STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH CITY HEALTH AND REHABILITATION	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/02/24 through 04/05/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # G97Q11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/02/24 through 04/05/24. Event ID# G97Q11. The following intake was investigated NC00214667. 1 of the 1 complaint allegation did not result in deficiency.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		4/13/24

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

Electronically Signed | 04/15/2024

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F 623	Continued From page 1	F 623		

resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

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F 623	Continued From page 2 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Ombudsman interview, the facility failed notify the Ombudsman in writing of the resident's transfer to the hospital for 3 of 4 residents reviewed for hospitalization (Resident #92, Resident #94, and Resident #349).	F 623	1. During recertification survey dated 4/2/224 to 4/5/2024, It was identified that the facility failed to notify the ombudsman of discharges to the hospital for Resident #92, #94, and #349 during the months of February 2024 and March 2024.	

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F 623	Continued From page 3 The findings included: 1. Resident #92 was admitted to the facility on 2/9/2021. The quarterly Minimum Data Set assessment dated 3/29/2024 revealed Resident #92 was severely cognitively impaired. Review of Resident #92's progress notes revealed the Resident was transferred to the hospital on 2/28/2024 and was readmitted to the facility on 3/5/2024. The review further revealed Resident #92 was transferred to the hospital on 3/19/2024, was readmitted to the facility on 3/26/204, and was again transferred to the hospital on 3/30/2024 and readmitted to the facility on 4/1/2024. Review of Resident #92's medical record on 4/3/2024 revealed no documentation in the medical record that the Ombudsman was notified of the transfers to the hospital. A review completed on 4/3/2024 of the Admission and Discharge Report sent to the Regional Ombudsman for the months of February 2024 and March 2024 revealed Resident #92's name was not listed on the reports. A review completed of updated Admission and Discharge Reports for February 2024 and March 2024 provided on 4/5/2024 by the facility revealed Resident #92's name was included on both reports. An interview completed on 4/5/2024 at 9:19am with the Ombudsman revealed Resident #92's	F 623	2. All residents have the potential to be affected by this deficient practice. A 100% audit of all discharges that were sent to the ombudsman from January 1, 2024 to April 12, 2024 was completed on 4/12/2024. The correct Discharge report for the dates of January 1, 2024 to April 12, 2024 was faxed to the ombudsman on 4/12/2024 via Social Worker #1. 3. Social Worker #1 and Social worker #2 were educated on 4/12/2024 by the administrator, as to the correct way to pull a discharge facility report and what information is required to be sent to the ombudsman. The required information that must be sent is: All discharges from the facility, both to a home setting and hospital setting. A copy of this education will be included in the new hire social worker education packets. 4. The administrator/ designee will audit the monthly discharge reports monthly x 3 months to ensure that the accurate information is being reported and sent to the ombudsman each month. The administrator will bring the results of the audits to the monthly Quality Assurance Committee x 3 consecutive meetings. The Quality Assurance Committee will evaluate the effectiveness of the training to determine if the audits are needed to be continued. 5. Compliance Date 4/13/2024	

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F 623	Continued From page 4	F 623		

name did not appear on the February 2024 Admission and Discharge Report she received via fax on 3/6/2024. The Ombudsman stated Resident #92's name also did not appear on the March 2024 Admission and Discharge Report she received via fax on 4/3/2024.

An interview completed on 4/05/24 at 9:32 a.m. with the Administrator revealed the information initially provided by the facility was not the correct information. The Administrator stated she was unable to explain why the updated report the facility provided did not match the list provided to the Ombudsman. She further revealed the Social Worker was responsible for transmitting the discharge list to the Ombudsman each month.
2. Resident #94 was admitted to the facility on 10/16/22.

The nursing progress note dated 3/11/24 at 12:30 pm revealed Resident #94 was transferred to the hospital. Resident #94 returned to the facility on 3/15/24.

Record review on 4/03/24 of the Ombudsman Discharge Notice for the month of March 2024 revealed Resident #94's discharge was not included in the report that was sent to the Ombudsman.

During an interview on 4/03/24 at 3:26 pm Social Worker #1 reported she was responsible for the Ombudsman Notification report for all residents that were transferred to the hospital, and the report was sent to the Ombudsman on a monthly basis. Social Worker #1 confirmed Resident #94 was not listed on the report received from the facility. The Social Worker #1 was unable to state why Resident #94 was omitted from the

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report.

Record review on 4/05/2024 of the updated Ombudsman Discharge Notice for the month of March 2024 documentation provided by the facility, revealed Resident #94's transfer was included on the report.

A telephone interview was conducted on 4/05/24 at 9:19 am with the Ombudsman who revealed Resident #94's hospital transfer on 3/11/24 was not included on the notice that was received from the facility via fax on 4/03/24.

An interview on 4/05/24 at 12:24 pm with the Administrator revealed the information initially provided by the facility was not the correct information. The Administrator stated she was unable to explain why the updated report the facility provided did not match the list provided to the Ombudsman.

3. Resident #349 was admitted to the facility on 3/8/2024.

Resident #349 was discharged to the hospital on 3/10/2024 due to a change in condition and did not return to the facility.

Record review of the admission and discharge report sent to the Ombudsman for the month of March 2024 revealed Resident #349's name was omitted from the list of residents who transferred to the hospital.

During an interview on 4/03/24 at 3:26 pm with Social Worker #1 she stated she was responsible for the Ombudsman and notification for all

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F 623	Continued From page 6 residents that were transferred to the hospital. She confirmed Resident #349 was not listed on the report received from the facility. Social Worker #1 was unable to explain why Resident #349 was omitted from the report. A telephone interview with the Ombudsman on 4/5/2024 at 9:19 a.m. revealed Resident #349's name did not appear on the Admission and Discharge report she received via facsimile on 4/3/2024. The Ombudsman stated she received a list of discharges from the facility monthly. An interview on 4/05/24 at 9:32 a.m. with the Administrator revealed the information initially provided by the facility was not the correct information. The Administrator stated she was unable to explain why the updated report the facility provided did not match the list provided to the Ombudsman. She further revealed the Social Worker was responsible for transmitting the discharge list to the Ombudsman each month.	F 623		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and	F 803		4/6/24

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F 803	Continued From page 7 ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations of the meal service tray line, record review, interviews with the Registered Dietitian and staff, the facility failed to ensure residents on the 900 hall received the correct portion sizes based on the menu. This failure had the potential to affect 1 out of 9 halls. The findings included: Review of the document, "Census List" dated 4/4/24 revealed diets and consistency of food textures served for 24 residents on the 900 hall. The report indicated 19 residents received textured foods of a regular consistency, and 5 residents received mechanically soft foods. Review of the weekly menu revealed on 4/4/24 items served for lunch included pulled pork, braised cabbage, and roasted sweet potatoes. Review of the kitchen measurement chart revealed the perforated spoodle was equivalent to half a cup or 4 to 5 ounces.	F 803	1. Based on observations of the meal service tray line on April 5, 2024, record review, interviews with Registered Dietician and the staff, the facility failed to ensure residents on the 900 hall received the correct portion size based on the menu. This failure had the potential to affect 1 out of 9 halls. Immediately upon this observation being identified, the meal trays were pulled from the tray cart and corrected before being served to the residents. 2. All residents have the potential to be affected by this deficient practice. Immediate education by the Dietary Manager was provided for the employee responsible for the inaccuracy in portion sizes that was placed on the 9 trays. In service education was also provided to the entire dietary team. 3. Education was provided on April 5, 2024 by the Dietary Manager to all dietary staff on providing accurate portion sizes for all items during every meal. No one	

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F 803	Continued From page 8 Review of the document, "Production Sheet" dated 4/4/24 included the portion sizes of food items listed on the lunch menu. For mechanically soft and regular textured diets, the pulled pork portion size was 4 ounces. A continuous observation of lunch meal service being prepared for residents was conducted on 4/4/24 from 11:37 AM through 12:20 PM. When serving the pulled pork, the Cook used a perforated spoodle to plate the meat and filled the utensil half full or less. The portions varied from plate to plate. When asked why she was not serving a sufficient portion size of the pulled pork, the Cook stated she was shaking off the excess grease from the spoodle when scooping the meat. The Dietary Manager then took the perforated spoodle from the Cook and showed her a full portion size of the pulled pork. He then removed all of the regular/mechanical consistency meal trays from the 900 hall meal cart that were served insufficient pulled pork. The Dietary Manager asked the Cook to provide the correct portion size of 4 ounces. An interview with the Dietary Manager was conducted on 4/04/24 at 12:20 PM. He revealed that he thought the Cook was nervous and may have served an insufficient portion size of the pulled pork as a result. However, the Dietary Manager stated that the Cook should have given the full portion size of 4 ounces for the pulled pork. The Registered Dietitian was interviewed on 4/05/24 at 9:43 AM. She revealed the portion size guide was included on the production sheets. If insufficient portion sizes occurred consistently, residents could possibly experience unintentional	F 803	was allowed to work before receiving in service education. The administrator reviewed the education for completion and accuracy and a copy of education was added to all new hire packets for dietary employees. 4. The Dietary Manager/ designee will complete a Kitchen Audit for Portion Size Accuracy of one Meal observed daily (Monday – Friday) x 4 weeks, then 3 meals weekly x 8 weeks. The Dietary Manager/designee will bring results to QA monthly. The quality assurance committee will evaluate the effectiveness of the training and audits to determine if the continuation of audits are necessary. 5. Compliance Date 4/6/2024	

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F 803	Continued From page 9 weight loss. She stated the Cook should have provided 4 ounce portions of pulled pork for all designated diets. During an interview with the Administrator on 4/05/24 at 8:09 AM, she revealed the Dietary Manager trained the kitchen staff on correct portion sizes. He corrected it in the moment, so that no resident received insufficient portion of the pulled pork. The Administrator stated the Dietary Manager and Assistant Dietary Manager should be auditing the service of portion sizes while in the kitchen. She indicated that the Cook should have provided a full serving of 4 ounces for the pulled pork.	F 803		
F 867 SS=B	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	F 867		4/13/24

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

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

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

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

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

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

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ensure that improvements are sustained.

§483.75(e) Program activities.

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

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

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

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s)

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ELIZABETH CITY HEALTH AND REHABILITATION	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 12 functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Ombudsman interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 1/27/23 recertification and complaint investigation survey. This was for two recited deficiencies on the current recertification and complaint investigation survey of 4/05/24 in the areas of Notice Requirements Before Transfer/Discharge (F623) and Accuracy of Assessments (F641). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F623: Based on record review, staff interviews, and Ombudsman interview, the facility failed notify the Ombudsman in writing of the residents transfer to the hospital for 3 of 4 residents reviewed for hospitalization (Resident #92, Resident #94, and Resident #349).	F 867	1. The facility failed to maintain implemented procedures and monitor the interventions the committee put into place following the 1/27/23 recertification and complaint investigation survey for recited deficiencies on the current recertification and complaint investigation survey on 4/5/24 in the areas of Notice/Requirements Before Transfer/Discharge (F623) and Accuracy of Assessments (F641). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. 2. All residents have the potential to be affected by this deficient practice. On 4/12/2024 the Quality Assurance Committee held a meeting to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee. 3. On 4/12/2024, the Regional Operations Manager educated the Administrator, the Director of Nursing, and the Interdisciplinary Department Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 04/05/2024

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F 867	Continued From page 13 During the 1/27/23 recertification and complaint investigation survey the facility failed to notify the Ombudsman in writing for residents transferred to hospital. F641: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment accurately in the area of discharge status for 1 of 29 resident assessments reviewed (Resident #148). During the 1/27/23 recertification and complaint investigation survey the facility failed to code the MDS assessment accurately for residents reviewed for nutrition. An interview was conducted on 4/05/24 at 12:24 pm with the Administrator who reported the previous administrative team completed the education and auditing and resolved the plan of corrections for the deficient practices and the facility had not identified any concerns prior to the current survey.	F 867	(IDT) on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include: identifying issues, correction of repeat deficiencies, use of rounding/auditing tools, daily review of documentation, observations during leadership rounds, identifying trends and reporting to the QAPI committee monthly for review and recommendations to ensure compliance is sustained. 4. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. 5. Compliance date 4/13/2024	

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:
	345036	A. BUILDING: _____ B. WING _____	4/5/2024

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ELIZABETH CITY HEALTH AND REHABILITATION	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	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) assessment accurately in the area of discharge status for 1 of 29 resident assessments reviewed (Resident #148). The findings included: Resident #148 was admitted to the facility on 12/7/23 with diagnoses that included chronic obstructive pulmonary disease and heart failure. Review of the nurse note dated 1/3/24 indicated Resident #148 was discharged to the hospital. Review of the discharge MDS dated 1/3/24 inaccurately coded Resident #148 was discharged to home/community. MDS Coordinator #1 was interviewed on 4/03/24 at 2:56 PM. She revealed that a discharge MDS assessment would be completed if a resident went to the hospital. Section A of the discharge MDS assessment was where the discharge location was coded, and the discharge location was retrieved from the resident's medical record. MDS Coordinator #1 stated that MDS Coordinator #2 completed Resident #148's discharge assessment. She stated MDS Coordinator #2 should have selected acute hospital as the discharge location. An interview with MDS Coordinator #2 was conducted on 4/04/24 at 9:17 AM. She revealed if a resident was discharged to the hospital, she would complete a discharge assessment with acute hospital coded as the discharge location. A resident's hospital status would be announced in the daily morning meeting and be included in the discharge report. MDS Coordinator #2 stated she could not recall Resident #148's discharge assessment, but home/community was coded as the discharge location due to data entry error. An interview was conducted with the Director of Nursing (DON) on 4/04/24 at 8:54 AM. She revealed the MDS Coordinators completed a discharge assessment if a resident went to the hospital, and the location of discharge should be coded as acute hospital. The DON indicated that the discharge assessment for Resident #148 should have been coded as acute hospital instead of home/community. During an interview with the Administrator on 4/04/24 at 9:26 AM, she revealed MDS Coordinators code the MDS assessments based on the resident's medical record. She stated that the discharge assessment should be accurate for their discharge location.