022-2023 Influenza Consent Form indicated consent to receiving the influenza immunization for the annual season of October 1, 2022-March 31,2023 was signed by the resident's responsible party on 3/10/23. A review of Resident #248's medical record revealed the facility Pneumococcal Consent Form	F 883	Resident #248 was given the Pneumococcal Immunizations (PNE20) on 4/24/23. Resident did not receive the Influenza Immunization as order was put on hold by the Nurse Practitioner until next season. Resident #44 did not receive the Influenza Immunization as order was put on hold by the Nurse Practitioner until next season. All current resident medical record immunization records were audited for PNE/Influenza Immunization. All immunizations were given as indicated. Any residents who had not received the Influenza shot for this season was put on hold by the Nurse Practitioner. Admission/Readmission checklist was revised to include immunization follow-up/through and RN Charge Nurse to complete and followup/through to ensure all consents/declinations are	

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F 883	Continued From page 20 indicated consent given to receive the pneumococcal vaccination was signed by the resident's responsible party on 3/10/23. A review of Resident #248's physician orders revealed the following orders dated 3/13/23: May have pneumococcal vaccine as recommended by the Centers for Disease Control (CDC). May have influenza vaccine annually unless contraindicated. Resident #248's 3/20/23 admission Minimum Data Set (MDS) assessment was listed as "in process" or incomplete. A review of the immunization section of Resident #248 's medical record did not indicate any information regarding the administration or refusal of the influenza or pneumococcal vaccinations. Review of Resident #248's Medication Administration Record (MAR) for March and April 2023 indicated no notation that the influenza or pneumococcal vaccinations were administered. Review of Resident #248's nursing progress notes from March 13/23 through April 6, 2023, revealed no notation of refusal or administration of the influenza or pneumococcal vaccinations. Interview with the Director of Nursing (DON) on 4/6/23 at 1:27 PM revealed the vaccinations were not given. DON stated it was an oversight that Resident #248's influenza and pneumococcal vaccinations were not administered. DON further indicated she expected that vaccinations would be administered within 8 days of the consent	F 883	followed through and recorded and/or administered as indicated. RN Charge Nurse inserviced on 4/11/23 related to revised checklist and instructions on completion. Director of Nursing or designee to audit all Admission/Readmissions to ensure Immunizations are given per policy weekly x's 4 weeks, then 50% of all admissions/readmissions weekly x's 4 weeks, then montly until next QAPI meeting. Audit results will be forwarded to the QAPI Committee for 2 Quarters for review and further recommendations as necessary.	

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being signed. DON revealed the Admissions Coordinator had the consent form for immunizations signed by the resident or responsible party on admission. The Admissions Coordinator then gave copies of the immunization consent forms to the nurse and the DON to ensure that the nurses administered the vaccinations. DON stated she must have overlooked the consents for Resident #248.

2. Resident #44 was admitted on 1/20/23.

A review of Resident #44's medical record revealed the 2022-2023 Influenza Consent Form indicated consent to receive the influenza immunization for the annual season of October 1, 2022-March 31,2023 was signed by the resident's responsible party on 1/20/23.

A review of Resident #44's physician orders revealed the following orders dated 1/20/23:
May have influenza vaccine annually unless contraindicated.

Resident #44's 1/27/23 admission Minimum Data Set (MDS) assessment revealed resident was cognitively impaired. Resident #44's influenza vaccination status was coded as No, had not received and reason not received coded as none of the above.

Review of Resident #44's nursing progress notes from 1/20/23-4/6/23, revealed no documentation of the influenza vaccination administered or refused.

Review of Resident #44's Medication Administration Record (MAR) from 1/20/23-4/6/23 revealed no documentation of influenza

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F 883	Continued From page 22 vaccination administration or refusal. Interview with Director of Nursing (DON) on 4/6/23 at 12:08 PM revealed she did not know why Resident #44 was not administered the influenza vaccination for the current influenza season. DON stated she expected the influenza vaccination would be administered by day 8 after admission. DON stated it was an oversight that Resident #44's vaccination was not administered.	F 883		