PRINTED: 11/07/2023 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		ISTRUCTION		SURVEY PLETED
		345397	B. WING_				C / 19/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472		10/	13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	00			
F 000		3.73, Emergency t ID # KW1K11.	F(00			
	survey was conducted 10/19/23. Event ID #	complaint investigation d from 10/16/23 through KW1K11. The following ed: NC 00208346. 1of the 1 did not result in a					
F 636 SS=B	10/31/23 at tag F641. Comprehensive Asse	ssments & Timing	Fé	36			11/6/23
	a comprehensive, acc	duct initially and periodically					
	A facility must make a assessment of a residence goals, life history and resident assessment by CMS. The assess the following:	ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least					
_ABORATORY I	(iii) Cognitive patterns		<u> </u>		TITLE		(X6) DATE

Electronically Signed 11/06/2023

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345397	B. WING _			C 10/19/2023
	ROVIDER OR SUPPLIER	TREME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472		10/13/2020
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F 636	(ix) Continence. (x) Disease diagnos (xi) Dental and nutrit (xii) Skin Conditions (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatme (xvi) Discharge plan (xvii) Documentatior regarding the addition the care areas trithe Minimum Data S (xviii) Documentation assessment. The assinclude direct observe with the resident, as licensed and nonlice members on all shift §483.20(b)(2) When timeframes prescribe chapter, a facility musus assessment of a restimeframes specified through (iii) of this supprescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmissis significant change in mental condition. (Fureadmission" means.	vior patterns. rell-being. rolling and structural problems. ris and health conditions. risional status. Ints and procedures. ring. ring of summary information roll assessment performed riggered by the completion of riset (MDS). ring of participation in rissessment process must relation and communication rivell as communication with rensed direct care staff	F 6	36		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345397	B. WING		C 10/19/2023
	ROVIDER OR SUPPLIER	REME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	10/10/2020
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F 636	Continued From pag or therapeutic leave. (iii)Not less than once		F 63	36	
	This REQUIREMENT by: Based on record reversely facility failed to compositive fail	iew and staff interviews the lete comprehensive MDS) assessments within the s as specified in the It Instrument (RAI) manual reviewed for MDS ent #47, Resident #46,		The statements made on this plan of correction are not an admission to an does not constitute an agreement with alleged deficiencies. To remain in compliance with all feder and state regulations the facility has sor will take the actions set forth in this plan of correction. The plan of correct constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F636 – Comprehensive Assessment Timing Corrective Action Minimum Data Set assessment for affected residents that were identified not being completed within the required 14 day timeframe was completed as follows: Resident #47 was admitted to the facility on 8/19/2021. Annual Minimum data set assessment with Assessment Reference Date of 9/28/2023 was completed on 10/13/2023. Assessment was accepted in the state database 10/19/2023 Minimum data set Batch #1896. Resident #46 was admitted to the facility on 3/4/2021. Significant Charm Minimum data set assessment with	ral taken s tion e and d as ed e m nt ent
	Nurse revealed there	3 at 4:50 PM with the MDS were different people essments including some		Minimum data set assessment with Assessment Reference Date of 9/14/was completed on 9/29/2023.	2023

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	ATE SURVEY OMPLETED
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SHORELA	AND HLTH CARE & RETI	REME		WHITEVILLE, NC 28472		
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F 636	Continued From page	e 3	F 6	36		
F 030	who worked remotely she was aware of the assessments and that be completed per the Instrument (RAI) mar she did not know why were completed late. A follow up interview 10/19/23 at 10:30 AM the assessments wer 14-day allotted time for Reference Date (ARI MDS Nurse stated content of the complete assession Nurse indicated she wastaff nurse when neethird week of the morn During the week on completed other task further stated she had admissions and discribing the were other nurse assist with completing Interview with the Adi Corporate Nurse Corp M revealed they we the MDS assessment regulatory timeframe assisted the MDS Nu assessments. The Adwas implementing ne	timing of the MDS at MDS assessments were to Resident Assessment anal. The MDS Nurse stated a some of the assessments with the MDS Nurse on a revealed she was aware re not completed during the rom the Assessment b) date established. The arporate nurses were helping ments remotely. The MDS assassigned to work as a ded and was on call every and for the entire week. all she worked the floor or as if needed. The MDS Nurse d a high volume of anarges, and this made it assessments within the The MDS Nurse stated assessments.	F 6:	Assessment was accepted in database 10/2/2023 Minimum batch #1888. Resident #4 was admitted facility on 8/27/2023. Significd Minimum data set assessment Assessment Reference Date was completed on 10/2/2023 Assessment was accepted in database 10/3/2023 Minimum Batch # 1883. Corrective action for resident potential to be affected by the deficient practice. All residents have the potential affected by the alleged deficient A 100 % review of all current with a comprehensive assess has been completed and sublast 30 days will be audited to assessments were completed days timeframes. This audit we completed by Regional RAI Clater than 11/2/2023. Effective 11/2/2023 the form Minimum data set coordinated the Minimum Data Set (MDS list in PCC Software daily (Most through Friday) and inform the interdisciplinary team member residents with assessment redates (ARD) for that date as residents with in progress asset that are due for completion (Mata set assessment Z0500 contacts and the minimum data set coordinated the	and data set and data set and do the cant Change int with of 9/15/2023 and the state in data set and to be ent practice. residents sment that mitted in the preview that do in the 14 will be consultant no acility r will review in progress onday in error in ference well as any sessments Minimum date) on that	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3	B) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	DDE	10/19/2023
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F 636	Continued From pag	e 4	F 63	members that have sections completion. This has been a daily stand up meeting procedure set coordinator will sen down report to Administrator all assessments due for compay have been completed. Regional RAI consultant current Minimum data set as progress list for comprehens assessments that are due to completed (Minimum data set due date) by 11/6/2023. Far data set coordinator with assessments (in progress of assessments (in progress of assessments with Z0500 du 11/6/23 or earlier) by 11/6/20. Systemic Changes By 11/6/2023, the Regional set consultant will complete training with the facility Minim Coordinator that includes the of ensuring that each reside comprehensive assessment the rules stated in Chapter 2 (resident assessment instruments). The monitoring procedure to the plan of correction is efferenced in compliance with the requirements. The Administrator or designations.	added to the ess. Minimum ad daily stand reporting that appletion that the will audit the essessments in sive to be et item Z0500 cility Minimum sistance of ent floater fied comprehensive the date of 023. Minimum data an in-service mum Data Set the importance ent receive at according to 2 of the RAI ment) Manual. The ensure that cive and that the regulatory in the contraction of the regulatory in the contraction of the regulatory.	t .

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
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F 638 SS=B	•	e 5 Least Every 3 Months		536	auditing the facility's compliance with comprehensive Minimum Data Set assessments completion time frames a stated in Chapter 2 of the RAI (residen assessment instrument) Manual using quality assurance survey tool entitled "Comprehensive Assessments and Tim Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and compliance with the regulatory requirements. This audit will be completed on 5 residents' completed assessments per audit and will be done weekly x 4 week and then monthly x 2 months or until substantial compliance is achieved and maintained. Reports will be presented the weekly Quality Assurance committe by the Administrator to ensure correctivaction for trends or ongoing concerns initiated as appropriate. The weekly Quality Assurance Meeting is attended the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Hellnformation Manager, Dietary Manager and the Activities Director. The title of the person responsible implementing the acceptable plan of correction; Administrator and /or Director of Nursin Date of Compliance: 11/6/2023	t the the ning in ss d to ee ve s by alth	11/6/23
30-5	§483.20(c) Quarterly A facility must assess						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345397	B. WING		C 10/19/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/13/2023	
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F 638	Continued From page	⊋ 6	F 638	3		
	and approved by CM once every 3 months	ument specified by the State S not less frequently than is not met as evidenced				
	Based on record rev facility failed to comp Set (MDS) assessment imeframe as specific Assessment Instrume residents reviewed for (Resident #21, Resident #21, Resident #31). Findings included: a. Resident #21 was 8/28/20 with diagnost chronic kidney diseas dementia. Review o quarterly Minimum Date in the second in the sec	ent (RAI) manual for 7 of 20 or MDS assessments ent #11, Resident #27, ot #32, Resident #25, as admitted to the facility on es which included in part se, failure to thrive and f Resident #21's 7/18/23		The statements made on this plan of correction are not an admission to an does not constitute an agreement wit alleged deficiencies. To remain in compliance with all fede and state regulations the facility has to r will take the actions set forth in this plan of correction. The plan of correctionstitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F638 Quarterly Assessment at Least Every 3 Months Corrective Action Minimum Data Set assessment for affected residents that were identified.	ral saken s tion	
	8/22/22 with diagnose Review of Resident # revealed the assessment 9/24/23. c. Resident #27 was 1/6/23 end stage renare Review of Resident # revealed the assessment 10/11/23. d. Resident #1 was	s admitted to the facility on es which included diabetes. 11's 9/8/23 quarterly MDS nent was completed on al disease and dialysis. 127's 9/26/23 quarterly MDS nent was completed on admitted to the facility on a admitted to the facility on so which included dementia		not being completed within the requir 14-day timeframe were completed an submitted to the state database as follows: Resident #21: Quarterly Minimu data set assessment with Assessmer Reference Date of 7/18/2023 was completed on 8/2/2023 and submitted/accepted into state databa on 8/3/2023 Minimum data set Batch #1856. Resident #11: Quarterly Minimum data set assessment with Assessmer Reference Date of 9/8/2023 was completed on 9/24/2023 and	m nt se	

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F 638	8/20/23 quarterly MD was completed on 9/ e. Resident #32 wa 3/20/23 with diagnos arthritis, diabetes and Resident # 32's 8/19/ the assessment was f. Resident #25 wa 4/19/23 with diagnos fracture. Review of F quarterly MDS revea completed on 9/8/23. g. Resident #31 wa 7/21/22 with diagnos lumbar disc degeneratementia. Review of quarterly MDS revea completed on 9/29/23. Interview with the ME 10:30 AM revealed s assessments were lacompleted during the the Assessment Refe MDS Nurse said ther assisted remotely with assessments. The M pulled to the floor to needed; was on call month for the entire worked the floor or dispersions.	eview of Resident #1's S revealed the assessment 7/23. Is admitted to the facility on is which included in part Id heart failure. Review of 1/23 quarterly MDS revealed completed on 9/7/23. Its admitted to the facility on is which included hip Resident #25's 8/22/23 Ided the assessment was Its admitted to the facility on is which included in part action, chronic pain and If Resident #31's 9/14/23 Ided the assessment was Its S Nurse on 10/19/23 at the was aware the te, and they were not Interval 14-day allotted time from the rence Date (ARD). The the were corporate nurses that In the completion of IDS Nurse stated she was work an assignment if the every third week of the the veek and if needed she Id other tasks as needed;	F 6	submitted/accepted into state on 9/25/2023 Minimum data #1885. • Resident #27: Quarterly data set assessment with Assert Reference Date of 9/26/202 completed on 10/11/2023 are submitted/accepted into state on 10/12/2023 Minimum data #1894. • Resident #1: Quarterly set assessment with Assess Reference Date of 8/20/202 completed on 9/7/2023 and submitted/accepted into state on 9/8/2023 Minimum data set assessment with Assert Reference Date of 8/19/202 completed on 9/7/2023 and submitted/accepted into state on 9/7/2023 Minimum data set assessment with Assert Reference Date of 8/19/202 completed on 9/7/2023 and submitted/accepted into state on 9/7/2023 Minimum data #1874. • Resident #25: Quarterly data set assessment with Assert Reference Date of 8/22/202 completed on 9/8/2023 and submitted/accepted into state on 9/11/2023 Minimum data #1894. • Resident #31: Quarterly data set assessment with Assert Reference Date of 9/14/202 completed on 9/29/2023 and	ly Minimum ssessment 3 was and te database ta set Batch Minimum data sment 3 was te database set Batch ly Minimum ssessment 3 was te database set Batch y Minimum ssessment 3 was te database set Batch y Minimum ssessment 3 was te database set Batch y Minimum ssessment 3 was te database set Batch y Minimum ssessment 3 was te database set Batch y Minimum ssessment 3 was te database set Batch	
	and stated there was admissions and discl Interview with the Ad	narges.		submitted/accepted into state on 10/2/2023 Minimum data #1888.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		(X3) DATE S COMPL	
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F 638	Corporate Nurse Con PM revealed she was the MDS assessment regulatory timeframe. the corporate nurses with completion of the other duties also. The revealed the MDS Nuthe floor as a staff nuron call for the nursing Administrator stated to new procedures to chemical procedures to chemical procedures was a staff nuron call for the nursing Administrator stated to the procedures to chemical procedures to chemical procedures as a staff nuron call for the nursing Administrator stated to the procedures to chemical procedures as a staff nuron call for the nursing Administrator stated to the procedure of the procedure o	sultant on 10/19/23 at 5:10 s aware of the situation with ts not completed within the The Administrator stated assisted the MDS Nurse e assessments, but they had e Administrator further urse was required to work rse and was required to be g department. The the facility was implementing	F6	Identification of other reside the potential to be affected deficient practice: All residents have the potential affected by the alleged defixed A 100 % review of all current with a quarterly assessment completed and submitted in days will be audited to review assessments were completed 14-day completion timefram will be completed by Region assessment instrument consider than 11/6/2023. • Effective 11/2/2023 the Minimum data set coordinate Minimum Data Set (MD list in PCC Software daily (Intrough Friday) and inform interdisciplinary team mem residents with assessment dates (ARD) for that date a residents with in progress at that are due for completion data set assessment Z0500 date. Minimum data set coordinator will set down report to Administrate all assessments due for coordinator will set on the proof of the data and the proof data set coordinator will set down report to Administrate all assessments due for coordinator will assessments due for coordinator	ntial to be icient practic nt residents nt that has ben the last 30 ew that ted in the mes. This au mal resident nsultant no e facility ator will revie DS) in progre Monday the abers of the reference as well as an assessments (Minimum 0 date) on thordinator will a team as that need a added to the cess. Minimum of daily star or reporting to mpletion that essment audit the curr	ged ce. een dit ew ess	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE	
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F 638	Continued From page	e 9	F	progress list for quarterly that are due to be comp due date) by 11/6/2023. Minimum data set coord assistance of floater start these identified quarterly 11/6/2023 By 11/1/2023 the region assessment instrument conduct education/traini Minimum Data Set Nurs importance of schedulin a Minimum Data Set ass residents at least once exper chapter 2 of the Residents at least once exper chapter 2 of the Residents at all residemore than 92 days betword that all Minimum Data Set assessment (Admiss Quarterly, Significant Chep placed on the importation that all Minimum Data Set be completed in the required swell as encoded and the required timeframes CMS as stated in Chapter Resident Assessment In Monitoring The monitoring proceduand/or in compliance with requirements; The Administrator areview 5 random resider recently completed Quarterly 21/20/20/20/20/20/20/20/20/20/20/20/20/20/	letted (item Z05 The facility linator with the ff will complete y assessment b al resident consultant will ang with the faci is on the g and completi is sessment for al every 3 months sident Assessme e education will ents must have yeen Assessme h Minimum Dat sion, Annual, nange). Focus ance of ensurin tet assessments uired time fram transmitted wit as set forth by ter 2 of the astrument Manual re to ensure the effective and tr remains correct thin the regulate and/or designee and/or desi	ility ng ll neent e no ent ta will ng s es, thin ual. at ne cted ory	

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E 000							
F 638	Continued From page	e 10	F	638			
					data set assessment to validate whether	er	
					or not most recent Minimum data set		
					quarterly assessment was completed	_	
					(Z0500 date) within the 14 day required	i	
					timeframe (date of Z0500 assessment		
					completion date). This will be complete using the Quality Assurance tool entitle		
					"Quarterly Completion of Minimum Data		
					Set Assessments" Audit tool. This will		
					done on a weekly basis for 4 weeks the		
					monthly for 2 months. Reports will be		
					presented to the weekly Quality		
					Assurance committee by the Administra	ator	
					to ensure corrective action for trends of	r	
					ongoing concerns is initiated as		
					appropriate. The weekly Quality		
					Assurance Meeting is attended by the		
					Administrator, Director of Nursing,		
					Minimum Data Set Coordinator, Unit		
					Manager, Support Nurse, Therapy, Hea		
					Information Manager, Dietary Manager		
					and the Activities Director.		
					The title of the person responsible for		
					implementing the acceptable plan of correction;		
					Administrator and /or Director of Nursir	na	
					Date of Compliance: 11/6/2023	9.	
F 641	Accuracy of Assessm	nents	F	641	Bate of Comphanics. 1170/2020		11/6/23
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30 5	-:(=)					ĺ	
	§483.20(g) Accuracy	of Assessments.					
		st accurately reflect the					
	resident's status.	-					
	This REQUIREMENT	is not met as evidenced					
	by:						
		n, staff interviews, and			The statements made on this plan of	ĺ	
		ility failed to accurately code			correction are not an admission to and	ſ	
	Minimum Data Set (N	IDS) assessments to reflect			does not constitute an agreement with	the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 641	Continued From page	e 11	F	641			
F 641	ostomy status and us ambulation, (Residen accurately assess a reparticipation in the assession (Resident #38), for 2 MDS assessments. 1. a. Resident #47 was 8/19/21 with diagnose Type 2 Diabetes Mell disease, right knee publadder incontinence. An observation of Re 10/16/23 at 2:30 PM. wheelchair self-proper additional observation the afternoon when Resident Council medical Review of an annual	e of assistive devices for t #47); and failed to esident's cognition and sessment and goal setting, of 23 residents reviewed for as admitted to the facility on es that included, in part: itus, Stage 3 chronic kidney ain, frequent bowel and and a history of falls. Sident #47 was made on She was sitting in her elling in the hallway. An an was made on 10/18/23 in the sident #47 attended the eting using a wheelchair. MDS assessment 23 documented Resident	F	641	alleged deficiencies. To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of corrections the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F-641 Accuracy of Assessments Corrective actions Resident #47 Minimum data set annuassessment with Assessment Referent date of 9/28/2023 reviewed and resided does not have wheelchair use coded of the Minimum Data Set. Minimum data assessment with Assessment reference date of 9/28/2023 was modified and corrected by the facility Minimum Data Nurse on 10/18/2023 to reflect accuract the time of the Assessment reference date look back timeframe of the	ual ce nt e set e Set	
	10:30 AM revealed R wheelchair for ambula period in September assessment had been MDS nurse remotely. clearly documented in Resident #47 used a during the assessment she did not know why did not document Resident ror ambula	n completed by a corporate She reported it had been in the electronic record that wheelchair for ambulation int period. She concluded if the corporate MDS Nurse sident #47 used a ation and that she had inent to accurately document			assessment. Resident #47 Minimum data set assessment with Assessment reference date of 6/28/2023 was reviewed and findings revealed resident did not have ostomy during the assessment reference date look back timeframe of the assessment. Minimum data set assessment with assessment reference date of 6/28/2023 was modified and corrected by the facility Minimum Data Nurse on 10/18/2023 to reflect accurate at the time of the Assessment reference date look back timeframe of the assessment.	e an ce e Set	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245207	B. WING			С	
		345397	B. WING _			10/19/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CI	TY, STATE, ZIP CODE		
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F 641	Continued From p	age 12	F				
1 041	b. The bowel and MDS assessment #47 documented services of all progrevealed Resident 10:30 AM revealed ostomy. She report completed by a confusion of the system that is concompleted incorreresident had an ostomy she concluded the assessment should information that at assessment to refan ostomy. She services in the se	bladder section of the quarterly dated 06/28/23 for Resident she had an ostomy. The section of the quarterly dated 06/28/23 for Resident she had an ostomy. The MDS Nurse on 10/19/23 at dot Resident #47 never had an orted the assessment had been proporate MDS Nurse remotely. She reviewed the data, she sk section in the computer appleted by Nurse Aides was cotly documenting that the stomy. This information auto assessment dated 06/28/23. The nurse who completed the document and changed the lect Resident #47 did not have tated she modified the curately document Resident		Resident #38 I assessment w Date of 9/13/2 for section C or participation at interview was Corrective active potential to be deficient practive All residents haffected by the A 100% audit of completed Min in the past 30 who use whee current resider urinary/bowel of completed in of following questin the section Good identified asses Reference Datasection H0100 Minimum data	Minimum data set quarter with Assessment Reference 023 coded "not assessed cognition and section Q and goal setting as the not completed with reside ion for residents with the affected by the alleged ice. ave the potential to be a alleged deficient practic of the most recent nimum data set assessmed all current reside elchair mobility devices are the work of Go600 Mobility devices of Go600 Mobility devices (20 Mobility Devices for essments with Assessment te 10/1/2023 or later) and pappliances on the set assessment: wheelchair (manual or	ee d'' ent. ee. ent ents end er or tely s	
	Administrator on 1 Administrator state assessments to be 2) Resident #38 v	conducted with the 0/19/23 at 4:30 PM. The ed she expected MDS e accurate. was admitted to the facility on ses included, in part, dementia		electric)/ section for Assessmer 10/1/2023 or late H0100C-ileostomy, and this audit will	on GG0120 Mobility Devi nt Reference Date ater Ostomy (including urosto		
	revealed section ("not assessed" an	y assessment dated 09/13/23 C for cognition was coded as d section Q for participation in loal setting was coded as "not		inaccurate coo the above que of that assessi	who is identified as having ding of any one or more o estions will have a correct ment completed y the facility Minimum Da	of ion	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345397	B. WING _				C 19/2023
	ROVIDER OR SUPPLIER	REME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472			13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 641	Worker (SW) on 10/1 revealed she was use completing section C assessments, but she time the assessment Activities Director wor for completing the assessment as portions the SW was unavailable. An interview with the 10/19/23 at 2:00 PM is assessment dated 09 for completing Reside section C and Q. The she could not rememic complete the assessment oversite." An interview was con Administrator on 10/1 Administrator stated if was to complete the in the state of the section C and Islands and Islands are section C and Islands are section	ducted with the Social 9/23 at 10:45 AM. The SW ally responsible for and section Q of the MDS was out of facility at the was due. She stated the alld have been responsible sessment for any MDS responsible for if she was Activities Director on revealed on the quarterly 1/13/23, she was responsible ent #38's assessment in a Activities Director stated ber why she did not ment and added "it was an ducted with the 9/23 at 4:55 PM. The ner expectation of the staff MDS assessments r entirety to reflect the	F	641	Set Coordinator. Any necessary Minim data set corrections will be completed later than 11/6/2023. Systemic Changes By 11/6/2023, the regional Minimum daset consultant will complete an in-servitraining with the facility Minimum Data Nurse that includes the importance of thoroughly reviewing each resident's medical record in order ensure that the assessment is coded accurately. Specemphasis will be placed on the following areas of the Minimum Data Set assessment: - GG0120C wheelchair mobility device the resident normally uses for locomoti (in room and in facility) (manual or electric): if the resident normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed another person. Do not include geri-chairs, reclining chairs with wheels positioning chairs, scooters, and other types of specialty chairs. -H0100C, ostomy (including urostomy, ileostomy, and colostomy) By 11/6/2023, the regional Minimum daset consultant will complete an in-servitraining with the facility Minimum Data Nurse, Social service coordinator, and activity director. In-service training includes the importance of thoroughly reviewing each resident's medical recoin order ensure that the assessment is coded accurately. Special emphasis we be placed on the following areas of the Minimum Data Set assessment: -Section C0100 Brief Interview for Men	no ata ce Set cial g s on e by s, ata ce Set	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
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F 641	Continued From pa	nge 14	F6	Status Interview (BIMS -Section Q0110 Particip Assessment and Goal S - Section Q0310 Reside The Minimum Data Set thoroughly reviewed for closing and locking the This information has be the standard orientation Minimum Data Set Cool The monitoring procedu the plan of correction is specific deficiency cited and/or in compliance wi requirements. The Administrator obegin auditing 5 random completed minimum data assessments for accurate Minimum data set at C0100 BIMs interview, Participation in assessm setting, and Q0310 Resignal. This audit will be oweeks and then monthly the audit tool titled "Accimps Audit Tool". Reporpresented to the weekly Assurance committee be to ensure corrective actiongoing concerns is initiappropriate. The weekl Assurance Meeting is at Administrator, Director of Minimum Data Set Cool Manager, Support Nurse Information Manager, D	action in Setting ent's Overall Godent's	to to v at last sted y ator	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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F 641	Continued From page	: 15	F6	641	1		
					and the Activities Director. The title of the person responsible implementing the acceptable plan of correction;		
					Administrator and/or Director of Nursing Date of Compliance: 11/6/2023	g.	
F 761 SS=D	Label/Store Drugs and CFR(s): 483.45(g)(h)(F 7	761			11/6/23
	Drugs and biologicals	/ and cautionary					
	§483.45(h) Storage o	f Drugs and Biologicals					
	Federal laws, the faci biologicals in locked of	rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys.					
	locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 at abuse, except when the package drug distributed quantity stored is minimal be readily detected. This REQUIREMENT by:	affixed compartments for drugs listed in Schedule II of drugs listed in Schedule II of drug Abuse Prevention and dother drugs subject to the facility uses single unit tion systems in which the dimal and a missing dose can dis not met as evidenced					
	Based on observation recommendations rev	ns, manutacturer's iew, and staff interviews,			The statements made on this plan of correction are not an admission to and	do	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345397	B. WING _			10/19/2023	
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SHUKELA	AND HLTH CARE & RE	IREME		WHITEVILLE, NC 28472			
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F 761	Continued From pa	ge 16	F 7	761			
F 761	the facility failed to on an unattended in hall) medication car pass and 2) failed to on the 300-hall medication carts revenue findings included: 1) A continuous obs 9:05 AM to 9:10 AM medication cup with 200-hall medication where residents and medication cart was of a nurse. Housek Assistant (NA) #1 p medication cart in the time the medication medication cart. The residents as well as medication cart. At of a resident room of to the unattended 2 Nurse #1 stated she medication in the w stated it was medication in the w stated it was medications.	1) securely store medication nedication cart for 1 of 2 (200 tts observed for medication of dispose of 2 expired inhalers dication cart for 1 of 2 viewed for medication storage. Servation on 10/18/23 from a revealed a white paper a white capsule on top of the a cart unattended in an area distaff could access. The sent within direct observation seeper #1 and Nursing assed the unattended in the hallway several times at the awas observed on top of the enere were cognitively impaired as visitors in the vicinity of the 9:10 AM Nurse #1 came out down the hallway and returned 00 hall medication cart. It was assigned to the 200-hall curse #1 observed the hite paper medicine cup, ation for a resident and she arit when she went to give the The medication used to treat	F 7	not constitute an agreement alleged deficiencies. To remain in compliance wit regulations the facility has ta take the actions set forth in correction. The plan of correconstitutes the facility's allege compliance such that all alledeficiencies cited have beer corrected by the dates indic F 761 The facility failed to follow the manufacturer's recommendate review to 1) securely store of an unattended medication carts of medication pass and 2) failed of 2 expired inhalers on the medication cart for 1 of 2 medication cart for 1 of 2 medication cart for 1 of 2 medication cart of 10/18/23 Nurse #1 (200 medication cart) disposed of medication cart) disposed of medication cart) disposed of #19's Stiolto Aero Respimat manufacturer's recommendation 10/18/23 Nurse #2 (300 medication cart) disposed of #16's Trelegy Ellipta 100 mi	h all state aken or will this plan of ection gation of eged n or will be ated ne ations and medication on art for 1 of 2 observed for ed to dispose 300-hall edication carts rage. sident(s) cient practice: hall f the papentin. hall f Resident inhaler per ations. hall f Resident		
	During an interview Nurse #1 revealed thave been left unat medication cart and	on 10/18/23 at 9:01 AM the medication should not tended on top of the I she must not have seen it ered medications to one of the		inhaler per manufacturer's recommendations. 2.Corrective action for resid potential to be affected by the deficient practice. On 10/30/23 the Director of	ents with the ne alleged		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SHORELA	ND HLTH CARE & RETI	REME			000 FLOWER-PRIDGEN DRIVE		
				V	WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
Г 761	0	. 47					
F 761	Continued From page	e 1 <i>1</i>	F	761			
					Managers audited all medication carts		
		ducted on 10/19/23 at 5:10			ensure that all medications were prope	-	
		e Nurse Consultant, in the			stored when medication cart unattende	ed.	
	presence of the Admi	nistrator. The Corporate			The results included: no concerns		
	Nurse Consultant furt	her stated Nurse #1 made a			identified. On 10/30/2023 the Director	of	
	mistake and should n	ot have left medication			Nursing / Unit Manager implemented		
	unattended on top of	the medication cart.			corrective action to include: ongoing		
					audits to ensure that all medications ar		
		the 300-hall medication cart			properly stored when medication cart is	8	
	and interview with Nurse #2, the nurse assigned, on 10/18/23 at 10:53 AM revealed the following:				unattended at least weekly x2 and		
					monthly x3.		
					On 10/30/23 the Director of Nurses/Un		
		er's recommendations			managers audited all medication carts		
	indicated the Stiolto A				ensure that no expired medication rem		
		assembly of the device			on carts by referencing the manufactur		
	(cartridge into the dis	pensing unit).			recommendations. The results include no concerns identified. On 10/30/2023		
	An observation of Re	sident #19's Stiolto Aero			the Director of Nursing / Unit managers	3	
	Respimat inhaler had	a pharmacy label which			implemented corrective action to include	le:	
	indicated the medicat	ion was delivered on 7/3/23			ongoing audits to ensure that no expire	ed	
	and had an expiration	n date of 10/1/23.			medication remain on carts by reference	ing	
					the manufacturer recommendations at		
	An interview on 10/18	3/23 at 10:53 AM with Nurse			least weekly x2 and monthly x3.		
	#2 revealed the label	on Resident #19's inhaler					
	indicated the medicat	ion was expired and it			3. Measures /Systemic changes to		
	should have been dis	carded. Nurse #2 stated			prevent reoccurrence of alleged deficie	nt	
	she had administered	I the Stiolto inhaler to			practice:		
		rning and did not recall			On 10/30/2023 the Director of Nurses		
	checking the expiration	on day prior to			began education of all Full Time, Part		
	administration.				Time, as needed nurses, medication		
					aides and agency nurses on facility pol		
		er's recommendations			related to medication safety that includ		
		Ellipta inhaler expired 6			safely securing and storing medications		
	weeks after it was op	ened.			labeling of the date medication opened		
					and checking expiration dates on		
	_	gy Ellipta 100 microgram			medications to assure no expired		
		the inhaler which indicated			medications are administered. Education	on	
		8/21/23 and to discard the			will be completed by 10/31/2023.		
	medication 6 weeks a	after it was opened. The			This information has been integrated in	ito	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER: `		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2020	
					00 FLOWER-PRIDGEN DRIVE			
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					VHITEVILLE, NC 28472		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 761	Continued From page	e 18	F 7	761				
	indicated an expiratio				the standard orientation training and in required in-service refresher courses for all staff identified above and will be			
		3/23 at 10:55 AM with Nurse			reviewed by the Quality Assurance			
		s on Resident #19 and			process to verify that the change has			
		ers indicated the medications			been sustained.			
		ould have been discarded.			Any of the above nursing staff who doe			
		urses were expected to			not receive scheduled in-service training	•		
		dates when administering #2 explained she thought the			will not be allowed to work until training has been completed by 11/1/23.	}		
		e checked by someone			The monitoring procedure to ensure			
		s not sure who did this or			that the plan of correction is effective a			
	when. Nurse #2 furth				that specific deficiency cited remains	iiu		
	***	lers to Resident #19 and			corrected and/or in compliance with the	e		
		rning and had not noticed			regulatory requirements:			
	that the medications v				Quality assurance audits will be			
		·			completed by the Director of Nurses or	,		
	An interview on 10/19	9/23 at 5:00 PM with the			designee for F761 Adequate Label/Sto	re		
	Director of Nursing (D	OON) revealed expired			Drugs and Biologicals to assess that a	il .		
	medications should b				medications are safely and appropriate	łly		
		e securely stored on the			stored, that no expired medications are			
	medication carts.				the medication cart. Audits of medication			
					carts to ensure all medications are stor	ed		
		ducted on 10/19/23 at 5:10			properly and secured when cart not in			
		rator and the Corporate			attendance and all medications stored			
		ne Administrator revealed			and disposed of per manufacturers'	_		
	-	ng to ensure there were no			guidelines will be completed weekly x 2	<u> </u>		
		on the medication cart. The			and monthly x 3 or until resolved for			
	I -	sultant stated it was a			compliance with this process.			
		facility did not discard the from the medication cart,			Reports will be presented to the	21/		
		that required constant staff			weekly Quality Assurance Committee the Director of Nursing to ensure	у		
	reminders and auditir				corrective action is initiated as			
	13.1111 GOLO GITG GGGIGI	' '			appropriate. Compliance will be monitor	ored		
					and the ongoing auditing program			
					reviewed at the weekly Quality Assurar	nce		
					Meeting. The weekly Quality Assurance			
					Meeting is attended by the Administrate			
					Director of Nursing, Minimum Data Set			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 761	Continued From page			761	Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activities Director. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 11/6/2023		
F 867 SS=D	'		F 8	367			11/6/23
	§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:						
	systems to obtain and from direct care staff, resident representativ information will be use	maintenance of effective duse of feedback and input other staff, residents, and ves, including how such ed to identify problems that ume, or problem-prone, and overment.					
	systems to identify, coinformation from all donot limited to the facil §483.70(e) and include	maintenance of effective oblect, and use data and epartments, including but ity assessment required at ling how such information up and monitor performance					
	§483.75(c)(3) Facility and evaluation of per	development, monitoring, formance indicators,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	TREME		STREET ADDRESS, CITY, STATE, ZIP CODE 200 FLOWER-PRIDGEN DRIVE WHITEVILLE, NC 28472	10/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 867	development, monitors §483.75(c)(4) Facilitic including the method systematically identification analyze and use data adverse events in the facility will use the disprevent adverse events and track performance implementing those and track performance improvements are results. §483.75(d)(1) The facility will use determine underlying impacting larger systemic action. §483.75(d)(2) The facility will be designed to elevel to prevent quality in the problems; and (iii) How the facility will be designed to elevel to prevent quality of its performance in ensure that improve §483.75(e) Program §483.75(e) (1) The facility will be designed to elevel to prevent quality of its performance in ensure that improve §483.75(e) Program §483.75(e) (1) The facility will be designed to elevel to prevent quality of its performance improve §483.75(e) (1) The facility will be designed to elevel to prevent quality of its performance improve §483.75(e) (1) The facility will be designed to elevel to prevent quality of its performance improve §483.75(e) (1) The facility will be designed to elevel to prevent quality and the prevent quality of its performance improve §483.75(e) (1) The facility will use the distribution of the prevent quality and the prevent qualit	dology and frequency for such oring, and evaluation. y adverse event monitoring, ds by which the facility will fy, report, track, investigate, a and information relating to be facility, including how the ata to develop activities to ents. It systematic analysis and actions, measure its success, ace to ensure that ealized and sustained. Accility will develop and addressing: a systematic approach to g causes of problems tems; yelop corrective actions that effect change at the systems lity of care, quality of life, or definition will monitor the effectiveness approvement activities to ments are sustained.	F 86	67		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 867	of problems in those a outcomes, resident sa resident choice, and of \$483.75(e)(2) Perform activities must track in resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activitied distinct performance in number and frequency conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project that problem-prone areas collection and analysis (c) and (d) of this section and (d) of this section and analysis (e) and (d) of this section. The (ii) Develop and implesting the program required under t	e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. mance improvement nedical errors and adverse yze their causes, and actions and mechanisms and learning throughout the 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). In must include at least at focuses on high risk or identified through the data is described in paragraphs tion. In seessment and assurance. In all y assessment and areports to the facility's esignated person(s) rning body regarding its inplementation of the QAPI der paragraphs (a) through	F8	67		

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F 867	Continued From page (iii) Regularly review data collected under resulting from drug re available data to make This REQUIREMENT by: Based on record rev interviews the facility Assurance (QAA) pro implemented procede interventions the com the recertification and survey completed on recertification survey was for three repeate the areas of compreh quarterly assessment storing of medication current recertification survey of 10/19/23. two or more federal se	and analyze data, including the QAPI program and data egimen reviews, and act on the improvements. This not met as evidenced siew, observations and staff its Quality Assessment and egram failed to maintain the put in place following indicate in place following indicate and the completed on 3/12/21. This deficiencies originally cited in place	F 86	DEFICIENCY)	lan of to and nt with the I federal has taken in this orrection on of will be I. sment and d to es and ittee put in n and completed n survey		
	specified in the Resid (RAI) manual for 3 of MDS assessments (Resident #4).	failed to complete num Data Set (MDS) he regulatory timeframes as dent Assessment Instrument 20 residents reviewed for Resident #47, Resident #46,		repeat deficiencies originally cituareas of comprehensive assess and timing (F636), quarterly asset least every 3 months, (F638) label/store of drugs and biologic recited on the current recertificate complaint investigation survey of 10/19/23. The continued failure or more federal surveys of recompattern of the facility's inability to an effective QA program.	ed in the aments sessments and strict (F761) and of during two rd shows a		

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F 867	timeframe for 2 of 9 monomplete a discharge assessment within the 9 residents and 3) fai MDS assessment wit for 1 of 9 residents reassessments. Interview with the Adright of 2 of 9 monomplete assessments. Interview with the Adright of 2 of 9 monomplete assessments did not continued long enough further revealed there that have caused the not be sustained. The closer monitoring and interventions implement sustain the QAA programmers assessment in the programmers of the facility failed to complete the programmers of the	um Data Set (MDS) Ints within the required esidents 2) failed to e with return anticipated e required timeframe for 1 of led to complete a 14-day hin the required timeframe eviewed for Resident ministrator on 10/19/23 at e QAA program for MDS work due to it not being gh. The Administrator e were changes in the facility measures implemented to the Administrator indicated di evaluation of the ented was necessary to the ented was necessary to the enter of th	F	867	1.Corrective action for resident(s) affect by the alleged deficient practice: F636: Corrective Action Minimum Data Set assessment for affected residents that were identified a not being completed within the required 14 day timeframe were completed as follows: Resident #47 was admitted to the facility on 8/19/2021. Annual Minimum data set assessment with Assessment Reference Date of 9/28/2023 was completed on 10/13/2023. Assessment was accepted in the state database 10/19/2023 Minimum data set Batch #1896. Resident #46 was admitted to the facility on 3/4/2021. Significant Change Minimum data set assessment with Assessment Reference Date of 9/14/20 was completed on 9/29/2023. Assessment was accepted in the state database 10/2/2023 Minimum data set batch #1888. Resident #4 was admitted to the facility on 8/27/2023. Significant Change Minimum data set assessment with Assessment Reference Date of 9/15/20 was completed on 10/2/2023. Assessment was accepted in the state database 10/3/2023 Minimum data set Batch #1883. F638: Corrective Action	e 023 ge	
	of the look-back period reviewed for resident	od) for 5 of 9 residents assessments.			Minimum Data Set assessment for affected residents that were identified a not being completed within the required		

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F 867 Continue	ed From pag	e 24	F 8	367				
Interview 5:10 PM assessm facility the not be so revealed systems why the F761 Bathe facility on an urthall) merpass and on the 3 medication locked trobserved During the investigation failed to medicate medicate date for of 1 medicate for of 1 medicate of 1 medicate for other for 1 medicate for other forms of 1 medicate for othe	with the Adrevealed the revealed the revealed the revealed the revealed the revealed. That the fact that were in previous prosed on obsety failed to 1 rettended medication carts (2) failed to 20-hall medication carts revious prosecutive recertification survey remove exponed to a recertification refrigued to the deficit of the def	ministrator on 10/19/23 at a QAA program for MDS work due to changes in the measures implemented to the Administrator further ility needed to improve aplemented and investigate gram did not work. Trivations and staff interviews, securely store medication edication cart for 1 of 2 (200 sobserved for medication dispose of 2 expired inhalers cation cart for 1 of 2 ewed for medication storage. Ition survey of 3/12/21, the unattended treatment and ointments) secured in a tro 1 of 1 treatment carts Ition and complaint of 6/24/22, the facility 1) ared medications from 2 of 3 on hall and 200 hall failed to record an opened cated in the locked box in 1 greators and 3) failed to stored on top of 1 of 3 on carts. (Medication storage ministrator on 10/19/23 at a QAA program should have cient practice related to of medication more closely	F 8	367	14-day timeframe were completed and submitted to the state database as follows: • Resident #21: Quarterly Minimum data set assessment with Assessment Reference Date of 7/18/2023 was completed on 8/2/2023 and submitted/accepted into state databasion 8/3/2023 Minimum data set Batch #1856. • Resident #11: Quarterly Minimum data set assessment with Assessment Reference Date of 9/8/2023 was completed on 9/24/2023 and submitted/accepted into state databasion 9/25/2023 Minimum data set Batch #1885. • Resident #27: Quarterly Minimum data set assessment with Assessment Reference Date of 9/26/2023 was completed on 10/11/2023 and submitted/accepted into state databasion 10/12/2023 Minimum data set Batch #1894. • Resident #1: Quarterly Minimum set assessment with Assessment Reference Date of 8/20/2023 was completed on 9/7/2023 and submitted/accepted into state databasion 9/8/2023 Minimum data set Batch #1875. • Resident #32: Quarterly Minimum data set assessment with Assessment Reference Date of 8/19/2023 was completed on 9/7/2023 and submitted/accepted into state databasion 9/8/2023 Minimum data set Batch #1875. • Resident #32: Quarterly Minimum data set assessment with Assessment Reference Date of 8/19/2023 was completed on 9/7/2023 and submitted/accepted into state databasion 9/7/2023 Minimum data set Batch #1874.	e e n e h data		

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	been revised as need maintaining the progr further stated ongoing was required to ensui	led to be successful at am. The Administrator g monitoring and education re that expired or unsecured observed on the medication		data set assessment Reference Date of 8/ completed on 9/8/20 submitted/accepted i on 9/11/2023 Minimu #1894.	/22/2023 was 23 and into state database um data set Batch Quarterly Minimum t with Assessment /14/2023 was 2023 and into state database um data set Batch cition follow the mmendations and r store medication or cation cart for 1 of 2 n carts observed for 1 2) failed to dispose on the 300-hall of 2 medication cart tion storage. #1 (200 hall posed of the l as gabapentin. #2 (300 hall posed of Resident respimat inhaler per mmendations. #2 (300 hall posed of Resident loosed of Resident loosed of Resident loosed of Resident loosed of Resident 100 microgram	3

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					completion. This has been added to the daily stand up meeting process. Minimulate set coordinator will send daily standown report to Administrator reporting the all assessments due for completion that	um id hat	

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F 867	Continued From page	÷ 27	F8	day have been completed. Regional resident assessment instrument consultant will audit to Minimum data set assessments progress list for comprehensive assessments that are due to be completed (Minimum data set its due date) by 11/6/2023. Facility data set coordinator with assistat Minimum data set assessment floor staff will complete the identified assessments (in progress completes assessments with Z0500 due data 11/6/23 or earlier) by 11/6/2023. F638: All residents have the potential traffected by the alleged deficient A 100 % review of all current resident will be audited to review the assessments were completed in 14-day completed by Regional reassessment consultant no later to 11/6/2023. Effective 11/2/2023 the facil Minimum data set coordinator with Minimum Data Set (MDS) in list in PCC Software daily (Mondathrough Friday) and inform the interdisciplinary team members of residents with assessment refered dates (ARD) for that date as well residents with in progress asses that are due for completion (Minimum (Minimum Completion) (Minim	the current in 20500 Minimum ance of loater rehensive ate of sidents thas been last 30 at the This audit esident than lity rill review progress day of the ence II as any esments		

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F 867	Continued From page	÷ 28	F	867	data set assessment Z0500 date) on the date. Minimum data set coordinator will review any interdisciplinary team members that have sections that need completion. This has been added to the daily stand up meeting process. Minimum data set coordinator will send daily stand down report to Administrator reporting all assessments due for completion that day have been completed. Regional resident assessment instrument consultant will audit the currum Minimum data set assessment in progress list for quarterly assessments that are due to be completed (item Z05 due date) by 11/6/2023. The facility Minimum data set coordinator with the assistance of floater staff will complete these identified quarterly assessments 11/6/2023. By 11/1/2023 the regional resident assessment instrument consultant will conduct education/training with the fact Minimum Data Set Nurse on the importance of scheduling and completic a Minimum Data Set assessment for all residents at least once every 3 months per chapter 2 of the Resident Assessment Instrument manual. The education will emphasize that all residents must have more than 92 days between Assessment Reference Dates of each Minimum Data Set assessment (Admission, Annual, Quarterly, Significant Change). Focus be placed on the importance of ensuring that all Minimum Data Set assessment be completed in the required time fram as well as encoded and transmitted with the fact of the required time fram as well as encoded and transmitted with the required time fram as well as encoded and transmitted with the fact of the required time fram as well as encoded and transmitted with the fact of the required time fram as well as encoded and transmitted with the fact of the required time fram as well as encoded and transmitted with the fact of the required time fram as well as encoded and transmitted with the fact of the required time fram as well as encoded and transmitted with the fact of the required time fram as well as encoded and transmitted with the fact of the required time fram as well as enc	leum nd that at rent 600 by ility ng lent eno ent ta will ng s es,		

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F 867	Continued From page	pe 29	F	FF A A A A A A A A A A A A A A A A A A	the required timeframes as set forth by CMS as stated in Chapter 2 of the Resident Assessment Instrument Manual F641: All residents have the potential to be affected by the alleged deficient practic A 100% audit of the most recent completed Minimum data set assessment the past 30 days of all current residents who use appliances for a current residents who use appliances for a current residents who use appliances for including questions were coded accurant the section of G0600 Mobility device (section GG0120 Mobility Devices for dentified assessments with Assessment Reference Date 10/1/2023 or later) and section H0100 Appliances on the Minimum data set assessment: A G0600C- wheelchair (manual or electric)/ section GG0120 Mobility Devices for Assessment Reference Date 10/1/2023 or later A H0100C- Ostomy (including urostor leostomy, and colostomy) This audit will be completed by Administrator no later than 11/6/2023. Any resident who is identified as having naccurate coding of any one or more of the above questions will have a correct of that assessment completed mediately by the facility Minimum Dasset Coordinator. Any necessary Minimum data set corrections will be completed in atter than 11/6/2023.	ee. ent ints id ices omy, g of tion ata	

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F 867	Continued From pag	e 31	F	867	failed to continue audits and sustain appropriate systemic changes when ar of improvement were identified. Facility Administrator and Director of nursing required further education on Quality Assurance Performance Improvement processes. 3. Measures/Systemic changes to prev reoccurrence of alleged deficient practic Education: On 10/31/2023, the Nurse Clinical Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate function of the Quality Assurance Performance Improvement Committee and the purpor of the committee to include identifying issues and correcting repeat deficiencie On 11/1/2023 the administrator comple in-servicing with the Quality Assurance Performance Improvement team members that include the Administrator Director of Nurses, LPN Support Nurse Minimum Data Set Coordinator, Therap Manager, Health Information Manager, Dietary Manager, Social Service Coordinator, BOM, Admissions and Marketing Director, Transportation Aide/Central Supply, Nurse Secretary/Housekeeping Supervisor, a Maintenance Director on the appropriate functioning of the Quality Assurance Performance Improvement Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the new empl	rent ce: ee ing ose es. es, es, oy	

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F 867	Continued From page	ge 32	F	Quality Assurance Per Improvement Committed above. This will be reviewed Assurance process to change has been sustant and the statement of the plan of correction specific deficiency cit and/or in compliance requirements.	by the Quality of verify that the stained. The stained of receive schedul not be allowed to be been completed dure to ensure that is effective and the dremains correct with regulatory or or designee will attilizing the F867 of weekly x 4 weekly be presented to be presented to be presented to the surance committed as the surance committed as the surance committed as the program because of the program or until no longer or compliance with the sessments and the saments at least labeling/storage of the weekly Quality attended by the prof Nursing, coordinator, Unit urse, Therapy, Heatler of the stain of the program, the profile of the pro	led by to the cate of the cate

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