STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345539	A. BUILDING _____ B. WING _____	07/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARBOR	300 CLYNELISH CLOSE PITTSBORO, NC 27312

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		7/18/16

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

Electronically Signed | 07/20/2016

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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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to completely assess a resident on the comprehensive assessment in the area of mental status for one of five sampled residents (Resident #12) reviewed for unnecessary medications. The findings included: Resident #12 was admitted to the facility on 9/11/12. The quarterly Minimum Data Set (MDS) assessment dated 5/27/16 indicated Resident #12 had unclear speech, was sometimes able to make herself understood, and was sometimes able to understand others. Section C, the Cognitive Patterns section, was not fully completed. Question C0100 was coded to indicate a brief interview for mental status (questions C0200 through C0500) was to be conducted. Questions C0200 through C0500 were coded with dashes that indicated the questions were not answered. An interview was conducted with the Social Worker (SW) on 7/6/16 at 3:20 PM. She indicated she was responsible for the completion of Section C of the MDS. Section C of the quarterly MDS dated 5/27/16 for Resident #12 was reviewed with the SW. She stated she began working at the facility on 4/25/16 and she was new to MDS coding at the time she completed the quarterly MDS dated 5/27/16 for Resident #12. She indicated when she completed this quarterly assessment for Resident #12 she had not known it was necessary to attempt to complete the brief interview for mental status for all residents unless they were rarely/never understood. She stated she was	F 272	After discussing with a consultant on July 15, 2016 and with the Arbor management team, it has been determined that the MDS in question could not be modified. There is a lack of supportive data that the staff interview was administered as required according to the facility review (Exhibit 1). Therefore, no modification of the assessment in question could occur. All other MDS assessments were reviewed by the Social Worker and MDS Coordinator on July 7, 2016 and were completed according to guidelines. An in-service was conducted on July 7, 2016 by the MDS Coordinator that reviewed the protocols for completing section C of the MDS with the Social Worker (Exhibit 2). The Social Worker will also attend a scheduled training for MDS 3.0 on August 25, 2016 to review protocols for MDS completion (Exhibit 3). The Social Work Director will review all of the social worker□s completed MDS assessments before final submittal for 3 months beginning on July 18, 2016 (Exhibit 4). The MDS Coordinator will review the entire MDS before submittal on a continuing basis to ensure accuracy and that proper guidelines were followed. Any issues noted during audits by the Social Work Director or continued reviews by the MDS Coordinator will be addressed directly to the Social Worker. The findings of the audit will be reported at the October	

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F 272	Continued From page 2 now aware of the requirements for the coding of Section C.	F 272	25, 2016 QAPI/QA meeting by the Social Work Director and assessed for further action by the QAPI/QA team. Other concerns related to RAI guidelines will be reported in future QAPI/QA meetings by the MDS Coordinator moving forward. The corrective action for the alleged deficiency for residents affected was completed on July 18, 2016.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		7/11/16

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F 278	Continued From page 3 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of active diagnoses (section I) for 4 (Residents #1, #21, #12 & #13) of 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident #1 was admitted to the facility on 6/13/16 with multiple diagnoses including Hypothyroidism, Hyperlipidemia, Hypertension and Depression. The admission Minimum Data Set (MDS) assessment dated 6/20/16 indicated that Resident #1 had received an antidepressant medication. The assessment also revealed that Depression, Hypothyroidism, Gastroesophageal reflux disease (GERD) and Hyperlipidemia were not checked under active diagnoses. The June and July 2016 physician's orders were reviewed. The orders included Sertraline (antidepressant drug) 50 milligrams (mgs) by mouth daily, Simvastatin (lipid lowering drug) 40 mgs by mouth daily, Synthroid (a synthetic thyroid hormone) 125 microgram (mcg) by mouth daily and Nexium (drug used to treat GERD) 40 mgs by mouth daily. The doctor's progress notes dated 6/7/16 were reviewed. The notes indicated that Resident #1 had medical problems including Hyperlipidemia and was on Simvastatin, Hypothyroidism and was on Synthroid and GERD and was on Nexium.	F 278	The residents affected by the alleged deficiency (residents # 1, 21, 12, and 13) had their MDS assessments modified by the MDS Coordinator and resubmitted on July 11, 2016 (Exhibit 5). All other MDS assessments by those potentially affected by the alleged deficiency were reviewed by the MDS Coordinator on July 11, 2016 with no concerns noted. The MDS Coordinator verified the diagnosis of depression for all residents with their physicians and alerted nursing staff to monitor for signs and symptoms of depression if not already doing so. Documentation guidelines were also distributed to review with staff what to monitor and review in terms of supportive documentation for active diagnosis(Exhibit 6). The MDS Coordinator was in-serviced on July 11, 2016 by the Director of Nursing on coding for active diagnosis and having supportive documentation on the MDS (Section I of the RAI Manual) (Exhibit 7). The MDS Coordinator will also attend a scheduled training for MDS 3.0 on August 25, 2016 to review protocols for MDS completion (Exhibit 3). The Director of Nursing will monitor each of the MDS Coordinator□s MDS	

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F 278	Continued From page 4 The drug regimen review dated 6/16/16 indicated that Resident #1 was on Sertraline for Depression. On 7/6/16 at 3:15 PM, the MDS Nurse was interviewed. The MDS Nurse stated that her interpretation of section I (active diagnoses) was if a resident was on a medication with a diagnosis and was stable, she did not have to code the diagnosis under section I. The MDS Nurse further indicated that if a resident had problems related to a diagnosis and was seen by the doctor within the look back period, she considered this diagnosis as an active diagnosis. 2. Resident #21 was admitted to the facility on 11/18/15 with multiple diagnoses included Depression and Anxiety/Agitation. The quarterly MDS assessment dated 5/24/16 indicated that Resident #21 had received antidepressant and antianxiety medications. The assessment also revealed that Depression and Anxiety were not checked under active diagnoses. The physician's orders for Resident #21 were reviewed. The orders included Ativan (anti-anxiety drug) 0.5 mgs by mouth twice a day and Sertraline 25 mgs by mouth daily. The May 2016 Medication Administration Records revealed that Resident #21 had received Ativan and Sertraline. On 7/6/16 at 3:15 PM, the MDS Nurse was interviewed. The MDS Nurse stated that her interpretation of section I (active diagnoses) was if a resident was on a medication with a diagnosis	F 278	submittals for 3 months beginning on July 18, 2016 (Exhibit 8). The monitor will review the active diagnosis and whether supportive documentation is sufficient during the look-back period. Any issues noted during audits will be addressed directly to the MDS nurse by the Director of Nursing. The findings will also be reported at the October 25, 2016 QAPI/QA meeting by the Director of Nursing and assessed for further action by the QAPI/QA team. Other concerns related to RAI guidelines will be reported in future QAPI/QA meetings by the MDS Coordinator moving forward. The corrective action for the alleged deficiency for residents affected was completed on July 11, 2016.	

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F 278	Continued From page 5	F 278		

and was stable, she did not have to code the diagnosis under section I. The MDS Nurse further indicated that if a resident had problems related to a diagnosis and was seen by the doctor within the look back period, she considered this diagnosis as an active diagnosis.

3. Resident #12 was admitted to the facility on 9/11/12. Her cumulative diagnoses included depression. A review of Resident #12's medical record revealed a physician's order for Cymbalta (antidepressant) 60 milligrams (mg) once daily for depression.

The quarterly Minimum Data Set (MDS) assessment dated 5/27/16 indicated Resident #12 had significant cognitive impairment. Resident #12 had received antidepressant medication on 7 of 7 days during the 5/27/16 MDS look back period. Section I, the Active Diagnosis Section, of the 5/27/16 MDS for Resident #12 indicated depression was not an active diagnosis.

A physician's progress note dated 5/27/16 indicated Resident #12's active problems list included depression.

The May 2016 Medication Administration Record (MAR) for Resident #12's 5/27/16 quarterly MDS indicated Cymbalta 60mg was administered once daily for depression on 7 of 7 days during the look back period.

An interview was conducted with the MDS Nurse on 7/6/16 at 3:15 PM. She stated she was responsible for completion of Section I, the Active Diagnosis Section, on the MDS. The MDS Nurse indicated her interpretation of the coding

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F 278	Continued From page 6	F 278		

requirements for Section I was that if a resident was on a medication for a specific diagnosis and they were stable on that medication that she was not to code that diagnosis as an active diagnosis on the MDS. She elaborated on her interpretation and stated that for a resident who was receiving an antidepressant for the diagnosis of depression and their depression was stable, then depression was not to be coded as an active diagnosis on their MDS. The MDS Nurse indicated if a resident was seen by the physician for a specific diagnosis during the look back period then she considered that diagnosis as an active diagnosis.

4. Resident #13 was admitted to the facility on 9/18/12. Her cumulative diagnoses included depressive disorder. Resident #13's medical record revealed a physician's order for Effexor (antidepressant) 75 milligrams (mg) twice daily for depression.

The quarterly Minimum Data Set (MDS) assessment dated 5/20/16 indicated Resident #13 had significant cognitive impairment. Resident #13 had received antidepressant medication on 7 of 7 days during the 5/20/16 MDS look back period. Section I, the Active Diagnosis Section, of the 5/20/16 MDS for Resident #13 indicated depression was not an active diagnosis.

The May 2016 Medication Administration Record (MAR) for Resident #13's quarterly MDS indicated Effexor 75mg was administered twice daily for depression on 7 of 7 days during the look back period.

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F 278	Continued From page 7 An interview was conducted with the MDS Nurse on 7/6/16 at 3:15 PM. She stated she was responsible for completion of Section I, the Active Diagnosis Section, on the MDS. The MDS Nurse indicated her interpretation of the coding requirements for Section I was that if a resident was on a medication for a specific diagnosis and they were stable on that medication that she was not to code that diagnosis as an active diagnosis on the MDS. She elaborated on her interpretation and stated that for a resident who was receiving an antidepressant for the diagnosis of depression and their depression was stable, then depression was not to be coded as an active diagnosis on their MDS. The MDS Nurse indicated if a resident was seen by the physician for a specific diagnosis during the look back period then she considered that diagnosis as an active diagnosis.	F 278		