STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE REHABILITATION AND HEALTHCARE CENTER	209 BEASLEY STREET KENANSVILLE, NC 28349

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/24/24 through 03/28/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XNKR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/24/2024 through 03/28/2024. Event ID# XNKR11. The following intakes were investigated NC00209801, NC00210434, NC00213371, and NC00213444. 7 of the 7 complaint allegations did not result in deficiency.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 18 resident assessments reviewed (Resident #72 and Resident # 5). The findings included: 1. Resident # 72 was admitted to the facility on 12/13/2023 with diagnosis that included diabetes and hypertension. Review of the nurse note dated 12/29/2023 indicated Resident # 72 was discharged home.	F 641	F 641 = Accuracy of Assessments What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Element #1 Per the 2567, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 18 resident assessments reviewed (Resident # 72 and Resident # 5) Resident #72 & Resident #5 were not affected by this	4/19/24

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

Electronically Signed | 04/16/2024

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F 641	Continued From page 1 Review of the discharge MDS dated 12/29/2023 inaccurately coded Resident # 72 was discharged to acute hospital. During the interview on 03/27/2024 at 10:29 AM, Minimum Data set (MDS) nurse reviewed the discharge MDS and confirmed it was inaccurate. The MDS nurse explained it was coded in error as Resident # 72 was discharged home not to the acute hospital. During an interview on 03/27/2024 at 11:30 AM, Director of Nursing (DON) indicated that MDS should have been coded accurately reflecting that the resident was discharged to the community not to the acute hospital. The Administrator was interviewed on 03/27/2024 at 11:42 AM and she stated it was her expectation for MDS assessment to be coded accurately. 2. Resident #5 was admitted to the facility on 1/26/24 with diagnoses of chronic diastolic heart failure, chronic respiratory failure, and chronic obstructive pulmonary disease (COPD). Resident #5's care plan created 1/27/24 indicated Resident #5 had oxygen therapy related to COPD. Interventions included administering oxygen per physician orders. Resident #5's physician's order dated 1/26/2024 indicated administer oxygen at 3 liters/minute via nasal cannula continuously. Resident #5's admission MDS dated 1/30/24 did not indicate Resident #5 used oxygen.	F 641	deficient practice. Resident #72 and Resident #5 had immediate modifications/corrections made to their MDS assessments on 3/27/24 to accurately reflect Resident #72's discharge status and Resident #5's MD ordered oxygen status. This was completed on 3/27/24 by the MDS Coordinator. Element #2 What corrective will be accomplished for other residents that potentially could be affected by this deficient practice. All residents have the potential to be affected by the deficient practice if their Minimum Data Set (MDS) is not coded accurately for proper discharge status and accurate documentation of MD ordered oxygen. 100% audit was completed to ensure all residents with a coded discharge status and MD ordered oxygen status where correctly coded on their MDS assessments. No adverse outcomes noted related to this 100% audit. This audit was completed by the MDS coordinator on 3/31/24. What measures have been put in place or systematic changes made to ensure the deficient practice does not recur: Element #3 The MDS coordinator/designee will ensure all MDS assessments are accurately coded for documentation of	

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F 641	Continued From page 2 During an interview with the MDS Nurse on 3/27/24 at 3:04 PM, she stated that Resident #5 had an order for oxygen use, and it should have been coded on the admission MDS. She further stated that it was an oversight. An interview was conducted on 3/27/24 at 3:17 PM with the Director of Nursing (DON). The DON stated anything going on with the Resident should be included in the Resident ' s MDS and that oxygen should have been coded in Resident #5 ' s admission MDS because there was an order for oxygen administration. During an interview on 3/27/24 at 3:22 PM, the facility Administrator verbalized oxygen should have been coded on Resident #5 ' s admission MDS since she was receiving oxygen.	F 641	discharge status and MD ordered oxygen usage. Education was provided to the MDS coordinator nursing staff, by the VP of Clinical Services, regarding MDS documentation and ensuring all assessments are accurate, and are accurately coded. This education was provided in written format and verbally reviewed with both MDS coordinators on 3/27/24. It is critical that MDS documentation and modification corrections are completed to ensure accurate care planning and resident outcomes. No adverse events noted after this audit was completed. This audit was completed on 3/31/24 by the MDS coordinator. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the MDS Director and/or designee will conduct compliance audits 5 x week x 12 weeks to ensure the resident's MDS is coded accurately for discharge status and MD orders for oxygen usage are coded accurately. If an MDS coding error is identified, it will be modified and corrected immediately by the MDS coordinator/designee. The facility will continue provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such	

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F 641	Continued From page 3	F 641	time that substantial compliance has been achieved x 3 months. Compliance Date: 4/19/2024	