STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345365	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Kinston	907 Cunningham Road Kinston, NC 28501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observations, resident interview and staff interviews, the facility failed to assess the ability of a resident to self-administer medications prior to leaving the resident's medications on the overbed table in the resident's room for 1 of 1 resident reviewed for pharmacy services (Resident #18). Resident #18 indicated she could not take a lot of medications together at one time and the medications were left on her overbed table to take when she wanted to. Findings included: Resident #18 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #18 was cognitively intact. Physician orders included the following medication orders for Resident #18 that were active on 10/14/24: - Acetaminophen 325 milligram (mg) tablets give two tablets for pain or fever every six hours as needed. - Augmentin 875-125 mg tablet give twice a day ending 10/15/2024. - Ciprofloxacin HCL 500 mg tablet give one tablet twice daily for seven days. There was no documentation in the Electronic Medical Record (EMR) that Resident #18 had been assessed to self-administer her medications, there was no physician's order for self-administration, and there was no care plan that addressed self-administration of medication. On 10/14/2024 at 10:48 am, two medication cups were observed on Resident #18's overbed table located between the Resident #18's open door and the right side of Resident #18's bed. There were two round white tablets in one medication cup and two white broken oblong tablets in the other medication cup. Residents were observed outside Resident #18's open door in the hallway self-propelling their wheelchairs. (continued on next page)

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.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/2024 at 10:48 am in an interview with Resident #18, she stated the two white, broken oblong tablets in the medication cup were her antibiotic, and the two white round tablets in the other medication cup were her pain medication. She said she could not take a lot of medications together at one time and the medications were left on her overbed tablet to take when she wanted to. An observation and an interview were conducted on 10/14/2024 at 10:50 am with Nurse #1. He was observed at a medication cart in the hallway and walked into Resident #18's room. Nurse #1 explained the two round tablets in one medication cup located on Resident #18's overbed table were Acetaminophen tablets, and the two broken white tablets in the other medication cup located on Resident #18's overbed table were an antibiotic. Nurse #1 explained he saw Resident #18 with the medication cup up at her mouth when he was in room to administer Resident #18 her medications before exiting the room. He stated he should have stayed in Resident #18's room and watched her swallow the medications. Nurse #1 was observed removing the two medications cups from the overbed table when exiting Resident #18's room. On 10/17/2024 at 10:15 am in a follow up phone interview with Nurse #1, he clarified the medications observed on the overbed table were Ciprofloxacin and Acetaminophen. He explained Resident #18 requested to visualize her antibiotic and pain medication separately in medication cups and her other morning medications were crushed in pudding and administered. Nurse #1 stated he observed Resident #18 take the medications administered in the pudding, and the Ciprofloxacin was at her mouth when he walked out of the Resident's room. On 10/17/2024 at 11:47 am in an interview with the Assistant Director of Nursing, she stated Resident #18's medications should not have been left on the overbed table, and Nurse #1 should have stayed with Resident #18 when administering her medications to ensure Resident #18 had taken her medications. On 10/17/2024 at 12:34 pm in an interview with the Interim Director of Nursing, she explained Resident #18 had not been assessed to perform self-administration of her medication. She stated Nurse #1 should have watched Resident #18 take her medication before leaving Resident #18's room when administering medications to Resident #18.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39731 Based on record review and staff interviews, the facility failed to provide the required Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (NOMNC) (form 10123) and the and failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (ABN) for 1 of 3 residents reviewed for beneficiary protection notification review (Resident #75). The findings included: Resident #75 was admitted to the facility on [DATE] with Medicare Part A skilled services. Resident #75's admission Minimum Data Set assessment dated [DATE] revealed she had moderate cognitive impairment. Resident #75's Medicare Part A skilled services ended on 4/12/24 and her Medicare Part A Skilled Nursing Facility benefit was not exhausted. She remained in the facility. Record review revealed no evidence that Resident #75 or the resident's responsible party were provided the NOMNC notice or the ABN. During an interview with the Business Office Manager on 10/16/24 at 11:24 AM she stated she had trained the former weekday Receptionist to do the required forms. She stated the Receptionist was no longer employed by the facility. The Business Office Manager stated the forms were not uploaded to the facility system and when she searched Resident #75's folder there were blank forms in the folder. The former Receptionist was unable to be contacted. An interview was conducted with the Administrator on 10/18/24 at 9:45 AM who indicated Resident #24 should have received the CMS-10123-NOMNC and the CMS-ABN as required by federal guidelines.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49159 Based on observation, resident and staff interviews, the facility failed to provide maintenance to the bathroom door and keep the grout on the floor at the base of the bathroom doorway clean from buildup of debris for 1 of 2 resident rooms (Resident #63's room) reviewed for environment. The findings included: a. Observation of Resident #63's room on 10/14/24 at 10:40 AM revealed the surface of the bathroom door approximately three quarters from the top of the doorframe, and as well as the sides of the doorway were scuffed. A large area, approximately 3 inches in height, and across the length of the bathroom door revealed peeling paint which exposed what appeared to be a wood-like color underneath. b. Observation of Resident #63's room on 10/14/24 at 10:40 AM revealed the bathroom doorway had what appeared to be a buildup of debris, black in color, on the grout in the right and left spaces at the base of the bathroom doorway. An interview was conducted on 10/14/24 at 10:40 AM and on 10/15/24 at 8:59 AM with Resident #63. During both interviews Resident #63 expressed how unhappy she felt about the condition of her bathroom door and doorway. She stated in each interview she reported the issues with her bathroom door and doorway to staff several times, however, she could not remember the names of the staff members or when she noticed the damaged door or dirty areas at the base of the bathroom doorway. An interview with the Assistant Maintenance Director was conducted on 10/16/24 at 8:46 AM. He stated room inspections were done monthly; random resident rooms were selected. He stated there was a maintenance logbook that was kept at the nurse's station for maintenance issues that needed to be addressed. He added this logbook was checked weekly. He also utilized an electronic work order system. This system was checked weekly. He was unable to find a pending or completed work order for Resident #63's room. He stated he was not aware of any issues with the bathroom door or bathroom doorway in Resident #63's room. On 10/16/24 at 9:24 AM the Assistant Maintenance Director conducted an observation of the areas of concern in Resident #63 room in conjunction with an interview with Resident #63 who resided in the room. Resident #63 showed the Assistant Maintenance Director the issues with her bathroom door, doorway, and floor area. Resident #63 informed the Assistant Maintenance Director she reported her concerns to staff many times, however, she could not remember the names of the staff members. A review of the maintenance logbook at nurses' station was conducted on 10/16/24. There was no work order request for Resident #63's room found. An interview was conducted with the Housekeeping Supervisor on 10/16/24 at 9:31 AM. He stated he was not aware of the blackened discoloration on both sides of the floor in Resident #63's room bathroom doorway. He added Resident #63's room was last deep cleaned on 10/8/24 and he was not notified of discoloration on the floor in the bathroom doorway. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview was conducted with the Maintenance Director on 10/17/24 at 9:36 AM. He stated the facility conducted ambassador rounds where resident rooms were assessed. He added the Administrator was responsible for ambassador rounds for Resident #63's room. In an interview with the Administrator on 10/17/24 at 9:47 AM he stated he conducted ambassador rounds daily for Resident #63's room. He stated he did not notice any issues with the bathroom door or discoloration on the bathroom doorway floor. He added Resident #63 did not tell him about any concerns. An interview was conducted with the interim Director of Nursing (DON) on 10/17/24 at 10:38 AM. She stated nursing staff were expected to notify housekeeping if a resident's room needed cleaning, as well as notify maintenance for anything in need of repair. The DON further stated the facility also conducted ambassador rounds daily.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observations, resident Interview and staff interviews, the facility failed to accurately code the Minimum data Set (MDS) assessment in the areas of medications, smoking, elimination and behaviors for 4 of 28 residents whose MDS assessments were reviewed (Resident #14, #17, #13, and #33). Findings included: 1. Resident #14 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus. There was a physician order for the following hypoglycemic medications on Resident #14's electronic medical record (EMR): * On 11/23/2023, Novolin Regular flex pen insulin 100 units per milliliter, give 11 units subcutaneous three times a day * On 11/23/2023, Novolin Regular flex pen insulin 100 units per milliliter per sliding scale before meals and at bedtime. * For blood glucose reading 200-250, give 3 units subcutaneous. * For blood glucose reading 251 -300, give 5 units subcutaneous. * For blood glucose reading 301-350, give 7 units subcutaneous. * For blood glucose reading 351-400, give 10 units subcutaneous. * For blood glucose reading 401-450, give 12 units subcutaneous. * For blood glucose reading 451-500, give 14 units subcutaneous. * For blood glucose reading 501-550, give 16 units subcutaneous. * For blood glucose reading 551-600, give 18 units subcutaneous. * On 3/10/22024, Empagliflozin (medication used to treat Diabetes Mellitus) 25 milligrams tablet once a day. * On 3/20/2024, Insulin Glargine solution 100 units per milliliter, give 65 units subcutaneous once a day in the morning. * On 3/20/2024, Insulin Glargine solution 100 units per milliliter, give 60 units subcutaneous once a day at bedtime. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the September 2024 Medication Administration Record recorded the hypoglycemic medications were given as ordered. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #14 was not coded for Resident #14 receiving hypoglycemic medications. Resident #14's care plan last reviewed 9/6/2024 included a focus for Diabetes Mellitus. Interventions included to administer medication as ordered by the physician. In an interview with MDS Nurse #1 on 10/17/24 at 10:32 pm, she stated Resident #14's annual MDS dated [DATE] should have been coded for the use of hypoglycemic medications. She explained the MDS worksheet used in the MDS department noted Resident #14 was receiving insulin and hypoglycemic medications. She stated it was human error in not coding Resident #14's annual MDS for hypoglycemic medications. In an interview with the Interim Director of Nursing on 10/17/24 at 12:34 pm, she stated Resident #14's annual MDS should have been coded accurately for the use of hypoglycemic medications based on Resident #14's assessment for the use of insulin. In an interview with the Administrator on 10/17/2024 at 1:05 pm, he stated Resident #14's MDS assessment should be an accurate assessment for the use of hypoglycemic medications. 2. Resident #17 was admitted to the facility on [DATE] with diagnoses including a stroke. Resident #17 care plan initiated on 1/28/2020 indicated Resident #17 was a smoker. A quarterly smoking assessment dated [DATE] reported Resident #17 was a smoker. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #17 was cognitively intact and did not use tobacco products. On 10/15/2024 at 8:30 am in an interview with Resident #17, she stated she was a smoker and used the facility's designated smoking area during the facility's designated times. On 10/15/2024 at 1:24 pm, Resident #17 was observed in the facility's designated smoking area supervised by the Activities Assistant #1 smoking a cigarette. On 10/17/2024 at 10:24 am in an interview with MDS Nurse #1, she stated she was aware Resident #17 was a smoker, and the annual MDS dated [DATE] should have been coded to reflect Resident #17 used tobacco products. She said she clicked the wrong answer on the MDS screen for the use of tobacco products and could not provide a specific reason why the MDS was coded incorrectly for the use of tobacco products for Resident #17. On 10/17/2024 at 12:34 pm in an interview with the Interim Director of Nursing, she stated the MDS assessment should have been coded accurately based on the smoking assessments for Resident #17. On 10/17/2024 at 1:05 pm in an interview with the Administrator, he stated Resident #17's annual MDS assessment should have been coded accurately for smoking. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49502 3. Resident #2 was admitted to the facility on [DATE] with diagnoses that included colostomy. Resident #2's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had moderate cognitive impairment and was not coded for an ostomy. Resident #2's care plan dated 9/27/24 revealed a focus for a colostomy for elimination. During an interview on 10/17/24 at 10:35 am with the MDS Coordinator, she stated the ostomy section for Resident #2 should have been coded for her colostomy and it was an error. In an interview with the Interim Director of Nursing (DON) on 10/17/24 at 10:51 am, she stated Resident #2's MDS assessment should have been coded correctly for her colostomy. 39731 4. Resident #13 was admitted to the facility on [DATE] with diagnoses that included dementia. Resident #13's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a gradual dose reduction for antipsychotic medication had not been attempted. Resident #13's care plan dated 10/4/24 revealed a gradual dose reduction of antipsychotic medication was attempted on 6/27/24. Review of a Pharmacy Consultant Report dated 7/5/24 revealed a contraindication for a gradual dosage reduction of antipsychotic medication signed by the physician. An interview was conducted with MDS (Minimum Data Set) Nurse #1 on 10/16/24 at 10:36 AM who stated it was an oversight and should have coded Resident #13's assessment to reflect the gradual dose reduction attempt for antipsychotic medication. During an interview on 10/17/24 at 10:30 AM the Interim Administrator stated Resident #13's assessment dated [DATE] should have been coded to reflect a gradual dosage reduction attempt for antipsychotic medication.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39731 Based on record review and resident and staff interviews the facility failed to refer a resident with a new diagnosis of mental illness for a Preadmission Screening and Resident Review (PASARR) evaluation for 1 of 1 resident reviewed for PASARR (Resident #33). Findings included: Resident #33 was admitted to the facility on [DATE] with diagnosis that included adjustment disorder. A physician progress note revealed Resident #33 was newly diagnosed with post-traumatic stress disorder on 6/27/24. Resident #33's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed she was cognitively intact. She was not coded as being screened for a PASARR evaluation. A review of Resident #33's care plan last reviewed 7/29/24 revealed she was care planned for behaviors such as nervousness, fears, and a general feeling of uneasiness related to history of a traumatic event. The interventions included encouraging the resident to voice fears and referral to a physician. During an interview with Resident #33 on 10/16/24 at 12:41 PM she stated she had not previously been diagnosed with post-traumatic stress disorder. She was assaulted in the past by a family member. Resident #33 stated she began having nightmares after the family member began calling her at the facility in July 2024. An interview with the facility Social Worker on 10/16/24 at 11:29 PM was conducted. She stated she did not refer Resident #33 to NC MUST (North Carolina Medical Uniform Screening Tool, a tool used to complete PASARR applications) because she felt Resident #33 was doing well. The Social Worker stated she was unaware that Resident #33 was having nightmares. During an interview on 10/17/24 at 11:00 AM the Administrator indicated if a new psychiatric diagnosis required a new referral to NC MUST for a PASARR application the Social Worker should have followed the correct referral process.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observation and staff interviews, the facility failed to complete an accurate medical record in documenting the administration of medication for 1 of 29 residents whose medical records were reviewed (Resident #18). Findings included: Resident #18 was admitted to the facility on [DATE] with diagnoses including peripheral vascular disease. Physician orders dated 2/14/2024 included Acetaminophen 325 milligram (mg) tablets give two tablets for pain or fever every six hours as needed for Resident #18. On 10/14/2024 at 10:52 am, Nurse #1 was observed administering Resident #18 Acetaminophen 650 mg in applesauce to Resident #18. There was no record of Resident #18 receiving Acetaminophen 650 mg on 10/14/2024 on Resident #18's October 2024 Medication Administration Record (MAR). There was no nursing documentation in Resident #18's medical record that Acetaminophen 650 mg was administered by Nurse #1 on 10/14/2024. On 10/17/2024 at 10:15 am in a phone interview with Nurse #1, he stated pain medications ordered as needed were to be documented on Resident #18's MAR after administration of the medication to the resident. He explained he thought he had documented the dose of Acetaminophen administered to Resident #18 on 10/14/2024 on Resident #18's MAR. On 10/17/2024 at 12:34 pm in an interview with the Interim Director of Nursing, she stated Nurse #1 should have documented the administration of Acetaminophen on Resident #18's MAR after administering the medication to the resident.