STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING ______ B. WING ______	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/30/23 through 11/2/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #EDYF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/30/23 through 11/2/23. Event ID# EDYF11. The following intakes were investigated NC00208764, NC00206455, and NC00209039. 3 of the 3 complaint allegations did not result in deficiency.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		11/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/22/2023

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 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain bathroom and closet doors in good repair in 5 of 13 rooms (Rooms 302, 304, 306, 313 and 316) on the 300 hallway. Findings included: a. During a tour of Room 302 on 11/1/23 at 3:08 PM, an observation revealed a horizontal length of splintered wood at the bottom of the bathroom door. Room 302's bathroom door was observed with the Environmental Services Director on 11/2/23 at 9:21 AM. In an interview with the Environmental Services Director on 11/2/23 at 9:22 AM, he stated the splintered wood at the bottom of the bathroom door was ten to twelve inches in length.	F 584	1. The bathroom in the following rooms will be repaired: 302, 304, 306, and 316. The closet door in room #313 will be repaired. The observed holes in the above listed doors will be repaired by 11-30-23. 2. All other bathroom and closet doors in resident rooms within the facility will be audited to determine if any of those doors have holes in them that need to be repaired. This audit will be completed by the Administrator. The audit will be completed by 11-30-23. 3. The Environmental Services staff will be inserviced by the Environmental Services Director on the importance of looking at the resident bathroom and closet doors daily and to report any	

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F 584	Continued From page 2 b. During a tour of Room 304 on 11/1/23 at 3:10 PM, an observation revealed a horizontal length of splintered wood at the bottom of the bathroom door. Room 304's bathroom door was observed with the Environmental Services Director on 11/2/23 at 9:23 AM. In an interview with the Environmental Services Director on 11/2/23 at 9:24 AM, he stated the maintenance department had placed wood putty at the bottom of the door, but it came off and there was a five inch wide length of splintered wood at the bottom of the bathroom door. c. During a tour of Room 306 on 11/1/23 at 3:11 PM, an observation revealed a hole near the bottom of the bathroom door. Room 306's bathroom door was observed with the Environmental Services Director on 11/2/23 at 9:25 AM. In an interview with the Environmental Services Director on 11/2/23 at 9:26 AM, he stated the hole in the bathroom door was the size of a fist and he thought it was caused from a wheelchair that bumped up against the door. d. During a tour of Room 313 on 11/1/23 at 3:14 PM, an observation revealed a horizontal length of splintered wood at the bottom of the A bed closet door. Room 313 bed A's closet door was observed with the Environmental Services Director on 11/2/23 at 9:27 AM. In an interview with the Environmental Services Director on 11/2/23 at 9:28 AM, he verified the horizontal length of splintered wood at the bottom of the closet door.	F 584	damage to the Environmental Services Director who will write up a Work Order for the repair(s). This inservice will be completed by 11-30-23. 4. An audit will be performed to ensure that resident bathroom and closet doors are free of any holes and that any holes to the bathroom or closet doors in a resident room is reported, a work order is filled out and the damage is repaired timely. This audit will be performed on a weekly basis x 4 weeks and then monthly x 3 months. This audit will look at 25% of the resident bathroom and closet doors per audit. The audit will be performed by the Administrator or their designee. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that the resident bathroom doors are free of holes and that any holes are reported to the Environmental Services Director, a work order was filled out and the appropriate repairs were made. Compliance Date: 11-30-23	

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F 584	Continued From page 3	F 584		

e. During a tour of Room 316 on 11/1/23 at 3:12 PM, an observation revealed a hole near the bottom of the bathroom door.

Room 316's bathroom door was observed with the Environmental Services Director on 11/2/23 at 9:28 AM. In an interview with the Environmental Services Director on 11/2/23 at 9:29 AM, he stated the hole in the bathroom door measured two and a half to three inches.

An interview was conducted with the Environmental Services Director on 11/2/23 at 9:30 AM. He oversaw the housekeeping and maintenance duties at the facility. He explained there were work order forms located in a plastic bin on the wall outside of the maintenance office. He said if staff observed an issue in a resident's room that needed to be addressed or repaired, they filled out the work order slip and placed it inside the bin on the wall or slid it under the maintenance office door. He shared once or twice a month the maintenance staff went through each room with a checklist and completed room audits that identified repairs needed in each room. The Environmental Services Director said he was aware of other rooms in the building that needed door repairs but had not been notified of rooms on the 300 hall with issues that needed to be addressed by maintenance staff. He added there had not been any work orders written in the past 3-6 months that specifically requested repairs of doors on the 300 hall.

The Administrator was interviewed on 11/2/23 at 10:41 AM. He shared the bathroom doors were hollow and "it doesn't take much to punch through them." He said the maintenance staff checked rooms frequently and thought it was "hard to

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F 584	Continued From page 4 know when it happened." He added when there was a hole or splintered wood in a door, staff either placed a patch on the door or replaced the door. The Administrator stated all staff looked in resident rooms for maintenance/environmental concerns but was not sure if everyone reported issues. He stated work orders were filled out by any staff member, "usually for bigger items/repairs." Often staff just called maintenance or told them of repair needs when they saw the maintenance/environmental staff in the hallway.	F 584		
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 accurately assess cognitive patterns, anticoagulant medication use, and mood for 3 of 20 Minimum Data Set (MDS) assessments reviewed (Resident #55, Resident #47, and Resident #62). Findings included: 1. Resident #55 was admitted to the facility on 8/31/2022 with diagnoses including non-Alzheimer's dementia. The annual Minimum Data Set (MDS) assessment dated 9/6/2023 indicated Resident #55 spoke clearly, made herself understood and had the ability to understand others. The assessment for the Brief Interview for Mental	F 641	1. A. The MDS assessment for Resident #55 dated for 9-6-23 will be corrected to show that the Brief Interview for Mental Status (BIMS) was conducted but that resident refused to answer the questions. This MDS assessment will be corrected by 11-30-23. B. The MDS assessment for Resident #47 dated for 9-20-23 was corrected to show that Resident #47 is receiving antiplatelet medication and not anticoagulant medication. This MDS assessment will be corrected by 11-30-23. C. The MDS assessment for Resident #62 dated for 8-11-23 will be corrected to show that the Mood Section was	11/30/23

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F 641

Continued From page 5

Status (BIMS) indicated an interview was not conducted because the "resident is rarely/never understood." A staff assessment for Resident #55's cognitive pattern was completed and noted short- and long-term memory problems and moderately impaired cognitive skills for daily decision making.

During an interview with Resident #55 on 10/30/2023 at 12:10 p.m., she was observed understanding questions asked and clearly speaking, making herself understood in answering. Resident #55 was able to verbalize how she changed her dressings to both of her lower legs daily.

In an interview with Social Worker (SW) #1 on 11/2/2023 at 10:29 p.m., she explained Resident #55's hearing, speech, and vision on the MDS assessment was completed by an MDS consultant who was helping the facility, and that she completed the cognitive pattern assessment. She stated Resident #55 could clearly verbalize answers to questions and participated in interviews depending on her mood. She stated "rarely understood" meant not participating in conversation, and the resident did not want to participate in the interview because she usually was found completing personal care. She explained she should have entered a note in the resident's record to explain why Resident #55 did not participate in the brief interview to assess mental status.

In an interview with the Director of Nursing on 11/2/2023 at 12:35 p.m., she stated Resident #55's speech was clear and was able to understand. She explained Resident #55 could answer questions if asked, and if she didn't

F 641

conducted but that resident did not respond to the questions. This MDS assessment will be corrected by 11-30-23.

2. A. The most recent MDS for each resident in the facility will be audited to ensure that the BIMS and Mood section was completed accurately. This audit will be completed by the Administrator and the audit will be completed by 11-30-23.

B. The most recent MDS for each resident in the facility taking aspirin will be audited to ensure that the aspirin is coded as an antiplatelet medication and not an anticoagulant medication. This audit will be completed by the Administrator and the audit will be completed by 11-30-23.

C. The most recent MDS for each resident in the facility will be audited to ensure that the BIMS and Mood section was completed accurately. This audit will be completed by the Administrator and the audit will be completed by 11-30-23.

3. A. The facility Social Worker and MDS nurses will be inserviced on making sure that the BIMS section and the Mood section of the MDS is filled out accurately. This inservice will be provided by the Administrator and will be completed by 11-30-23.

B. The MDS nurses in the facility will be inserviced regarding aspirin should be listed as an antiplatelet medication on the MDS assessment and not as an anticoagulant medication. This inservice

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answer at first, one needed to ask again, and she would answer. She stated SW #1 should have completed the brief interview for mental status on the MDS assessment for Resident #55 so a BIMS score could be calculated.

2. Resident # 47 was admitted to the facility on 9/13/2023, and diagnoses included coronary artery disease.

Physician orders dated 9/14/2023 included Aspirin (an antiplatelet that helps to thin the blood and prevent blood clots) 81 milligrams in the morning for cardiac disease.

The admission Minimum Data Set (MDS) assessment dated 9/20/2023 indicated Resident #47 received anticoagulants (reduces the blood's ability to clot; increasing the risk for bleeding) for seven days in the 7-day look back period.

The care plan dated 10/11/2023 indicated Resident #47 was on antiplatelet (prevents platelets from sticking together and forming a blood clot) therapy, and interventions included administering antiplatelet medications as ordered by physician.

In an interview with MDS Nurse #1 (MDS Coordinator) on 11/2/2023 at 10:47 a.m., she explained Aspirin was an antiplatelet medication. After reviewing the physician orders, she stated Resident #47 should not have been coded for receiving anticoagulants and referred questioning why Resident #47 was coded for the use of anticoagulants to MDS Nurse #2 since she was the person responsible for completing MDS assessments.

F 641

will be provided by the Administrator and will be completed by 11-30-23.

C. The facility Social Worker and MDS nurses will be inserviced on making sure that the BIMS section and the Mood section of the MDS is filled out accurately. This inservice will be provided by the Administrator and will be completed by 11-30-23.

4. A. An audit will be completed on all MDS assessments that are completed in the next 120 days to ensure that the BIMS and Mood section is filled out accurately. This audit will be performed on a weekly basis x 4 weeks and then monthly x 3 months. The audit will be performed by the Administrator or their designee.

B. An audit will be completed on all MDS assessments that are completed in the next 120 days to ensure that aspirin is coded as an antiplatelet medication and not an anticoagulant medication. This audit will be performed on a weekly basis x 4 weeks and then monthly x 3 months. The audit will be performed by the Administrator or their designee.

C. An audit will be completed on all MDS assessments that are completed in the next 120 days to ensure that the BIMS and Mood section is filled out accurately. This audit will be performed on a weekly basis x 4 weeks and then monthly x 3 months. The audit will be performed by the Administrator or their designee.

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F 641	Continued From page 7 In a telephone interview with MDS Nurse #2 on 11/2/2023 at 11:17 a.m., she stated she coded Resident #47's use of Aspirin wrong. She stated Aspirin was an antiplatelet and should not have been coded as an anticoagulant. She was not able to give a reason why Resident #47's MDS was coded incorrectly. In an interview with the Administrator on 11/2/23 at 11:45 a.m., he stated the MDS assessment should be an accurate assessment of Resident #47. In an interview with the Director of Nursing on 11/2/2023 at 12:39 p.m., she stated Aspirin was an anticoagulant and Resident #47's MDS was coded wrong. 3. Resident #62 was admitted to the facility on 7/24/23. Diagnoses included, in part, non-Alzheimer's dementia. The admission MDS assessment dated 8/11/23 revealed Resident #62 was coded as usually understands others and was understood by others. She had clear speech. The Brief Interview for Mental Status (BIMS) was completed with the resident and she was coded as having severe cognitive impairment. Further review of the MDS assessment demonstrated the mood section was completed by Social Worker (SW) #1. The resident mood interview was not completed with Resident #62. A review of the first question in the mood section, "Should resident mood interview be conducted?" was coded as, "No, resident is rarely/never understood." Resident #62 was interviewed on 10/30/23 at 11:45 AM. During the interview, the resident's	F 641	5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that (1) the BIMS and Mood sections on the MDS assessments are being filled out accurately and (2) that aspirin is being coded as an antiplatelet medication and not an anticoagulant medication on the MDS assessments. Compliance Date: 11-30-23	

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F 641		F 641		

Continued From page 8
speech was clear. She stated she thought she had been at the facility for a couple of days.

During an interview with SW #1 on 10/31/23 at 11:08 AM, she explained she was responsible for completion of the mood section of the MDS assessment. SW #1 stated she had not documented whether Resident #62 responded verbally to her when she attempted the mood interview but thought the resident must have been uncooperative and unresponsive which is why she coded her as rarely/never understood.

The Speech Therapist was interviewed on 11/1/23 at 9:55 AM. She shared she conducted the BIMS interview for all new admissions. She verified she met with Resident #62 and interviewed her for the BIMS portion of the cognition section of the MDS assessment. She stated during her interview with Resident #62, the resident verbally communicated her wants and needs. Additionally, the Speech Therapist explained during the BIMS interview, the resident heard the questions but had not correctly answered the questions. She added staff understood Resident #62's speech but "it may not have been appropriate."

In an interview with MDS Nurse #1 on 10/31/12 at 11:30 AM, she shared she had worked at the facility for two months and was new to the MDS position. She stated if the communication section indicated the resident was understood, and the BIMS interview was completed with the resident, then the resident mood interview should have also been completed.

MDS Nurse #2 was interviewed by telephone on 11/1/23 at 1:21 PM. She shared when she met

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F 641	Continued From page 9 with Resident #62 and completed her portion of the MDS assessment, the resident answered her questions with clear speech. She stated Resident #62 should have been able to understand and respond to the SW's questions for the mood interview. During an interview with the Administrator on 11/2/23 at 10:55 AM, he explained when Resident #62 first came to the facility she was not always cooperative with care. He thought the reason SW #1 coded the resident as being rarely understood was because the resident wouldn't answer the mood interview questions.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:	F 644		11/30/23

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F 644	Continued From page 10 Based on record review and staff interviews, the facility failed to complete a Preadmission Screening and Resident Review (PASRR) screening for 1 of 1 resident reviewed for PASRR (Resident #51). Findings included: Review of Resident #51's PASRR dated 12/27/18 revealed her PASRR number ended in an 'E' (which was a level II PASRR) and expired on 1/26/19. Resident #51 was admitted to the facility on 8/12/22. Her active diagnoses included schizophrenia. Review of Resident #51's significant change Minimum Data Set assessment dated 7/9/23 revealed she was assessed as not being considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Review of North Carolina Medicaid Uniform Screening Tool (NC MUST) documentation on 10/31/23 at 10:34 AM with Social Worker #1 revealed Resident #51's most recent PASRR screen was on 12/27/18 and her PASRR number ended in an 'E' and was expired on 1/26/19. Resident #51 did not have a current PASRR. During an interview on 10/31/23 at 10:36 AM Social Worker #1 stated Resident #51 was transferred from the facility's Assisted Living section to the facility's Skilled Nursing section, and she was unsure what happened during the transfer and why Resident #51 did not have a PASRR upon admission to Skilled Nursing. The	F 644	1. The PASRR for resident #51 was requested and obtained on 11-6-23. 2. An audit will be completed on all current residents in the facility to ensure that they all have a current PASRR. This audit will be completed by the Administrator and will be completed by 11-30-23. 3. The facility social worker, admissions coordinator and RCC will be inserviced on ensuring that all residents in the facility and all residents that are admitted in the future have a current PASRR. This inservice will be conducted by the administrator and will be completed by 11-30-23. 4. All new admissions to the facility will be audited to ensure that they have a current PASRR before being admitted to the facility. This audit will take place weekly x 4 weeks and then monthly x 3 months. This audit will be completed by the Administrator or their designee. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that each resident in the facility has a current PASRR. Compliance Date: 11-30-23	

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F 644	Continued From page 11 admission from Assisted Living to Skilled Nursing was handled by Rest Home Care Coordinator #1 (RCC #1) who was on vacation today, but the Administrator also may have further information. She concluded resident's PASRRs were to be sent in for a rescreen if it expired or if there was a significant change in status completed on the resident. During an interview on 10/31/23 at 10:51 AM the Administrator stated RCC #1 was responsible for ensuring residents transferred from the Assisted Living to Skilled Nursing with the appropriate documentation. He concluded all residents should have a PASRR screen prior to being admitted to Skilled Nursing and he did not know what happened with Resident #51. During an interview on 11/1/23 at 9:49 AM RCC #1 stated Resident #51 had been on hospice while she was in Assisted Living and RCC #1 did not think hospice residents required a PASRR. She concluded when Resident #51 transferred to Skilled Nursing, she did not know anything about Skilled Nursing and let them handle that part of the admission to Skilled Nursing.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		11/30/23

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F 657	Continued From page 12 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure an individualized person-centered care plan was accurate for smoking for 1 of 19 residents reviewed for comprehensive care plan (Resident #47). Findings included: Resident #47 was admitted to the facility on 9/13/2023. The 5-day admission Minimum Data Set (MDS) assessment dated 9/20/2023 indicated Resident #47 was moderately cognitive impaired and did not use tobacco products. The smoking assessment dated 10/4/2023 indicated Resident #47 was safe to smoke with supervision based on Resident #47 cognitive	F 657	1. Resident #47 care plan has updated to ensure that the correct information regarding resident□s smoking status is reflected accurately in their care plan. This was completed on 10-31-23. 2. The care plans for all current residents in the facility will be audited to ensure that an individualized person-centered care plan is accurate for smoking. This audit will be performed by the administrator and will be completed by 11-30-23. 3. The MDS nurses in the facility will be inserviced on ensuring that an individualized person-centered care plan is accurate for smoking for the residents of the facility. This inservice will be	

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F 657	Continued From page 13 loss, visual deficits, and dexterity problems. The smoke assessment further indicated Resident #47 needed adaptive equipment (smoking apron) when smoking, and the facility was to store Resident #47's cigarette and lighter. The care plan dated 10/4/2023 indicated Resident #47 wished to smoke cigarettes and had been assessed as safe to smoke independently. Interventions included Resident#47 was informed on the facility's smoking policy and encouraged to adhere, and Resident #47 may have access to smoking materials. The care was updated on 10/18/2023 that directed Resident #47 may smoke only with the use of a smoking apron. On 11/2/2023 at 10:58 a.m. in an interview with MDS Nurse #1, she stated she had been at the facility for two months and was responsible for completing and updating care plans. She explained Resident #47 was not identified as a smoker after the completion of the admission MDS assessment when the family brought Resident #47 some cigarettes. She stated when the smoking assessment was completed, Resident #47 was care planned as an independent smoker because she understood Resident #47 was identified as a safe smoker. She recalled around 10/18/2023, the administrative staff questioning his cognitive status and were planning to reassess the cognitive status of Resident #47. She stated she didn't want to change the care plan to indicate Resident #47 was an unsafe smoker until someone informed her different than what was on his care plan. She said she attended morning meetings and didn't recall that a final decision as to if Resident #47 was a safe smoker or unsafe	F 657	provided by the administrator and will be completed by 11-30-23. 4. Care plans will be audited on a weekly basis x 4 weeks and then monthly x 3 months to ensure that an individualized person-centered care plan is accurate for smoking. The facility will audit 25% of the facility population on each audit. The audit will be completed by the administrator or their designee. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that an individualized person-centered care plan is accurate for smoking. Compliance Date: 11-30-23	

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smoker that needed supervision was discussed or was informed to change Resident #47's care plan to require supervision for smoking.

On 11/2/2023 at 11:17 a.m. in a phone interview with MDS #2, she stated she recalled although there was some discussion of nursing administration reassessing Resident #47 cognitive status, the MDS department staff were not informed of any changes in Resident #47's admission assessment. Therefore, since the smoking assessment was used to care plan for smoking, Resident #47 care plan should had been changed to reflect he was a supervised smoker when the care plan was revised on 10/18/2023 for the use of a smoking apron. She explained there were two MDS nurses in the department, and she conducted the MDS assessments and MDS Nures #1 was responsible for the care plans.

On 11/2/2023 at 11:39 a.m. in an interview with the Assistant Director of Nursing/Staff Development Coordinator, she stated she did not reassess Resident #47's cognitive status, and she based the need for supervision when smoking on Resident #47 cognitive status when the smoking assessment was conducted on 10/4/2023 due to Resident #47 being confused at times.

On 11/2/2023 at 11:45 a.m. in an interview with the Administrator, he stated nursing staff should notify a member of the administrative staff when there was a difference in Resident #47's care plan and his smoking assessment to be addressed. Since Resident #47 was assessed as a resident needing supervision to smoke, he should had been care planned as a supervised

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F 657	Continued From page 15 smoker and not an independent smoker. On 11/2/2023 at 12:39 a.m. in an interview with the Director of Nursing, she stated based on Resident #47's smoking assessment, he should had been care plan as requiring supervision when smoking instead of an independent smoker.	F 657		
F 689 SS=E	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 record review, observations, resident interview and staff interviews, the facility failed to provide supervision to a resident (Resident # 47), who was assessed as a supervised smoker, while Resident #47 was smoking in the designated smoking area, secure Resident #47's smoking materials and complete quarterly smoking assessments for a resident (Resident #7), who was assessed as not requiring supervision when smoking, for 2 of 2 residents reviewed for accidents. Findings included: 1. The facility's undated "Smoking Policy" stated a safe to smoke with supervision-assisted smoker: a. Must request smoking items, which are to	F 689	1. A. Resident #47 smoking assessment was updated on 10-31-23. Upon reassessment resident was determined to be an independent smoker and did not need any assistance or restrictions when he is smoking. B. A quarterly smoking assessment was performed on Resident #7 on 10-31-23. 2. A. An audit will be performed to ensure that all residents who smoke have an accurate smoking assessment completed. This audit will be performed by the administrator and will be completed by 11-30-23. B. An audit will be performed to ensure	11/30/23

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be stored at the nursing station, form staff daily and return them to the station at end of day.

b. All tobacco products must be lit by either a staff member of a responsible adult.

c. May not possess or use matches, lighters, or any other flame producing device.

d. Must smoke in designated areas.

Resident #47 was admitted to the facility on 9/13/2023.

The 5-day admission Minimum Data Set (MDS) assessment dated 9/20/2023 indicated Resident #47 was moderately cognitive impaired and did not use tobacco products.

The smoking assessment dated 10/4/2023 indicated Resident #47 was safe to smoke with supervision based on Resident #47 cognitive loss, visual deficits, and dexterity problems. The smoke assessment further indicated Resident #47 needed adaptive equipment (smoking apron) when smoking, and the facility was to store Resident #47's cigarette and lighter.

The care plan dated 10/4/2023 indicated Resident #47 wished to smoke cigarettes and had been assessed as safe to smoke independently. Interventions included Resident#47 was informed on the facility's smoking policy and encouraged to adhere, and Resident #47 may have access to smoking materials. The care was updated on 10/18/2023 that directed Resident #47 may smoke only with the use of a smoking apron. A white smoking apron was observed in a chair in Resident #47's room.

An observation and interview with Resident #47

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that all residents who smoke have a currently quarterly smoking assessment completed. This audit will be performed by the administrator and will be completed by 11-30-23.

3. A. All facility staff will be inserviced on the facility smoking policy and the different types of smoking categories that a resident my be assessed at along with the possible restrictions for each type of smoking category. This inservice will be performed by the Director of Nursing or their designee and will be completed by 11-30-23.

B. The facility nurses will be inserviced on completing quarterly smoking assessments on all those residents who smoke. This inservice will be performed by the Director of Nursing or their designee and will be completed by 11-30-23.

4. A. An audit will be completed on those residents who smoke to ensure that the smoking assessment is accurate and any restrictions are in place, if needed. This audit will be completed weekly x 4 weeks and then monthly x 3 months. The audit will be performed by the Director of Nursing or their designee.

B. An audit will be completed to ensure that quarterly smoking assessments and being completed on the residents who smoke. This audit will be completed weekly x 4 weeks and then monthly x 3 months. The audit will be performed by

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F 689	Continued From page 17 were conducted on 10/30/2023 at 11:56 a.m. A pack of cigarettes and a lighter were observed on Resident #47's bedside table. Resident #47 stated he was allowed to keep his smoking materials in his room. He explained he did not require staff to supervise him when he smoked, and he wore an apron when he was outside in the designated smoking area smoking. On 10/31/2023 at 1:47 p.m. an observation and interview were conducted. Resident #47 was observed sitting outside in the designated smoking area not wearing a smoking apron and holding a lit cigarette in his left hand between his second and third fingers. There were no staff members observed in the smoking area to supervise Resident #47 while he smoked. Resident #47 stated he lit his own cigarette and forgot to bring his smoking apron. At 1:51 p.m., Resident #47 was observed dropping a lit cigarette he was holding between his lips when he spoken to another resident in the designated smoking area. The cigarette fell from his lips, onto his shirt and between his legs before landing onto the concrete. There were no burnt areas observed to Resident #47's clothing. Resident #47 was observed picking up the lit cigarette from the concrete and continued to smoke. On 10/31/2023 at 1:53 p.m. in an interview with Medication Aide #2 (assigned to Resident #47), she stated Resident #47 was able to keep his smoking materials in his room. She explained Resident #47 was to wear a smoking apron when smoking and did not require supervision (watching) to smoke in the designated smoking area. She stated NA #3 (NA assigned to Resident #47) assisted Resident #47 to the designated smoking area. In a follow up interview with	F 689	the Director of Nursing or their designee. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that (1) residents who smoke have an accurate smoking assessment completed and any restrictions are in place, if needed and (2) that quarterly smoking assessments are completed on residents who smoke. Compliance Date: 11-30-23	

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Medication Aide #2 on 10/31/2023 at 3:09 p.m., she stated she learned from the Assistant Director of Nursing/Staff Development Coordinator Resident #47 required supervision when smoking after his observation smoking outside in the designated smoking area without supervision earlier in the day, and he was to wear the smoking apron when smoking. She said she had not observed Resident #47 smoking in his room or with burnt holes in his clothes.

On 10/31/2023 at 1:56 p.m. in an interview with the Assistant Director of Nursing/Staff Development Coordinator, she stated she conducted Resident #47's smoking assessment on 10/4/2023. She said a staff member was to accompany Resident #47 to the designated smoking area when he was smoking, and Resident #47 was to wear a smoking apron when smoking. She further stated Resident #47's smoking materials were to be locked in the medication cart and obtained from the nursing prior to smoking. She further stated Resident #47 had not smoked in his room, and she had not observed burnt areas on Resident #47's clothing.

On 10/31/2023 at 2:14 p.m. in an interview with NA #3, she stated Resident #47 kept his smoking materials in his room and was able to go to the designated smoking area at any time. She explained Resident #47 did not require supervision when smoking and usually did not wear the smoking apron. She stated she tried to get Resident #47 to wear the smoking apron when she observed him going to the designated smoking area, and Resident #47 would not wear the smoking apron. In a follow up interview with NA #3, she stated she had not observed anything written at the facility identifying Resident #47 as a

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supervised smoker or communicated by the nurse.

On 10/31/2023 at 2:17 p.m., the Administrator was informed how Resident #47 was observed with smoking materials in his room on 10/30/2023 and 10/31/2023 and smoking in the designated smoking area not supervised and dropping his cigarette on 10/31/2023. The Administrator explained residents requiring supervision when smoking could not keep smoking materials in their room. He stated Resident #47 wore an apron majority of the time, and he had not been observed smoking unsafely.

In a follow up interview with the Administrator on 11/2/2023 at 11:45 a.m., he stated since Resident #47's was assessed as a supervised smoker, a staff member should supervise Resident #47 when he is smoking in the designated smoking area.

In an interview with the Director of Nursing on 11/2/2023 at 12:39 p.m., she explained the facility was not aware Resident #47 was a smoker until the family brought smoking materials into the facility for Resident #47. She stated after the family brought Resident #47 smoking materials, a smoking assessment was conducted, and Resident #47 was assessed as requiring staff supervision and the use of an apron when smoking. She explained nurse aides did not have access to Resident #47's smoking assessment. She stated if a smoking task for Resident #47 was not listed in the electric medical record for nurse aides, the nurse aide must ask the nurse for instructions on Resident #47 smoking.
2. Review of the facility's undated smoking policy revealed all smokers were required to undergo a

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smoking assessment quarterly.

Resident #7 was admitted to the facility on 12/16/21.

Review of Resident #7's comprehensive Minimum Data Set assessment dated 12/22/22 revealed he was assessed to use tobacco.

Review of Resident #7's quarterly Minimum Data Set assessment dated 9/20/23 revealed he was assessed as cognitively intact.

Review of Resident #7's care plan dated 9/29/23 revealed he was care planned to wish to smoke cigarettes and had been assessed as safe to smoke independently. The interventions included to inform the resident of facility smoking policy and encourage adherence, inform the resident that noncompliance could lead to removal of smoking items, monitor for adherence to smoking policy, orient resident to designated smoking areas, resident may have access to smoking materials, and update the smoking assessment quarterly.

Review of Resident #7's medical record revealed his last smoking assessment was completed on 3/21/22. He was assessed to be safe to smoke without supervision.

During an interview on 10/30/23 at 10:59 AM Resident #7 stated he was a safe smoker and was able to smoke independently.

During an interview on 10/31/23 at 9:00 AM Nurse #1 stated smoking assessments were done quarterly and the electronic health record automatically populated an alert for the staff if

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F 689	Continued From page 21 smoking assessments were due. She stated she did not know why Resident #7's assessment had not been done since 2022 and why the electronic health record was not notifying staff of the need for a smoking assessment. During an interview on 10/31/23 at 9:07 AM the Director of Nursing stated smoking assessments were to be completed quarterly and the last that was done for Resident #7 was in March of 2022. She reported there should have been smoking assessments quarterly throughout 2023 for Resident #7. She concluded she would complete a smoking assessment on Resident #7. Review of the smoking assessment completed on 10/31/23 by the Director of Nurisng revealed Resident #7 was assessed as safe to smoke without supervision. During observation on 10/31/23 at 2:27 PM Resident #7 was observed smoking in the smoking area smoking. No concerns were identified with Resident #7's ability to smoke independently.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		11/30/23

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F 690	Continued From page 22 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews, the facility failed to attach an indwelling urinary catheter tubing to a secure device to prevent tension and possible injury, to position the urinary collection bag at a lower level than the urinary bladder to allow gravity drainage of urine into the collection bag, to ensure the urinary tubing was not touching the floor for 1 of 2 residents reviewed for urinary catheter (Resident #47). Findings included:	F 690	1. Resident #47 had the indwelling urinary catheter tubing attached to a secure device to prevent tension and possible injury. The catheter collection bag was positioned at a lower level then the urinary bladder to allow gravity drainage of urine into the collection bag. The urinary tubing was ensured to not be touching the floor. This was completed on 11-3-23. 2. An audit will be performed on the current residents with an indwelling	

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F 690	Continued From page 23 Resident #47 was admitted to the facility on 9/13/2023, and diagnoses included obstructive uropathy. The 5-day admission Minimum Data Set (MDS) assessment dated 9/20/2023 indicated Resident #47 was moderately cognitively impaired and used an indwelling catheter for urination. Physician orders dated 9/13/2023 included using an indwelling catheter to bedside drainage for urinary retention. In reviewing the electronic medical record from 9/13/2023 to 11/2/2023, there was no nursing documentation indicating the use of a catheter secure device for Resident #47. On 10/30/2023 at 10:31 a.m., after Nurse Aide (NA) #1 had assisted him to his wheelchair, Resident #47 was observed in the hallway self-propelling the wheelchair with other residents in the hallway. Resident #47's catheter bag was observed hanging from the arm of the wheelchair on the right side, which would have been either above or equal to the resident's bladder. The level of urine in the bag was observed to be at the fifty milliliters mark. On 10/30/2023 at 11:49 a.m., Resident #47 was observed lying in the bed with the head of bed elevated. The observation was conducted in conjunction with an interview with the resident. The urine collection bag was observed positioned at the top of the footboard on the bed. The urine collection bag was positioned higher than Resident #47's bladder as evidenced by the bag being at a level above the resident's hips, and yellow urine was observed in the urine collection	F 690	urinary catheter to ensure that the tubing is attached with a secure device to prevent tension and possible injury, that the catheter collection bag is positioned at a lower level then the urinary bladder to allow gravity drainage of urine into the collection bag and that the urinary tubing is not touching the floor. This audit will be performed by Director of Nursing or their designee and will be completed by 11-30-23. 3. The facility nursing staff will be inserviced regarding ensuring that the indwelling urinary catheter tubing is attached with a secure device to prevent tension and possible injury, that the catheter collection bag is positioned at a lower level then the urinary bladder to allow gravity drainage of urine into the collection bag and that the urinary tubing is not touching the floor. This inservice will be performed by Director of Nursing or their designee and will be completed by 11-30-23. 4. An audit will be performed to ensure that residents with an indwelling urinary catheter have their tubing attached with a secure device to prevent tension and possible injury, that the catheter collection bag is positioned at a lower level then the urinary bladder to allow gravity drainage of urine into the collection bag and that the urinary tubing is not touching the floor. This audit will be performed weekly x 4 weeks and then monthly x 3 months and will be completed by the Director of Nursing or their designee.	

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F 690	Continued From page 24 bag at the fifty milliliters mark. He explained the urine collection bag was usually positioned on the side to the bed frame, and a "girl" placed it on the footboard. He said it got on his nerves that the urine collection bag was not positioned lower so urine would drain into the collection bag. On 10/30/2023 at 12:05 p.m., the catheter tubing was observed lying alongside the right leg while the resident rested in bed. The observation was conducted in conjunction with an interview. There was no secure device observed on either thigh to secure the indwelling catheter. Resident #47 stated the secure device was lost about three months ago and had not been replaced. He stated he had to be careful when moving so the catheter would not pull because it hurt when the indwelling catheter was pulled. On 10/30/2023 at 2:08 p.m., Resident #47 was observed self-propelling his wheelchair in the hallway with the urine collection bag hanging under the seat of the wheelchair, and the tubing was touching the floor. On 10/31/2023 at 2:07 p.m. in an interview with NA #1 (assigned to Resident #47 on 10/30/2023 7:00 a.m. to 3:00 p.m.), she stated Resident #47 used a dressing to keep the indwelling catheter tubing from pulling and thought Resident #47 had a dressing securing the indwelling catheter tubing when she was dressing Resident #47 on 10/30/2023. She further explained she placed the indwelling catheter with enough tubing to not pull when Resident #47 was moving. When NA #1 was asked about the positioning of the urine collection bag on the arm of the wheelchair and footboard of the bed observed on 10/30/2023, NA #1 stated the urine collection bag was to be at the	F 690	5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that any resident with indwelling urinary catheters have their tubing is attached with a secure device to prevent tension and possible injury, that the catheter collection bag is positioned at a lower level then the urinary bladder to allow gravity drainage of urine into the collection bag and that the urinary tubing is not touching the floor. Compliance Date: 11-30-23	

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F 690	Continued From page 25	F 690		

lower level of the bed frame to allow urine to flow into the urine collection bag and she did not position the urine collection bag on the arm rest of the wheelchair or the footboard of the bed on 10/30/23. She explained Resident #47 would reposition the urine collection bag. She further stated the indwelling catheter tubing should not touch the floor, and she did not see the tubing touching the floor when she placed the urine collection bag underneath the wheelchair.

On 11/1/2023 at 9:10 a.m., Resident #47's indwelling catheter was observed not secured with a device when NA #2 and Nurse #3 (Wound Nurse) removed Resident #47's adult brief for wound care. The indwelling catheter tubing was positioned upward out of the brief on the left hip area underneath the adult brief. There was no secure device observed on the right or left thigh.

On 11/1/2023 at 09:15 a.m., NA #2 was observed reapplying Resident #47's adult brief after wound care was completed without securing the urinary catheter to a secure device.

In an interview with NA #2 on 11/1/2023 at 9:15 a.m., she said the facility used a secure strap to secure the indwelling catheter and Resident #47 may have taken it off. She stated his assigned nurse would need to reapply a secure strap for the catheter.

In an interview with Medication Aide #1 on 11/1/2023 at 2:13 p.m., she stated NA #2 had informed her Resident #47 needed a secure device for the indwelling catheter. NA #2 explained nurse aides and nurses could apply a secure device and did not know why a secure device had not been applied to Resident #47.

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F 690	Continued From page 26 In an interview with the Central Supply Coordinator on 11/1/2023 at 2:44 p.m., she stated no one had requested a secure device and a cover for the urine collection bag for Resident #47. She explained the secure device was part of the indwelling catheter kits and were also assessable in central supply for use on Resident #47 as needed. In an interview with the Director of Nursing on 11/1/2023 at 4:18 p.m., she explained when Resident #47's indwelling catheter.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to administer supplemental oxygen as prescribed by the physician and failed to place signage indicating the use of oxygen for 1 of 1 resident reviewed for oxygen use (Resident #269). Findings included: Resident #269 was admitted to the facility on 10/20/2023, and diagnoses included chronic	F 695	1. A. Resident #269 oxygen level was adjusted to 3L per minute to ensure the oxygen they were receiving was consistent with the physician order. This was completed on 11-2-23. B. Resident #269 had an oxygen in use signed placed outside their door on 10-31-23. 2. A. An audit will be performed on	11/30/23

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F 695 Continued From page 27
obstructive pulmonary disease (COPD).

The baseline care plan dated 10/20/2023 indicated Resident #269 was cognitively intact, received oxygen therapy while a resident in the facility and had COPD. Interventions included setting oxygen at 3 liters per minute by nasal prongs continuously and humified (increased moisture level).

Physician orders dated 10/20/2023 included oxygen via nasal cannula at 3 liters per minute every shift for shortness of breath.

Nursing documentation dated 10/20/2023 at 5:40 p.m. by Nurse #2 reported Resident #269 was receiving oxygen at 4 liters via nasal cannula on admission. There was no further documentation in Resident #269 electronic medical record related to his use of oxygen, complaints of shortness of breath, or increasing the oxygen level of administration.

Hospice medication list dated 10/23/2023 included wearing oxygen at 3 liters per minute.

A review of the admission Minimum Data Set (MDS) assessment dated 10/26/2023 was shown as "in progress", and there was no data recorded related to the use of oxygen.

A review of the October 2023 Treatment Administration Record (TAR) reported nursing staff recorded Resident #269 received 3 liters per minute of oxygen every shift.

On 10/30/2023 at 11:03 a.m., there was no "Oxygen in Use" signage observed outside Resident #269's room, and Resident #269's

F 695

those residents receiving oxygen to ensure that they were receiving the amount that was ordered by their physician. This audit will be performed by the Director of Nursing or their designee and will be completed by 11-30-23.

B. An audit will be performed on those residents receiving oxygen to ensure that they have an oxygen in use sign placed outside of their room door. This audit will be performed by the Director of Nursing or their designee and will be completed by 11-30-23.

3. A. The facility nurses and med aides will be inserviced on ensuring that the residents who receive oxygen are receiving the correct amount based on the physician order for each resident. This inservice will be performed by the Director of Nursing and will be completed by 11-30-23.

B. The facility nursing staff will be inserviced on ensuring that the residents who are receiving oxygen have an oxygen in use sign placed outside of their room door. This inservice will be performed by the Director of Nursing and will be completed by 11-30-23.

4. A. An audit will be performed to ensure that any resident who is receiving oxygen is receiving the correct amount based on their doctor order. This audit will be performed weekly x 4 weeks and then monthly x 3 months. This audit will be performed by the Director of Nursing or

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oxygen was observed set delivering 4 liters of oxygen per minute via nasal cannula.

On 10/31/2023 at 3:30 p.m. in an interview with the Assistant Director of Nursing/ Staff Development Coordinator, she stated since Resident #269 was using oxygen, a "Oxygen in Use" sign was to be placed outside the door. She said the nurse who admitted Resident #269 or applied Resident #269's oxygen was responsible for initially placing the "Oxygen in Use" signage outside the door. She explained she checked daily for "Oxygen in Use" signs were outside residents' door and had not checked Resident #269's room on this day.

On 11/1/2023 at 2:14 p.m., Resident #269 was observed sitting in his wheelchair in the center of his room wearing oxygen via nasal cannula with oxygen administration level set at 4 liters per minute.

On 11/1/2023 at 2:20 p.m. in an interview with Medication Aide #1, she stated she was responsible for checking the oxygen administration level was set to deliver oxygen as prescribed by the physician. She explained she checked the oxygen administration level that morning and was unable to recall the oxygen administration level setting. After reviewing Resident #269's Medication Administration Record, she stated Resident #269 was receiving oxygen at 3 liters per minute. When informed Resident #269's oxygen was observed set at 4 liters per minute, she stated she didn't know why Resident #269's oxygen would be set at 4 liters per minute, and the oxygen administration level should be set as ordered by the physician.

F 695

their designee.

B. An audit will be performed to ensure that any resident who is receiving oxygen has an oxygen in use sign placed on the outside of the room door. This audit will be performed weekly x 4 weeks and then monthly x 3 months. This audit will be performed by the Director of Nursing or their designee.

5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that (1) any resident who is receiving oxygen is receiving the correct amount based on their physician order and (2) any resident who is receiving oxygen has an oxygen in use sign placed outside of their room door.

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F 695	Continued From page 29 On 11/1/2023 at 1:59 p.m. in a phone interview with Nurse #2, she recalled admitting Resident #269 to the facility on 10/20/2023 and stated on arrival at the facility the transportation team connected Resident #269 to the facility's oxygen concentrator. She explained she was responsible for continuing oxygen therapy on admission as ordered and documenting in the admission note and was not able to recall physician's order. She stated she did not place a "Oxygen in Use" sign outside Resident #269's door and did not know whose responsibility it was for putting the "Oxygen in Use" signage outside the door. On 11/1/2023 at 4:18 p.m. in an interview with the Director of Nursing, she stated the nursing staff should have placed "Oxygen in Use" sign outside Resident #269's door due to his use of oxygen. She explained Resident #269 increased the level of oxygen administration if he was feeling short of breath. She stated nursing staff were to ensure the oxygen administration level was set at 3 liters per minute as ordered by the physician and were to call the physician if oxygen administration levels needed to be increased for Resident #269. On 11/2/2023 at 9:28 a.m. in an interview with Resident #269, the oxygen administration level was observed set at 3 liters per minute. Resident #269 stated since admission to the facility, he had not increased the oxygen administration level or experienced shortness of breath that required the oxygen administration level to be increased to 4 liters per minute.	F 695		
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	F 867		11/30/23

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F 867	Continued From page 30 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 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	F 867		

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F 867	Continued From page 31 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 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.	F 867		

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F 867	Continued From page 32 §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 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 observations, record review and resident and staff interview, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint surveys of 6/30/22 and 4/13/21. This	F 867	A. Upon review it was determined that the accuracy of assessments for the BIMS, mood section and antiplatelet medication were not be accurately coded on the MDS. B. Upon review it was determined that	

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was for 5 recited deficiencies in the areas of Accuracy of Assessments (F641), Preadmission Screening and Resident Review (PASRR) (F644), Baseline Care Plans (F655), Care Plan Timing and Revision (F657), and Free of Accident Hazards/ Supervision/Devices (F689). The continued failure during 2 or more federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.

The findings included:

The tag is cross-referenced to:

F641-Based on record review and staff interviews, the facility failed to accurately assess cognitive patterns, anticoagulant medication use, and mood for 3 of 20 Minimum Data Set (MDS) assessments reviewed (Resident #55, Resident #47, and Resident #62).

During the recertification and complaint survey of 4/13/21 the facility was cited for failing to code the MDS accurately in the areas of discharge planning, hospice, PASRR, and pressure ulcers.

During the recertification and complaint survey of 6/30/22 the facility was cited for failing to accurately code the MDS in the areas of hospice, discharge status, tobacco use, urinary continence, bowel continence, oxygen therapy, and falls.

F644-Based on record review and staff interviews, the facility failed to complete a Preadmission Screening and Resident Review (PASRR) screening for 1 of 1 resident reviewed for PASRR (Resident #51).

F 867

one resident in the facility did not have a current PASRR within the NC Must system.

C. Upon review it was determined that there was no documentation that the baseline care plan was offered or provided to the resident or resident representative.

D. Upon review it was determined that the facility failed to ensure an individualized person-centered care plan was accurate for smoking within their comprehensive care plan.

E. Upon review it was determined that the facility smoking policy was not being followed based on the results from the resident□s smoking assessment and that quarterly smoking assessments were not being completed per facility smoking policy.

To correct all of the above issues, the facility has put into place the following audits:

A. The MDS Coordinator will complete an audit weekly to ensure that the MDS assessments completed within the last 7 days to ensure that the BIMS, mood section and that aspirin is coded as an antiplatelet. This audit tool will be turned into the Administrator who will perform a double check to ensure the accuracy of the BIMS, mood section and aspirin being coded as an antiplatelet. These audit will

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	345377	A. BUILDING ______ B. WING ______	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(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

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During the recertification and complaint survey of 4/13/21 the facility failed to complete a PASRR screening for a resident.

F655-Based on staff interviews and record review, the facility failed to document evidence that a copy of the baseline care plan was offered or provided to the resident or Resident Representative for 1 of 5 residents (Resident #62) reviewed for baseline care plans.

During the recertification and complaint survey of 4/13/21 the facility failed to complete a baseline care plan.

F657-Based on record review and staff interviews, the facility failed to ensure an individualized person-centered care plan was accurate for smoking for 1 of 19 residents reviewed for comprehensive care plan (Resident #47).

During the recertification and complaint survey of 4/13/21 the facility failed to review and revise the plan of care related to discharge planning and invite a resident's representative to a care plan meeting.

During the recertification and complaint survey of 6/30/22 the facility failed to include the interdisciplinary team (IDT) and the resident's representative (RP) in the development of the comprehensive care plan after a significant change and quarterly assessment, failed to develop a comprehensive care plan, and failed to include hospice in the current comprehensive care plan.

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be reviewed weekly during a facility IDT meeting and then reviewed and discussed with the QAPI committee monthly for 90 days to ensure that this process is being monitored.

B. The Social Worker will complete an audit weekly to ensure that any new admissions to the facility within the last 7 days have a current PASRR on file. This audit tool will be turned into the Administrator who will perform a double check to ensure that each new admission to the facility has a current PASRR on file. These audit will be reviewed weekly during a facility IDT meeting and then reviewed and discussed with the QAPI committee monthly for 90 days to ensure that this process is being monitored.

C. The Director of Nursing or their designee will complete an audit weekly to ensure that there is documentation that the baseline care plan was offered or provided to the resident or the resident representative after it was reviewed with them. This audit will be turned into the Administrator who will perform a double check to ensure there is documentation that the baseline care plan was offered or provided to the resident or the resident representative. These audit will be reviewed weekly during a facility IDT meeting and then reviewed and discussed with the QAPI committee monthly for 90 days to ensure that this process is being monitored.

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F 867	Continued From page 35 F689-Based on record review, observations, resident interview and staff interviews, the facility failed to provide supervision to a resident (Resident # 47), who was assessed as a supervised smoker, while Resident #47 was smoking in the designated smoking area, secure Resident #47's smoking materials and complete quarterly smoking assessments for a resident (Resident #7), who was assessed as not requiring supervision when smoking, for 2 of 2 residents reviewed for accidents. During the recertification and complaint survey of 4/13/21 the facility failed to repair a loose siderail which resulted in a fall with injuries. During the recertification and complaint survey of 6/30/22 the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions. During an interview on 11/02/23 01:16 PM the Administrator stated they provided in-services on a regular basis to prevent repeat deficiencies. He further stated a large amount of turnover, especially within the MDS department including the department head had contributed to some repeat deficiencies. He indicated he felt many of the concerns were isolated and not a systemic issue which meant the concerns were human error and not a fault of the systems in place.	F 867	D. The MDS Coordinator will complete an audit weekly to ensure that an individualized person-centered care plan is accurate for residents who smoke within their comprehensive care plan. This audit will be turned into the Administrator who will perform a double check to ensure that there is an individualized person-centered care plan that is accurate for residents who smoke within their comprehensive care plan. These audit will be reviewed weekly during a facility IDT meeting and then reviewed and discussed with the QAPI committee monthly for 90 days to ensure that this process is being monitored. E. The Staff Development Coordinator will complete an audit weekly to ensure that the facility smoking policy is being followed based on any possible restrictions placed on residents who smoke based on their most recent smoking assessment. The audit will also include ensuring that quarterly smoking assessments are being completed timely on those residents who choose to smoke. This audit will be turned into the Administrator who will perform a double check to ensure that the facility smoking policy is being followed based on any possible restrictions placed on residents who smoke based on their most recent smoking assessment and that the quarterly smoking assessments are being completed timely on those residents who choose to smoke. These audit will be reviewed weekly during a facility IDT	

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F 867	Continued From page 36	F 867	meeting and then reviewed and discussed with the QAPI committee monthly for 90 days to ensure that this process is being monitored. Compliance Date: 11-30-23	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 636	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. (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.

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

The above isolated deficiencies pose no actual harm to the residents

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This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within the regulatory timeframes for 1 of 20 residents reviewed for MDS assessments (Resident #26).

Findings included:

Resident #26 was re-admitted to the facility on 10/4/2023 following a discharge from the facility on 8/29/2023 to the hospital.

On 11/1/2023, a review of Resident #26's admission MDS dated 10/10/2023 was not completed in the following areas: behaviors, preferences for routine and activities, functional abilities and goals, bladder and bowel, oral and dental status, special treatments, procedures and programs, and participation in assessment and goal setting.

On 11/2/2023 at 10:55 a.m. in an interview with MDS Nurse #1, she stated she was responsible for completing resident care plans and MDS Nurse #2 completed the MDS assessments. She further stated she did not know the requirements for the time frames for MDS completion. She explained she had not received MDS training and had been employed for two months.

On 11/2/2023 at 11:28 a.m. in a phone interview with MDS Nurse #2, she explained the admission MDS assessment was to be completed within 14 days after admission, and she had been out of work sick.

On 11/2/2023 at 11:45 a.m. in an interview with the Administrator, he stated he didn't know the number of days MDS staff had to complete Resident #26's MDS assessment. He stated Resident #26's MDS assessment was to be completed in the time allotted in the regulation for MDS assessments.

On 11/2/2023 at 12:38 p.m. in an interview with the Director of Nursing, she stated MDS assessments were to be completed within the regulated time frames. She explained the reasons for the MDS assessment not completed within the 14-day time frame was because of turnover in the MDS department, new MDS staff and staff out of work due to sickness in the MDS department.

F 655

Baseline Care Plan
CFR(s): 483.21(a)(1)-(3)

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-

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(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to document evidence that a copy of the baseline care plan was offered or provided to the resident or Resident Representative for 1 of 5 residents (Resident #62) reviewed for baseline care plans.

Findings included:

Resident #62 was admitted to the facility on 7/24/23. Diagnosis included, in part, non-Alzheimer's dementia.

The medical record was reviewed and revealed a baseline care plan was completed on 7/24/23 and signed by Minimum Data Set (MDS) Nurse #2. Further review of the baseline care plan demonstrated signature lines for the resident and Resident Representative were blank. Additionally, there was no documented evidence that a copy of the baseline care plan was offered or given to the resident or Resident Representative.

The admission MDS assessment dated 8/11/23 revealed Resident #62 had severely impaired cognition.

A telephone interview was conducted with MDS Nurse #2 on 11/1/23 at 1:21 PM. She explained the facility Social Worker (SW) typically set up a meeting with the resident and Resident Representative to review the

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care plan and the SW documented when the care plan meetings were held. When asked if the facility documented in the medical record that a written summary of the baseline care plan was provided or offered to a resident and Resident Representative, MDS Nurse #2 said, "I'll make sure we start doing this."

During an interview with SW #1, MDS Nurse #1 and the Administrator on 11/1/23 at 11:04 AM, the Administrator explained typically a copy of the baseline care plan was provided to the resident or left in the resident's room. The MDS Nurse reviewed it with the resident and/or Resident Representative. SW #1 added she did not think the facility had documented where a summary of the baseline care plan was offered or provided to the resident or Resident Representative. The Administrator said he was unsure if the facility had been documenting that they offered a summary of the baseline care plan to the resident or Resident Representative.