

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/18/2016
NAME OF PROVIDER OR SUPPLIER CAROLINA RIVERS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DRIVE EXTENSION JACKSONVILLE, NC 28540		
(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 156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and 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 or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal</p>	F 156		9/6/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/31/2016

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

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F 156	<p>Continued From page 1 funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on document reviews and staff interviews the facility failed to provide Medicare non-coverage letters indicating residents were notified at least two days prior to Medicare coverage ending for two of three resident's reviewed. (Resident #35 and Resident #82).</p> <p>The findings included:</p> <p>1. Review of Resident # 35's Medicare non-coverage letter revealed the non-coverage letter did not include a date when Medicare coverage ended. Although the Medicare non-coverage letter was signed, noting Resident #35's name, the letter did not include a date the Medicare non-coverage letter was signed as notification that Medicare coverage was ending.</p> <p>During and interview on 08/17/2016 at 3:36 PM, the temporary Business Office Manager stated Resident #35's Medicare coverage ended on 4/28/16 and Resident # 35 was discharged home. She revealed she was not the Business Office Manager at that time and she did not know what happened.</p> <p>During an interview on 08/18/2016 at 9:54 AM, the Administrator stated her expectation was that the Medicare non-coverage letters be given timely.</p> <p>2. Review of Resident #82's Medicare non coverage letter, revealed his Medicare coverage ended on 4/21/16. Resident #82 was notified</p>	F 156	<p>F156 Residents #35 and #82 both were discharged prior to the onset of the survey. All current residents receiving coverage under Medicare have been reviewed for anticipated discharge on 08/29/2016, Medicare non-coverage letters have been issued as indicated. Accounts Receivable Bookkeeper and the back-up Accounts Receivable Bookkeeper have been retrained on the process of administering Medicare non-coverage letters at least two days prior to Medicare coverage ending. The Administrator will monitor residents receiving Medicare coverage weekly x 8 weeks then monthly X's 1 utilizing the Daily Medicare Part A Meeting Worksheet. Accounts Receivable Bookkeeper will provide copy of Medicare non-coverage letter issued to the beneficiary to the Administrator weekly x 8 weeks then monthly x1 month to ensure timely provision of notice. The Administrator will check dates of letters to projected day of cessation of coverage weekly x 8 weeks then monthly X's 1 utilizing the Daily Medicare Worksheet. The Executive QI committee will meet monthly and review audits of provision of Medicare non-coverage letters and address any issues, concerns and/or trends and to make changes as needed,</p>		

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F 156	Continued From page 3 Medicare coverage was ending and he signed the Medicare non-coverage letter on 4/22/16, which was one day after Medicare coverage ended and the date Resident #82 was discharged from the facility. During an interview on 8/17/16 at 3:34 PM, the temporary Business Office Manager recalled the facility stopped billing Resident #82 on 4/22/16 and he was discharged home. She stated she was not aware of what happened because she was not the Business Office Manager. During an interview on 08/18/2016 at 9:54 AM, the Administrator stated her expectation was that the Medicare non-coverage letters be given timely.	F 156	to include continued frequency of monitoring monthly 3 months.		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		9/6/16	

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F 278	<p>Continued From page 4</p> <p>\$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately assess 4 of 5 residents (Residents #44, #93 #7, #117) reviewed for accurate diagnoses under Section I. The findings included: 1. Resident #44 was admitted to the facility on 6/27/2018 and readmitted on 11/9/2015 with depression, and atypical psychosis. Review of the Physician ' s Orders dated 11/13/15 and the medication administration record for August 2016 revealed Resident #44 was receiving Seroquel 25 mg by mouth for atypical psychosis. Review of the Admission Minimum Data Set (MDS) Assessment dated 11/23/2015 revealed Resident #44 had received an antipsychotic medication 7 times during the 7 day look back period but did not assess Resident #44 as having a psychosis disorder disease under Section I-Active Diagnoses. On 8/18/16 at 9:09 AM the MDS Coordinator stated that she should have left the medication Seroquel off Resident #44 ' s MDS list. On 8/18/16 at 10:22 AM the Administrator stated that if a resident was receiving a medication then the diagnoses needed to be listed under section I.</p>	F 278	<ol style="list-style-type: none"> Residents #44, #93, #7, and #117 had MDS modification completed on 8/18/16 for the addition of the diagnosis of Psychosis and Diabetes Mellitus by the MDS nurses. 100% audit of all current resident most current MDS will be reviewed, to include residents #44, #93, #7 and #117, by the Director of Nursing to ensure all MDS's completed are accurate to include all diagnosis are coded correctly, was completed on 08/29/2016 using a MDS Accuracy QI tool. Any issues will be addressed and documented at that time by the MDS Coordinator by modification of the MDS as warranted. 100% in-service of the MDS nurses to ensure all MDS assessments are completed accurately to include all diagnosis are coded correctly on the MDS was completed on 08/31/2016 by the MDS consultant. 10% of completed MDS's, to include resident's #44, #93, #7, and #117 will be reviewed to ensure MDS accuracy for all diagnosis by the Director of Nursing or Staff Facilitator weekly times 8 weeks and 		

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F 278	<p>Continued From page 5</p> <p>2. Resident #93 was admitted to the facility on 1/20/16 with a diagnoses of psychosis. Review of the Physician ' s Orders dated 1/21/16 and review of the medication administration record for August 2016 revealed Resident #93 was receiving Seroquel 50 mg by mouth for psychosis. Review of the Admission Minimum Data Set assessment dated 1/27/16 revealed Resident #93 had received an antipsychotic medication 7 times during the 7 day look back period but did not assess Resident #93 as having a psychosis disorder disease under Section I-Active Diagnoses. During an interview on 8/18/16 at 9:06 AM the MDS Coordinator stated that she looked at the Physician ' s documentation and could not find a diagnoses for psychosis. She stated that Resident #93 was receiving Seroquel so she listed it for antipsychotics. On 8/18/16 at 10:22 AM the Administrator stated that if a resident was receiving a medication then the diagnoses needed to be listed under section I.</p> <p>3. Resident #7 was admitted to the facility on 11/26/11 and readmitted on 3/11/16 with diagnoses of psychosis and aggressive behavior. Review of the Physician's Orders dated 5/18/16 and review of the recapitulation orders for August 2016 revealed Resident #7 was receiving Zyprexa 2.5 mg. by mouth for psychosis and aggressive behaviors. Review of the change in condition Minimum Data Set (MDS) Assessment dated 6/15/16 revealed Resident #7 had received an antipsychotic medication 4 times during the 7 day look back period but did not assess Resident #7 as having</p>	F 278	<p>then monthly X's 1 utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the Director of Nursing or Staff Facilitator by retraining appropriate staff making the coding error and the MDS nurse will make modifications to the MDS. The Administrator will review and initial the MDS Accuracy QI tool weekly X's 8 weeks and then monthly X's 1 to ensure any areas of concerns have been addressed. 4. The Executive QI committee will meet monthly and review audits of MDS Accuracy tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.</p>		

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F 278	<p>Continued From page 6</p> <p>a psychotic disorder disease under Section I as her Active Diagnoses.</p> <p>On 8/18/16 at 10:06 AM the MDS Coordinator stated she looked at the diagnoses from the Physician ' s orders and Resident #7 did not have a diagnoses of psychosis. She stated she looked at the Medication Administration Record and Resident #7 was receiving an antipsychotic medication and should have been entered under Section I.</p> <p>On 8/18/16 at 10:22 AM the Administrator stated that if a resident was receiving a medication then the diagnoses needed to be listed under section I.</p> <p>4. Resident #117 was admitted to the facility on 6/18/16 with a diagnoses of an psychotic disorder. Review of the admission Physician ' s Orders dated 6/18/16 and the recapitulation orders for August 2016 revealed Resident #117 was receiving 75 milligrams (mg) of Seroquel by mouth every night at bedtime for a diagnoses of an psychotic disorder.</p> <p>Review of the admission Minimum Data Set (MDS) Assessment dated 6/30/16 revealed Resident #117 was on an antipsychotic medication for 7 days during the look back for evaluation. There was no diagnoses under section I for the use of an antipsychotic.</p> <p>On 8/18/16 at 10:13 AM the MDS Coordinator stated she looked at the diagnoses from the Physician ' s Orders and Resident #17 did not have a diagnoses of psychosis. She stated she looked at the Medication Administration Record and Resident #17 was receiving an antipsychotic</p>	F 278			

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F 278	Continued From page 7 medication and should have been entered under Section I.	F 278			
F 279 SS=D	On 8/18/16 at 10:22 AM the Administrator stated that if a resident was receiving a medication then the diagnoses needed to be listed under section I. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan for 1 of 4 residents (Resident #44) reviewed for receiving antipsychotic medications. The findings included:	F 279	The care plan for resident #44 was reviewed and updated on 08/18/2016 by the Director of Nursing to reflect the resident's use of antipsychotic medications.	9/6/16	

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F 279	Continued From page 8 Resident #44 was admitted to the facility on 6/27/2018 and readmitted on 11/9/2015 with depression, and atypical psychosis. Review of the Annual Minimum Data Set (MDS) dated 5/2/16 revealed Resident #44 was severely impaired for cogitation and received an antipsychotic 7 times during the 7 day look back period. Review of the care plan dated 11/2015 revealed that there was not a care plan for antipsychotic medications for Resident #44. On 8/18/16 at 9:12 Am the MDS Coordinator stated that she did not specifically indicate that Resident #44 was on antipsychotics but that was what she referred to. She stated that she would update the care plan immediately. On 8/18/16 at 9:20 AM the Administrator stated that she would expect Resident #44 would have been care planned for antipsychotic use.	F 279	A 100% audit of all residents care plans was initiated on 08/18/2016 by the Director of Nursing including care plan for Resident #44 to ensure comprehensive care plans have been developed per the comprehensive assessment to include any resident with the use of antipsychotic medications, completed by 08/23/2016. The care plans were updated for any identified areas of concern by the MDS Coordinator by 08/23/2016. The Care Plan Team to include the MDS Nurses, Director of Nursing, Activity Director, Dietary and Social Services were in-serviced on care planning requirements, per instructions provided in the RAI Manual on 08/31/2016 by the Facility MDS Consultant. New residents, or existing residents that are prescribed antipsychotic medications will be identified daily through the pink slip review by the MDS Coordinator. The MDS Coordinator will review the pink order slips to include any for resident #44, 5x week and ensure the care plan is updated to reflect the use of antipsychotic medications. The Director of Nursing or Staff Facilitator will review all pink slips to ensure any newly identified resident taking antipsychotic medications has been addressed on the resident care plan 5 x week for 4 weeks, then audit 10% of care plans weekly x 2 months and to ensure that care plans reflect the residents current medical, nursing, mental, and psychosocial needs utilizing a care plan audit tool. The MDS Coordinator will		

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F 279	Continued From page 9	F 279	<p>immediately update the care plan for all identified areas of concerns and the Director of Nursing or Staff Facilitator will provide retraining with the identified staff member. The results of the Care Plan Audit Tool will be reviewed and initialed by the Administrator weekly x 8 weeks and monthly times 1 month.</p> <p>The Quality Improvement Executive Committee will review all results of the care plan audit tool monthly x 3 months for any recommendations, take action as appropriate, and to monitor for continued compliance.</p>		