STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	C 01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE HEALTH AND REHABILITATION	111 HARRELSON STREET CHERRYVILLE, NC 28021

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 01/02/24 through 01/05/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# HRSQ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/02/24 through 01/05/24. Event ID# HRSQ11. The following intakes were investigated NC00195276, NC00203195, NC00204722 and NC00206319. 8 of the 8 complaint allegations did not result in deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of hospice services, seizure disorder, and discharge for 3 of 6 residents whose MDS assessments were reviewed (Resident #15, # 205 and #83). Findings Include: 1. Resident #15 was admitted to the facility on 11/08/23 with diagnoses that included end stage renal failure. Review of Resident #15's care plan initiated on 11/09/23 for Hospice care with interventions that	F 641	The statements included in the plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Residents #15 was modified on 1/4/2024	1/6/24

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

Electronically Signed | 01/29/2024

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F 641	Continued From page 1 included Hospice services provided, facility to work with Hospice team and continue to make Resident #15 comfortable. The admission MDS assessment dated 11/16/23 indicated Resident #15 was moderately cognitively impaired. He was not coded for receiving Hospice services both "while a resident" and "while not a resident". An interview with the MDS Coordinator on 01/04/24 at 2:04 PM revealed Resident #15 was admitted to the facility on Hospice care and continued to receive Hospice care while at the facility and his MDS currently did not reflect him receiving Hospice care but should. She stated Resident #15's MDS not reflecting him receiving Hospice care was an oversight based on human error and a correction would need to be made. A telephone interview with the Hospice Nurse on 01/05/24 at 11:34 AM revealed that Resident #15 had been admitted to the facility under Hospice care and had continued to receive Hospice care while a resident at the facility. The Director of Nursing (DON) and Administrator were interviewed on 01/05/24 at 5:49 PM who revealed Resident #15 was receiving Hospice services prior to coming to the facility and currently while at the facility. They stated their process would be for the MDS to reflect current orders and to be accurate and they felt it was just an oversight based on human error on the part of the MDS Coordinator. 2. Resident #205 was admitted to the facility on 12/20/23 with diagnoses that included seizure disorder.	F 641	to reflect accurate coding of Hospice and 6 months or less to live diagnosis on the MDS. Resident #205 was modified on 1/4/2024 to reflect accurate coding of seizure disorder on the MDS. Resident #83 was modified on 1/4/2024 to reflect accurate discharge location on the MDS. All current residents on census as of 1/5/2024 were audited for the following: 1 Hospice accurate coding for diagnosis with life expectancy of less than six months.; 2 accurate coding of seizure disorders, 3 All residents that were discharged in the last 30 days were audited to ensure accurate discharge location was transmitted on MDS. These audits was completed on 1/5/2024 by MDS nurse and Regional MDS Manager. Any errors found were corrected on 1/5/2024. MDS Coordinators were educated on by the Regional MDS Manager on 1/5/2024. This education includes accurate coding Hospice, Discharge Location, and Seizure Disorders. This education will be included on any new MDS, or Social Services staff hired at the time of orientation. The Regional MDS Manager /designee will complete 5 MDS audits weekly for accurate coding Hospice, Seizure disorder, and Discharge location x 4 weeks, then 2 chart audits weekly x 4 weeks, then 5 chart audits x 1 Month. The Administrator will bring the audit for MDS accuracy to the Committee monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness	

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F 641	Continued From page 2 A hospital discharge summary dated 12/20/23 revealed Resident #205 had a history of epileptic seizures. The admission MDS assessment dated 12/27/23 indicated Resident #205 was cognitively intact. Resident #205 was not coded for a seizure disorder during the assessment. Review of Resident #205's Medication Administration Record (MAR) dated December 2023 revealed the following order, Keppra 1,000 milligrams twice a day for non-epileptic seizures. An interview with the MDS Coordinator on 01/04/24 at 2:04 PM revealed Resident #205 was admitted into the facility on 12/20/23 with a diagnosis listed of seizure disorder. She stated she normally would look at the hospital discharge summary to obtain a diagnosis list, however, did not see it at the time she completed the MDS assessment. The MDS Coordinator stated she had missed the diagnosis by mistake. 3. Resident #83 was admitted to the facility on 09/22/23 with diagnoses that included hypertension and cardiomyopathy. The discharge MDS assessment dated 10/12/23 indicated Resident #83 was cognitively intact. Resident #83 was coded as discharged to the hospital. A discharge summary dated 10/12/23 revealed Resident #83 was discharged home with home health services. An interview with the MDS Coordinator on	F 641	of the training to determine if continued auditing is necessary to maintain compliance.	

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F 641	Continued From page 3 01/04/24 at 2:04 PM revealed Resident #83 had a planned discharge home with home health services. She stated she had coded the discharge MDS in error. The interview revealed the MDS should have been coded that Resident #83 was discharged to the community and not the hospital.	F 641		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure items stored ready for use were labeled and dated and/or failed to remove expired food items in 1 of 2 nourishment rooms (300 Hall). These practices had the potential to affect food served to residents.	F 812	The statements included in the plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and	1/6/24

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F 812	Continued From page 4 Findings included: An observation of the 300 Hall nourishment room and interview with the restorative Nurse on 01/02/23 at 10:30 AM revealed in the nourishment room three thick and clear lemon-flavored liquid cups with use by date 12/19/23 and nine thick and liquid lemon-flavored cups with the use by date 12/20/23. The restorative Nurse further revealed dietary was responsible for checking nourishment refrigerators daily, but staff had been educated to throw away according to the use by date. The Nurse indicated items stored should have been already discarded. An interview conducted with the Dietary Manager (DM) on 01/04/24 at 2:28PM revealed dietary staff stocked the nourishment rooms and the items had gotten pushed back into a bottom drawer out of the way. The interview further revealed dietary was responsible for removing the items and cleaning out the refrigerator once items expired daily. The DM indicated staff should have been checking the entire refrigerator for dates and removing expired items. An interview conducted with the Administrator on 01/05/23 at 6:15 PM revealed he expected nourishment rooms to be checked consistently. The Administrator stated expired items in the nourishment rooms refrigerators needed to be discarded.	F 812	state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The expired food items found during observation in the nourishment room (300 Hall) were discarded immediately on 1/2/2024 by the Administrator. All nourishment room fridges were audited for proper storage of food and cleanliness on 1/2/2024 by the Dietary Manager. Any findings were corrected at the time of the audit by the Dietary Manager. All dietary cooks and aides were educated by the Dietary Manager on 1/5/2024 regarding proper food storage. The education will be added to the dietary staff□s orientation for all cooks and dietary aides hired. The Dietary Manager or Designee will audit two of the nourishment room fridges for proper storage of food twice weekly for 4 weeks, then weekly for 8 weeks. The Dietary Manager will report the findings of these audits to the facility Quality Assurance Committee monthly for three months and thereafter as directed by the committee. The Administrator and Quality Assurance/Performance Improvement (QAPI) committee analyze the data and report any patterns/trends to the regional Operations Manager for immediate correction. Findings of the QAPI committee will be reviewed monthly for three months to ensure continued	

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F 812	Continued From page 5	F 812	compliance. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance.	
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. §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.	F 867		1/6/24

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F 867	Continued From page 6 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness 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,	F 867		

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F 867	Continued From page 7	F 867		

resident choice, and quality of care.

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

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

§483.75(g) Quality assessment and assurance.

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

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F 867	Continued From page 8 available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation surveys that occurred on 08/12/21 and 08/25/22. This was for one deficiency cited in August 2021 and August 2022 in the area of Accuracy of Assessments and subsequently cited on the current recertification and complaint investigation survey of 01/05/24. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referred to: F641: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of hospice services, seizure disorder, and discharge for 3 of 6 residents whose MDS assessments were reviewed (Resident #15, #205 and #83) During the recertification and complaint investigation survey conducted on 08/25/22, the facility failed to accurately code the MDS assessments in the areas of hospice services, level of assistance needed for eating, oral/dental status, and cognition for 10 of 18 sampled residents whose MDS was reviewed.	F 867	The facility□s Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the facility put into place following the recertification survey on 8/12/21 and 8/25/22 in the areas of Accuracy of Assessments. A plan of Correction for F641 were cited during the annual survey on 08/12/21 and 8/25/22. These POC□s were submitted to CMS and accepted with follow up and return to compliance visits. Plans of correction were put into place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Administrator initiated an in-service to all administrative staff on 01/5/2024 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included	

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F 867	Continued From page 9 During the recertification and complaint investigation survey conducted on 08/12/21, the facility failed to accurately code the Minimum Data Set (MDS) assessment reviewed for the areas of hospice to reflect prognosis for 1 of 1 resident reviewed for hospice and the number of falls for 1 of 3 residents reviewed for falls. During an interview on 01/05/24 at 5:05 PM with the Administrator, he reported his quality assurance team met monthly and included the Medical Director who comes quarterly, the pharmacist who attends every other month, the registered dietician who attends quarterly and all the department heads who attend monthly. He reported they currently had Process Improvement Plans (PIPs) addressing falls, weight loss, and wound care and said they would be adding another PIP for MDS compliance. The Administrator stated he felt like they had resolved the issue by hiring a second MDS coordinator but said she had recently been out on maternity leave for 12 weeks and it was clear now that one MDS coordinator could not handle the workload. He further stated they would be monitoring for MDS compliance and said that human error did occur.	F 867	ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education. To ensure quality assurance, the Administrator will review the facility Quality Assurance Master Checklist and scheduled audits monthly to ensure that those areas noted to be deficient are systemically analyzed and corrective action implemented. The Administrator will be responsible for the plan of correction.	