STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345365	A. BUILDING _____ B. WING _____	C 10/17/2024

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SIGNATURE HEALTHCARE OF KINSTON	907 CUNNINGHAM ROAD KINSTON, NC 28501

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 10/14/2024 through 10/17/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # VNCE11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/14/2024 through 10/17/2024. Event ID# VNCE11. The following intakes were investigated NC00209323, NC00215727, NC00216308, NC00220556, NC00222238 and NC00222729. 1 of the 9 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews, the facility failed to assess the ability of a resident to self-administer medications prior to leaving the resident's medications on the overbed table in the resident's room for 1 of 1 resident reviewed for pharmacy services (Resident #18). Resident #18 indicated she could not take a lot of medications together at one time and the medications were left on her overbed table to take when she wanted to. Findings included:	F 554	1. Resident #18 is no longer in the facility at this time. 2. Evaluation for self-administration of medications of all alert and oriented residents was conducted by the Director of Nursing. These evaluations were started on 11/4/24 and then completed on 11/5/24. None of the residents desired or were deemed appropriate to self-administer medications upon review.	11/12/24

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

Electronically Signed | 11/08/2024

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F 554	Continued From page 1 Resident #18 was admitted to the facility on 1/13/2023. The quarterly Minimum Data Set (MDS) assessment dated 8/16/2024 indicated Resident #18 was cognitively intact. Physician orders included the following medication orders for Resident #18 that were active on 10/14/24: - Acetaminophen 325 milligram (mg) tablets give two tablets for pain or fever every six hours as needed. - Augmentin 875-125 mg tablet give twice a day ending 10/15/2024. - Ciprofloxacin HCL 500 mg tablet give one tablet twice daily for seven days. There was no documentation in the Electronic Medical Record (EMR) that Resident #18 had been assessed to self-administer her medications, there was no physician's order for self-administration, and there was no care plan that addressed self-administration of medication. On 10/14/2024 at 10:48 am, two medication cups were observed on Resident #18's overbed table located between the Resident #18's open door and the right side of Resident #18's bed. There were two round white tablets in one medication cup and two white broken oblong tablets in the other medication cup. Residents were observed outside Resident #18's open door in the hallway self-propelling their wheelchairs. On 10/14/2024 at 10:48 am in an interview with Resident #18, she stated the two white, broken oblong tablets in the medication cup were her	F 554	3. On 11/6/2024, education on the resident self-administration and Medication administration process was initiated by the Director of Nursing for all Nursing administration. The education emphasized to never leave medications at beside unless following self-administration policy. Education will be completed by 11/7/24. Any licensed nurses and medication aides that have not received the education will not be allowed to work until they are educated on self-administration of medication and medication administration per policy. Newly hired nurses and medication aides will be educated on the policy by the Director of Nursing and Staff development Coordinator during new hire orientation. The Director of Nursing, Staff Development Coordinator and the Administrator are responsible for ensuring the education is conducted. 4. The Director of Nursing and/or designated nurse manager will monitor residents with the desire to self-administer medication and ensure and evaluation of self-administration is completed per facility policy. This will occur weekly for 4 weeks and then monthly for 3 months using a residents self-administration monitoring tool. Reports will be presented to the weekly QA committee by the Administrator and/or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program	

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F 554	Continued From page 2 antibiotic, and the two white round tablets in the other medication cup were her pain medication. She said she could not take a lot of medications together at one time and the medications were left on her overbed tablet to take when she wanted to. An observation and an interview were conducted on 10/14/2024 at 10:50 am with Nurse #1. He was observed at a medication cart in the hallway and walked into Resident #18's room. Nurse #1 explained the two round tablets in one medication cup located on Resident #18's overbed table were Acetaminophen tablets, and the two broken white tablets in the other medication cup located on Resident #18's overbed table were an antibiotic. Nurse #1 explained he saw Resident #18 with the medication cup up at her mouth when he was in room to administer Resident #18 her medications before exiting the room. He stated he should have stayed in Resident #18's room and watched her swallow the medications. Nurse #1 was observed removing the two medications cups from the overbed table when exiting Resident #18's room. On 10/17/2024 at 10:15 am in a follow up phone interview with Nurse #1, he clarified the medications observed on the overbed table were Ciprofloxacin and Acetaminophen. He explained Resident #18 requested to visualize her antibiotic and pain medication separately in medication cups and her other morning medications were crushed in pudding and administered. Nurse #1 stated he observed Resident #18 take the medications administered in the pudding, and the Ciprofloxacin was at her mouth when he walked out of the Resident's room.	F 554	reviewed at the monthly QA meeting. The weekly QA Meeting is attended by the Administrator, DON, SDC, MDS Coordinator, Social Services Director, Medical Records Director, and the Dietary Manager.	

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F 554	Continued From page 3 On 10/17/2024 at 11:47 am in an interview with the Assistant Director of Nursing, she stated Resident #18's medications should not have been left on the overbed table, and Nurse #1 should have stayed with Resident #18 when administering her medications to ensure Resident #18 had taken her medications. On 10/17/2024 at 12:34 pm in an interview with the Interim Director of Nursing, she explained Resident #18 had not been assessed to perform self-administration of her medication. She stated Nurse #1 should have watched Resident #18 take her medication before leaving Resident #18's room when administering medications to Resident #18.	F 554		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		11/12/24

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F 582	Continued From page 4 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the required Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (NOMNC) (form 10123) and the and failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled	F 582	1. Resident #75 received a new NOMNC and skilled nursing advanced beneficiary notice (SNF ABN) of noncoverage notice on 10/21/24. 2. All Medicare Part A skilled service	

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F 582	Continued From page 5 Nursing Facility Advanced Beneficiary Notice (ABN) for 1 of 3 residents reviewed for beneficiary protection notification review (Resident #75). The findings included: Resident #75 was admitted to the facility on 2/12/24 with Medicare Part A skilled services. Resident #75's admission Minimum Data Set assessment dated 2/18/24 revealed she had moderate cognitive impairment. Resident #75's Medicare Part A skilled services ended on 4/12/24 and her Medicare Part A Skilled Nursing Facility benefit was not exhausted. She remained in the facility. Record review revealed no evidence that Resident #75 or the resident's responsible party were provided the NOMNC notice or the ABN. During an interview with the Business Office Manager on 10/16/24 at 11:24 AM she stated she had trained the former weekday Receptionist to do the required forms. She stated the Receptionist was no longer employed by the facility. The Business Office Manager stated the forms were not uploaded to the facility system and when she searched Resident #75's folder there were blank forms in the folder. The former Receptionist was unable to be contacted. An interview was conducted with the Administrator on 10/18/24 at 9:45 AM who indicated Resident #24 should have received the CMS-10123-NOMNC and the CMS-ABN as	F 582	residents have the potential to be affected by the alleged deficient practice. On 11/4/24, the Director of Nursing reviewed/audited all NOMNCs and SNFABNs by the facility for the last 90 days. Results of findings: 23 out of 24 NOMNCs/SNF ABNs were determined to be issued per facility policy. On 11/6/24 the missing NOMNC/SNF ABN was sent per company policy. 3. On 11/6/24 the Regional Nurse Consultant educated the Business office Manager (BOM) on the policy and regulation pertaining to Medicare Non-Coverage (NOMNC) and SNF ABNs. This education was completed on 11/6/24. 4. The Administrator and/or designee will monitor three NOMNC's/SNF ABNs of discharging residents per week. This will occur weekly for 4 weeks and then monthly for 3 months using a QA NOMNC/SNF ABN monitoring tool. Reports will be presented to the monthly QA committee by the Administrator or Director of Nursing to ensure corrective action is initiated as needed. Compliance will be monitored, and ongoing audit program reviewed at the monthly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, SDC, MDS Coordinator, Social Services Director, Medical Records Director, Business Office Manager and Dietary Manager.	

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F 582	Continued From page 6 required by federal guidelines.	F 582		
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, 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,	F 584		11/12/24

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F 584	Continued From page 7 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 observation, resident and staff interviews, the facility failed to provide maintenance to the bathroom door and keep the grout on the floor at the base of the bathroom doorway clean from buildup of debris for 1 of 2 resident rooms (Resident #63's room) reviewed for environment. The findings included: a. Observation of Resident #63's room on 10/14/24 at 10:40 AM revealed the surface of the bathroom door approximately three quarters from the top of the doorframe, and as well as the sides of the doorway were scuffed. A large area, approximately 3 inches in height, and across the length of the bathroom door revealed peeling paint which exposed what appeared to be a wood-like color underneath. b. Observation of Resident #63's room on 10/14/24 at 10:40 AM revealed the bathroom doorway had what appeared to be a buildup of debris, black in color, on the grout in the right and left spaces at the base of the bathroom doorway. An interview was conducted on 10/14/24 at 10:40 AM and on 10/15/24 at 8:59 AM with Resident #63. During both interviews Resident #63 expressed how unhappy she felt about the condition of her bathroom door and doorway. She stated in each interview she reported the issues	F 584	1. Residents #63-bathroom door and doorway was immediately cleaned and painted by the Assistant Maintenance Director and the Director of Housekeeping Services to ensure no peeling paint or black debris was present on 10/14/24. 2. All residents with bathrooms have the potential to affected by this alleged deficient practice. On 11/5/24 the Administrator completed an audit on all resident bathrooms. Findings: 26 out of 26 Bathrooms required cleaning and painting of the bathroom door and/or doorways. All resident's bathroom doors and doorways will be free from peeling paint and black debris by 11/8/24. 3. On 11/4/24, the Administrator completed an education/in-service on ensure residents rooms remain from peeling paint and clean doorways with the Maintenance Staff and the Housekeeping Director. Education will be completed by 11/7/24. 4. Any Maintenance staff or Housekeeping that have not received the education will not be allowed to work until they are educated peeling paint removal	

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F 584	Continued From page 8 with her bathroom door and doorway to staff several times, however, she could not remember the names of the staff members or when she noticed the damaged door or dirty areas at the base of the bathroom doorway. An interview with the Assistant Maintenance Director was conducted on 10/16/24 at 8:46 AM. He stated room inspections were done monthly; random resident rooms were selected. He stated there was a maintenance logbook that was kept at the nurse's station for maintenance issues that needed to be addressed. He added this logbook was checked weekly. He also utilized an electronic work order system. This system was checked weekly. He was unable to find a pending or completed work order for Resident #63's room. He stated he was not aware of any issues with the bathroom door or bathroom doorway in Resident #63's room. On 10/16/24 at 9:24 AM the Assistant Maintenance Director conducted an observation of the areas of concern in Resident #63 room in conjunction with an interview with Resident #63 who resided in the room. Resident #63 showed the Assistant Maintenance Director the issues with her bathroom door, doorway, and floor area. Resident #63 informed the Assistant Maintenance Director she reported her concerns to staff many times, however, she could not remember the names of the staff members. A review of the maintenance logbook at nurses' station was conducted on 10/16/24. There was no work order request for Resident #63's room found. An interview was conducted with the	F 584	and cleaning rooms and doorways. Newly hired Maintenance staff and/or Housekeeping will be educated by the Director of Maintenance and Director of Housekeeping during new hire orientation. The Administrator and/or designee will monitor 3 random residents□ rooms to ensure rooms maintain a clean and unpeeling paint environment. This will occur weekly for 4 weeks and then monthly for 3 months using a QA monitoring tool. Reports will be presented to the weekly QA committee by the Administrator and/or Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the monthly QA meeting. The weekly QA Meeting is attended by the Administrator, DON, SDC, MDS Coordinator, Social Services Director, Medical Records Director, and the Dietary Manager.	

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F 584	Continued From page 9 Housekeeping Supervisor on 10/16/24 at 9:31 AM. He stated he was not aware of the blackened discoloration on both sides of the floor in Resident #63's room bathroom doorway. He added Resident #63's room was last deep cleaned on 10/8/24 and he was not notified of discoloration on the floor in the bathroom doorway. An interview was conducted with the Maintenance Director on 10/17/24 at 9:36 AM. He stated the facility conducted ambassador rounds where resident rooms were assessed. He added the Administrator was responsible for ambassador rounds for Resident #63's room. In an interview with the Administrator on 10/17/24 at 9:47 AM he stated he conducted ambassador rounds daily for Resident #63's room. He stated he did not notice any issues with the bathroom door or discoloration on the bathroom doorway floor. He added Resident #63 did not tell him about any concerns. An interview was conducted with the interim Director of Nursing (DON) on 10/17/24 at 10:38 AM. She stated nursing staff were expected to notify housekeeping if a resident's room needed cleaning, as well as notify maintenance for anything in need of repair. The DON further stated the facility also conducted ambassador rounds daily.	F 584		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		11/12/24

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F 641	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident Interview and staff interviews, the facility failed to accurately code the Minimum data Set (MDS) assessment in the areas of medications, smoking, elimination and behaviors for 4 of 28 residents whose MDS assessments were reviewed (Resident #14, #17, #13, and #33). Findings included: 1. Resident #14 was admitted to the facility on 7/22/2015 with diagnoses including Diabetes Mellitus. There was a physician order for the following hypoglycemic medications on Resident #14's electronic medical record (EMR): * On 11/23/2023, Novolin Regular flex pen insulin 100 units per milliliter, give 11 units subcutaneous three times a day * On 11/23/2023, Novolin Regular flex pen insulin 100 units per milliliter per sliding scale before meals and at bedtime. * For blood glucose reading 200-250, give 3 units subcutaneous. * For blood glucose reading 251 -300, give 5 units subcutaneous. * For blood glucose reading 301-350, give 7 units subcutaneous. * For blood glucose reading 351-400, give 10 units subcutaneous. * For blood glucose reading 401-450, give 12 units subcutaneous. * For blood glucose reading 451-500, give 14 units subcutaneous. * For blood glucose reading 501-550, give 16 units subcutaneous.	F 641	1. On 10/16/24 resident #14 Section N on the MDS was Modified to ensure accuracy On 10/17/24 resident #17 Section J on the MDS was Modified to ensure accuracy On 10/17/24 resident #13 Section N on the MDS was Modified to ensure accuracy On 10/17/24 resident #2 Section H on the MDS was Modified to ensure accuracy The following education was provided to the MDS Nurses regarding accurate coding of residents GDR, Insulin, Smoking, and Ostomy coding on 10/18/24 Provided by: Lisa Gipson, Clinical Reimbursement Specialist 2. On 10/25/24 the Clinical Reimbursement Specialist audited the last 14 days of resident assessment for accuracy on Section Z, H, J, and N. Findings 0 out of 141 MDS assessments need to be modified. These audits were completed on 10/25/24. 3. On 10/18/2024. The Clinical reimbursement Specialist in-serviced the MDS nurses on the accuracy of assessments Education: Section Z- Assessment Administration Z400. Signature of persons completing the assessment or entry/death. Reporting I certified that the accompanying	

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F 641	Continued From page 11 * For blood glucose reading 551-600, give 18 units subcutaneous. * On 3/10/22024, Empagliflozin (medication used to treat Diabetes Mellitus) 25 milligrams tablet once a day. * On 3/20/2024, Insulin Glargine solution 100 units per milliliter, give 65 units subcutaneous once a day in the morning. * On 3/20/2024, Insulin Glargine solution 100 units per milliliter, give 60 units subcutaneous once a day at bedtime. A review of the September 2024 Medication Administration Record recorded the hypoglycemic medications were given as ordered. The annual Minimum Data Set (MDS) assessment dated 9/6/2024 indicated Resident #14 was not coded for Resident #14 receiving hypoglycemic medications. Resident #14's care plan last reviewed 9/6/2024 included a focus for Diabetes Mellitus. Interventions included to administer medication as ordered by the physician. In an interview with MDS Nurse #1 on 10/17/24 at 10:32 pm, she stated Resident #14's annual MDS dated 9/6/2024 should have been coded for the use of hypoglycemic medications. She explained the MDS worksheet used in the MDS department noted Resident #14 was receiving insulin and hypoglycemic medications. She stated it was human error in not coding Resident #14's annual MDS for hypoglycemic medications. In an interview with the Interim Director of Nursing on 10/17/24 at 12:34 pm, she stated Resident #14's annual MDS should have been	F 641	information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate quality care, and as a basis for payment for federal funds. I further understand that payment of such federal funds and continued participation in the government funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil and or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf. RAI Manual Chapter 3 Section H: Ostomy coding Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste	

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F 641	Continued From page 12	F 641		

coded accurately for the use of hypoglycemic medications based on Resident #14's assessment for the use of insulin.

In an interview with the Administrator on 10/17/2024 at 1:05 pm, he stated Resident #14's MDS assessment should be an accurate assessment for the use of hypoglycemic medications.

2. Resident #17 was admitted to the facility on 3/4/2013 with diagnoses including a stroke.

Resident #17 care plan initiated on 1/28/2020 indicated Resident #17 was a smoker.

A quarterly smoking assessment dated 5/3/2024 reported Resident #17 was a smoker.

The annual Minimum Data Set (MDS) assessment dated 8/1/2024 indicated Resident #17 was cognitively intact and did not use tobacco products.

On 10/15/2024 at 8:30 am in an interview with Resident #17, she stated she was a smoker and used the facility's designated smoking area during the facility's designated times.

On 10/15/2024 at 1:24 pm, Resident #17 was observed in the facility's designated smoking area supervised by the Activities Assistant #1 smoking a cigarette.

On 10/17/2024 at 10:24 am in an interview with MDS Nurse #1, she stated she was aware Resident #17 was a smoker, and the annual MDS dated 8/1/2024 should have been coded to reflect Resident #17 used tobacco products. She said

RAI Manual Chapter 3 Section J:
Smoking coding
1. Ask the resident if they used tobacco in any form during the 7-day look-back period.
2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes.

RAI Manual Chapter 3 Section N:
Insulin coding
High risk drug classes
o Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
o Column 2: If Column 1 is checked, check if there is an indication noted for all medications in the drug class.
N0415J1. Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).

RAI Manual Chapter 3 Section N:
GDR coding
Coding Instructions for N0450A " Code 0, no: if antipsychotics were not received: Skip N0450B, N0450C, N0450D and N0450E. " Code 1, yes: if antipsychotics were received on a routine basis only: Continue to N0450B, Has a GDR been attempted? " Code 2, yes: if antipsychotics were received on a PRN basis only: Continue to N0450B, Has a

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F 641	Continued From page 13 she clicked the wrong answer on the MDS screen for the use of tobacco products and could not provide a specific reason why the MDS was coded incorrectly for the use of tobacco products for Resident #17. On 10/17/2024 at 12:34 pm in an interview with the Interim Director of Nursing, she stated the MDS assessment should have been coded accurately based on the smoking assessments for Resident #17. On 10/17/2024 at 1:05 pm in an interview with the Administrator, he stated Resident #17's annual MDS assessment should have been coded accurately for smoking. 3. Resident #2 was admitted to the facility on 9/22/21 with diagnoses that included colostomy. Resident #2's most recent quarterly Minimum Data Set (MDS) assessment dated 9/27/24 revealed she had moderate cognitive impairment and was not coded for an ostomy. Resident #2's care plan dated 9/27/24 revealed a focus for a colostomy for elimination. During an interview on 10/17/24 at 10:35 am with the MDS Coordinator, she stated the ostomy section for Resident #2 should have been coded for her colostomy and it was an error. In an interview with the Interim Director of Nursing (DON) on 10/17/24 at 10:51 am, she stated Resident #2's MDS assessment should have been coded correctly for her colostomy.	F 641	GDR been attempted? " Code 3, yes: if antipsychotics were received on a routine and PRN basis: Continue to N0450B, Has a GDR been attempted? In N0450B and N0450C, include GDR attempts conducted since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, OR since the resident was started on the antipsychotic medication, if the medication was started after the resident was admitted. 4. The Clinical Reimbursement Specialist or designee will monitor compliance utilizing the F641 Quality Assurance Tool weekly x 4 weeks and monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the QA committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed at the weekly Quality Assurance meeting, indefinitely or until no longer deemed necessary for compliance with the MDS process. The weekly quality assurance meeting is attended by the Administrator, Director of Nursing, MDS coordinator, Therapy Manager, Medical Records, and the Dietary Manager.	

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F 641	Continued From page 14	F 641		

4. Resident #13 was admitted to the facility on 6/21/24 with diagnoses that included dementia.

Resident #13's most recent quarterly Minimum Data Set (MDS) assessment dated 8/4/24 revealed a gradual dose reduction for antipsychotic medication had not been attempted.

Resident #13's care plan dated 10/4/24 revealed a gradual dose reduction of antipsychotic medication was attempted on 6/27/24.

Review of a Pharmacy Consultant Report dated 7/5/24 revealed a contraindication for a gradual dosage reduction of antipsychotic medication signed by the physician.

An interview was conducted with MDS (Minimum Data Set) Nurse #1 on 10/16/24 at 10:36 AM who stated it was an oversight and should have coded Resident #13's assessment to reflect the gradual dose reduction attempt for antipsychotic medication.

During an interview on 10/17/24 at 10:30 AM the Interim Administrator stated Resident #13's assessment dated 8/4/24 should have been coded to reflect a gradual dosage reduction attempt for antipsychotic medication.

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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: Based on record review and resident and staff interviews the facility failed to refer a resident with a new diagnosis of mental illness for a Preadmission Screening and Resident Review (PASARR) evaluation for 1 of 1 resident reviewed for PASARR (Resident #33). Findings included: Resident #33 was admitted to the facility on 4/23/24 with diagnosis that included adjustment disorder. A physician progress note revealed Resident #33 was newly diagnosed with post-traumatic stress disorder on 6/27/24.	F 644	1. Resident #33 PASARR was referred to the NC MUST on 10/16/2024. 2. All Residents with new psychiatric diagnosis have the potential to be affected by the alleged deficient practice. On 11/5/24, the Director of Nursing and designees reviewed/audited all Residents Electronic Medical record for new psychiatric diagnosis that may not of been reported to NC MUST, Results of findings: 12 residents were identified to need a new referral to the NC MUST program. On 11/7/24 all 12 residents were refered to NC Must	11/12/24

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F 644	Continued From page 16 Resident #33's quarterly Minimum Data Set (MDS) assessment dated 7/29/24, revealed she was cognitively intact. She was not coded as being screened for a PASARR evaluation. A review of Resident #33's care plan last reviewed 7/29/24 revealed she was care planned for behaviors such as nervousness, fears, and a general feeling of uneasiness related to history of a traumatic event. The interventions included encouraging the resident to voice fears and referral to a physician. During an interview with Resident #33 on 10/16/24 at 12:41 PM she stated she had not previously been diagnosed with post-traumatic stress disorder. She was assaulted in the past by a family member. Resident #33 stated she began having nightmares after the family member began calling her at the facility in July 2024. An interview with the facility Social Worker on 10/16/24 at 11:29 PM was conducted. She stated she did not refer Resident #33 to NC MUST (North Carolina Medical Uniform Screening Tool, a tool used to complete PASARR applications) because she felt Resident #33 was doing well. The Social Worker stated she was unaware that Resident #33 was having nightmares. During an interview on 10/17/24 at 11:00 AM the Administrator indicated if a new psychiatric diagnosis required a new referral to NC MUST for a PASARR application the Social Worker should have followed the correct referral process.	F 644	(PASARR screening system). 3. On 10/22/24 the Director of Nursing reeducated the Social Services Director on the company policy and regulation pertaining to PASARRs. This education was completed on 10/22/24. 4. The Director of Nursing and/or designee will monitor 3 residents with new psychiatric diagnosis a week. This will occur weekly for 4 weeks and then monthly for 3 months using a PASARR QA tool. Reports will be presented to the monthly QA committee by the Administrator or Director of Nursing to ensure corrective action is initiated as needed. Compliance will be monitored, and ongoing audit program reviewed at the monthly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, SDC, MDS Coordinator, Social Services Director, Medical Records Director, and the Dietary Manager.	
F 842 SS=D	Resident Records - Identifiable Information	F 842		11/12/24

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F 842	Continued From page 17 CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 18 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to complete an accurate medical record in documenting the administration of medication for 1 of 29 residents whose medical records were reviewed (Resident #18). Findings included: Resident #18 was admitted to the facility on	F 842	1. On 10/18/24 Licensed Nurse #1 was reeducated and competencied on Medication administration with extra emphasis on administering as needed medication and documentating administration immediately after giving the medication by Assistant Director of Nursing and the Director of Nursing. 2. All residents receiving as needed	

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F 842	Continued From page 19 1/13/2023 with diagnoses including peripheral vascular disease. Physician orders dated 2/14/2024 included Acetaminophen 325 milligram (mg) tablets give two tablets for pain or fever every six hours as needed for Resident #18. On 10/14/2024 at 10:52 am, Nurse #1 was observed administering Resident #18 Acetaminophen 650 mg in applesauce to Resident #18. There was no record of Resident #18 receiving Acetaminophen 650 mg on 10/14/2024 on Resident #18's October 2024 Medication Administration Record (MAR). There was no nursing documentation in Resident #18's medical record that Acetaminophen 650 mg was administered by Nurse #1 on 10/14/2024. On 10/17/2024 at 10:15 am in a phone interview with Nurse #1, he stated pain medications ordered as needed were to be documented on Resident #18's MAR after administration of the medication to the resident. He explained he thought he had documented the dose of Acetaminophen administered to Resident #18 on 10/14/2024 on Resident #18's MAR. On 10/17/2024 at 12:34 pm in an interview with the Interim Director of Nursing, she stated Nurse #1 should have documented the administration of Acetaminophen on Resident #18's MAR after administering the medication to the resident.	F 842	medications have the potential to be affected by the alleged deficient practice. On 10/18/24 the Director of Nursing and Nurisng Administrations started observing med passes of all licensed nurses to ensure all residents receiving as needed medications received and documentations was completed immediately after. Findings were: No discrepancies were observed. 3. On 10/18/24, the Director of nursing/or designee in serviced all Nursing staff (including agency) on medication administration with extra emphasis on ensuring as need medications are documented as given immediately after administration. On 11/7/24 the DON ensured all licensed nurses passed a competency on medication administration to include documentation. This training included all current Licensed Nurses including agency. As of 11/7/24, all licensed nurses have been educated. The Director of Nursing will ensure that any agency or new hires will be trained prior to administering medications going forward. 4. The Director of Nursing will monitor medication administrations with extra emphasis on documenting as needed medications immediately after. This will be completed on 3 random nurses weekly. This monitoring will be completed on a Medication administration Observation tool weekly for 4 weeks and then monthly for 3 months. Reports will be presented to the weekly QA committee	

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F 842	Continued From page 20	F 842	by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	