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

PRINTED: 05/07/2024 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER KENANSYLLE REHABILITATION AND HEALTHCARE CENTER KENANSYLLE, NC 28349 PAGE PROVIDER STATEMENT OF DEPTICENCY PROVIDER ST	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
SIRREL ADDRESS CITY, STATE, 2P CODE 299 BEASELY STREET		345150		B. WING			
PREFIX (EACH DEFICIENCY NUST BE PRECEDED BY FULL TAG CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE OF THE APPROPRIATE CROSS-REFERENCE OF THE APPRO					209 BEASLEY STREET	00/20/2021	
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. F 000 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 641 SS=B 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 # 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.	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPLETION	
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indicated Resident # 72 was discharged home. Resident #5 were not affected by this		1. Resident # 72 was 12/13/2023 with diag and hypertension.	admitted to the facility on nosis that included diabetes		accurately code the Minimum Data So (MDS) assessment for 2 of 18 resider assessments reviewed (Resident # 73	nt	
		indicated Resident #	72 was discharged home.		Resident #5 were not affected by this		

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

(X6) DATE

04/16/2024 **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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345150	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	0.100	1		TREET ADDRESS, CITY, STATE, ZIP CODE	03/	28/2024	
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KENANSV	ILLE REHABILITATION	AND HEALTHCARE CENTER			09 BEASLEY STREET ENANSVILLE, NC 28349			
	OLIMANA DV OT	ATEMENT OF REFIGIENCIES		<u> </u>			0.5	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page 1		F 6	641				
		ge MDS dated 12/29/2023 esident # 72 was discharged			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			
	Minimum Data set (M discharge MDS and c	on 03/27/2024 at 10:29 AM, DS) nurse reviewed the confirmed it was inaccurate. sined it was coded in error			discharge status and Resident #5's MD ordered oxygen status. This was completed on 3/27/24 by the MDS Coordinator.)		
	as Resident # 72 was acute hospital.	discharged home not to the			Element #2			
	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.				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	r		
	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).				Minimum Data Set (MDS) is not coded accurately for proper discharge status accurate documentation of MD ordered oxygen. 100% audit was completed to	and I		
					ensure all residents with a coded discharge status and MD ordered oxyg status where correctly coded on their MDS assessments. No adverse outcomes noted related to this 100%			
	Resident #5 had oxyg	included administering			audit. This audit was completed by the MDS coordinator on 3/31/24.			
	indicated administer of	an's order dated 1/26/2024 oxygen at 3 liters/minute via			What measures have been put in place systematic changes made to ensure th deficient practice does not recur:			
	nasal cannula continu	iously.			Element #3			
	Resident #5's admission MDS dated 1/30/24 did not indicate Resident #5 used oxygen.				The MDS coordinator/designee will ensure all MDS assessments are accurately coded for documentation of			

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		345150	B. WING			C 03/28/2024	
NAME OF PROVIDER OR SUPPLIER			1	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	
KENANSVII I E RI	HARII ITATION	AND HEALTHCARE CENTER		209	BEASLEY STREET		
RENAMOVIELE RE	INABILITATION	AND HEALTHOAKE GENTER		KEI	NANSVILLE, NC 28349		
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F 641 Contir	nued From pag	e 2	F 6	641			
During 3/27/2 had all been of stated. An interpolation of the properties of the pro	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.				discharge status and MD ordered oxygusage. Education was provided to the MDS coordinator nursing staff, by the Nof 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 of 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 a this audit was completed. This audit woompleted on 3/31/24 by the MDS coordinator. How the corrective actions will be monitored to ensure the deficient pract will not recur, and what quality assurant program will be put into place: Element #4 To ensure ongoing compliance, the MED irector and/or designee will conduct compliance audits 5 x week x 12 weeks 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 correctimediately by the MDS coordinator/designee. The facility will continue provide education on any area of concern. The results of the audits will be reported at the monthly QAPI meeting until such	on Ifter ras ice ice ice ice ice ice ice	

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					9 BEASLEY STREET					
KENANS	ILLE REHABILITATION	N AND HEALTHCARE CENTER			ENANSVILLE, NC 28349					
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F 641	Combined France									
Г 0 4 I	Continued From pag	ge 3	F 6	041	Aires Ales Association and the second in the					
					time that substantial compliance has be achieved x 3 months.	een				
					Compliance Date: 4/19/2024					