STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345267		· /	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		A. BUILDIN		с		
		B. WING _		1	2/15/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIF	PCODE	
BLADEN B	EAST HEALTH AND RI	EHAB. LLC		804 S POPLAR STREET		
		,,		ELIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
F 000	conducted on 12/12	ent ID #MTNR11.	F0	00		
		d complaint investigation was 12/2022 through 12/15/2022.				
F 641 SS=D	1 of the 3 complain substantiated but d Accuracy of Assess CFR(s): 483.20(g)	id not result in a deficiency.	F 6	41		1/6/23
	resident's status.	cy of Assessments. ust accurately reflect the NT is not met as evidenced				
	Based on record re facility failed to cod (MDS) assessment Preadmission Scree (PASRR) Level II for	eview and staff interviews the e the Minimum Data Set accurately in the area of ening and Resident Review or 2 of 2 residents (Resident # 38) reviewed for PASRR.		 Residents #19 and #3 comprehensive assessm corrected on 12/27/22 to Level II PASRR coding. Residents residing in t the potential to be affected deficiency. Administrator 	ents were reflect accurate he facility have ed by stated	
	Findings included: 1. Resident #19 wa	s admitted to the facility on		Nursing completed an au of all current residents comprehensive MDS ass	idit on 12/26/22 most recent	
	09/20/2011 with mu	Itiple diagnoses that included polar disorder, and major		validate accurate coding PASRR status. Resident inaccurate coding of PAS most recent comprehens	of resident⊡s ts identified with SRR status on the	
		cated Resident #19 had a ening and Resident Review		assessment had correction the Administrator, MDS C	ons completed by	

Electronically Signed

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.

12/28/2022

		ND HUMAN SERVICES MEDICAID SERVICES				ORM APPROVE 3 NO. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345267	B. WING _			C 12/15/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE		
	EAST HEALTH AND REH			804 S POPLAR STREET			
DEADEN				ELIZABETHTOWN, NC 28337			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE	
F 641	Continued From page	e 1	F 6	641			
	(PASRR) Level II Det 11/10/2021. The Annual Minimum assessment dated 11 "No" to question A156 #19 had been evalua determined to have a and/or intellectual dis The Minimum Data S completion was not a during the survey. During an interview of Administrator stated s completing the PASR facility. She indicated level II since 11/10/20 have been coded. The MDS nurse failed to of 11/18/2022 to reflect level II. She stated sh the MDS nurse failed 2. Resident #38 was 5/16/22 with multiple anxiety disorder, bipo depressive disorder. Record review indica Preadmission Screer (PASRR) Level II Det 6/20/22.	termination Notification dated a Data Set (MDS) 1/18/2022 was answered 00 which asked if Resident ted by a level II PASRR and a serious mental illness sability or a related condition. Set Nurse responsible for available for an interview on 12/15/2022 at 11:32 AM, she was responsible for RR for the residents at the I Resident#19 had PASRR 021 and the MDS should the Administrator indicated the code the Annual MDS dated Resident#19 had PASRR the did not know the reason		and/or Assistant Director correct MDS inaccuracies completing MDS assess educated by the Adminis and 12/30 on the importa coding of PASRR status comprehensive MDS ass well as the new process comprehensive MDS ass to submission to the state 3. The Administrator and Nursing will maintain and all comprehensive MDS a completed to validate acd the resident s PASRR s Assessments will be valid submission to the state d Inaccuracies will be ident Administrator and/or Dire and corrected by the MD submission. These audit no less than 12 months to current residents will be r 4. The Administrator and Nursing will inform the Q. monthly of the audit resu inaccuracies that were id QAPI Committee will revi for a minimum of 12 mon current residents have a MDS assessment that ha	s. The nurses ments will be trator on 12/29 ance of accurate on sessments as of auditing all sessments prior e database. /or Director of on-going audit of assessments curate coding of tatus. dated prior to database. tified by the ector of Nursing 'S nurse prior to ts will continue for o ensure all reviewed. /or Director of API Committee lts including any lentified. The iew audit findings tths to ensure all comprehensive		
		h asked if Resident #38 had					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345267		B. WING			C 12/15/20	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BLADEN I	EAST HEALTH AND REH	AB, LLC			804 S POPLAR STREET ELIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641 F 867 SS=F	determined to have a and/or intellectual dist The Minimum Data Sc completion was not at during the survey. An interview was com- PM with the Administr explained she complet residents at the facilith had failed to completed Significant Change M Administrator stated t been completed for R and she did not know QAPI/QAA Improvem CFR(s): 483.75(c)(d)(§483.75(c) Program f monitoring. A facility must establis policies and procedur collections systems, a adverse event monitor procedures must inclu following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativ information will be use are high risk, high vol opportunities for impre-	serious mental illness ability or a related condition. et Nurse responsible for vailable for an interview ducted on 12/13/22 at 12:24 rator. The Administrator bet the PASRR for the y; however, the MDS nurse e the coding on the DS dated 9/20/22. The he MDS coding should have tesident #38 PASRR Level II why it was not done. ent Activities (e)(g)(2)(i)(ii) eedback, data systems and sh and implement written es for feedback, data and monitoring, including yring. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and yes, including how such ed to identify problems that ume, or problem-prone, and		867			1/6/23

Facility ID: 943301

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
345267		B. WING			12/15/2022		
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
BLADEN	EAST HEALTH AND REH	AB, LLC			804 S POPLAR STREET ELIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	not limited to the facili §483.70(e) and including will be used to develop indicators. §483.75(c)(3) Facility and evaluation of perf including the methods development, monitor §483.75(c)(4) Facility including the methods systematically identify analyze and use data adverse events in the facility will use the data prevent adverse events \$483.75(d) Program s systemic action. §483.75(d)(1) The face aimed at performance implementing those a and track performance implement policies ad (i) How they will use a determine underlying impacting larger syste (ii) How they will devents will be designed to effi- level to prevent qualitit safety problems; and	epartments, including but ity assessment required at ding how such information p and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will y, report, track, investigate, and information relating to facility, including how the ta to develop activities to its. systematic analysis and cility must take actions e improvement and, after ctions, measure its success, e to ensure that alized and sustained. cility will develop and ldressing: a systematic approach to causes of problems	F	867			

Facility ID: 943301

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345267		(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING				/15/2022	
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BLADEN	EAST HEALTH AND REH	AB, LLC			804 S POPLAR STREET ELIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	ensure that improvem §483.75(e) Program a §483.75(e)(1) The fac performance improve high-risk, high-volume consider the incidenc of problems in those a outcomes, resident sa resident choice, and o §483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activitie distinct performance in number and frequence conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas collection and analysi (c) and (d) of this sec §483.75(g)(2) The qu	provement activities to nents are sustained. activities. cility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. mance improvement nedical errors and adverse yze their causes, and e actions and mechanisms and learning throughout the of their performance s, the facility must conduct improvement projects. The ey of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). Is must include at least t focuses on high risk or identified through the data is described in paragraphs tion.	F	867			

If continuation sheet Page 5 of 7

			FORM	: 01/12/2023 APPROVED . 0938-0391	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	(X3) DATE SURVEY COMPLETED	
345267			12/15/2022		
R	•	STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
REHAB, LLC		804 S POPLAR STREET			
·		ELIZABETHTOWN, NC 28337			
CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
or designated person(s) governing body regarding its ng implementation of the QAPI d under paragraphs (a) through n. The committee must: implement appropriate plans of identified quality deficiencies; view and analyze data, including nder the QAPI program and data ug regimen reviews, and act on make improvements. IENT is not met as evidenced netrviews and record review, the Assessment and Assurance e failed to maintain implemented monitor these interventions that ut into place following the rtification survey. This was for a y on the current recertification cy of assessments. The e during two federal surveys of the facility's inability to sustain A program. d: referenced to: record review and staff cility failed to code the Minimum assessment accurately in creening and Resident Review I for 2 of 2 residents (Resident nt # 38) reviewed for PASRR.	F 8	 The facility QAPI plan ha reviewed and revised to ens QAPI Committee has sufficie effectively review, offer feed identify potential problems w process of reviewing MDS c accuracy for resident PASRI 2. Residents residing in the the potential to be affected. Committee members will be or before 12/30/22 by the ac the QAPI plan and revision t sufficient time to effectively n feedback, and identify poten with the new process of revi coding accuracy for resident status. The Administrator will ens Committee reviews monthly audits of comprehensive MD assessments to ensure accu of the resident s PASRR st offers feedback as needed to compliance is met and main 	sure that the ent time to black, and with the new coding R status. facility have The QAPI educated on dministrator on to allow review, offer ntial problems ewing MDS t PASRR sure the QAPI the on-going DS urate coding atus and o ensure tained.		
	IDENTIFICATION NUMBER:	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A BUILDIN 345267 B. WING_ R D PREHAB, LLC ID INTY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL BY OR LSC IDENTIFYING INFORMATION) ID page 5 or designated person(s) governing body regarding its ing implementation of the QAPI d under paragraphs (a) through n. The committee must: FE implement appropriate plans of identified quality deficiencies; view and analyze data, including inder the QAPI program and data ug regimen reviews, and act on or make improvements. MENT is not met as evidenced Interviews and record review, the Assessment and Assurance the failed to maintain implemented monitor these interventions that ut into place following the rtification survey. This was for a ey on the current recertification iccy of assessments. The e during two federal surveys of the facility's inability to sustain A program. d: referenced to: record review and staff cility failed to code the Minimum assessment accurately in creening and Resident Review If for 2 of 2 residents (Resident int # 38) reviewed for PASRR.	RE & MEDICAID SERVICES (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: 345267 R 345267 R STREET ADDRESS, CITY, STATE, ZIP CC 804 S POPLAR STREET ELIZABETHTOWN, NC 22337 RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YOR LSCIDENTIFYING INFORMATION) D PREFIX TAG Page 5 Cross-Reference Control CROSS-REFERENCE TO DEFICIENCY page 5 F 867 or designated person(s) governing body regarding its ng implementation of the QAPI d under paragraphs (a) through n. The committee must: F 867 implement appropriate plans of identified quality deficiencies; view and analyze data, including nder the QAPI program and data ug regimen reviews, and act on make improvements. AENT is not met as evidenced 1. The facility QAPI plan ha reviewed and revised to ens QAPI Committee has suffici effectively review, offer feed to thinto place following the rification survey. This was for a y on the current recertification icy of assessments. The e during two federal surveys of the facility's inability to sustain A program. 1. The facility QAPI plan ha reviewed and revision t sufficient time to effectively if eedback, and identify potential problems will be or before 12/30/22 by the ac the QAPI plan and revision sufficient time to effectively if eedback, and identify potential problems will be or before 12/30/22 by the ac the QAPI plan and revision sufficient time to effectively if eedback, and identify poten with the new process of revision status. accuracy for resident Revision it # 30 (revised to Resident th # 30)	H AND HUMAN SERVICES DB CONCES DB NO SEX & MEDICAID SERVICES DB NO (x1) PROVIDERSUPPLENCUA DESNTFICATION NUMBER 345267 B. WING 345267 B. WING B. WING	

Facility ID: 943301

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/12/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY PLETED
	345267		B. WING			C 12/15/2022	
NAME OF P	ROVIDER OR SUPPLIER	I		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BLADEN	EAST HEALTH AND REH	AB, LLC			04 S POPLAR STREET LIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	level II Preadmission Review (PASRR). During an interview o Administrator reveale monthly to discuss ide She indicated PASRF recently in the QAA m	Screening and Resident n 12/15/22 at 11:10 AM, the d the QAA committee meets entified issues in the facility. R level II was not discussed neetings since she was not had concerns with coding	F	867	review the accuracy of MDS PASRR coding at least monthly for a period of less than 12 months to ensure contin compliance.		

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