STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING _____ B. WING _____	08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

(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
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey conducted on 8/18/2016. Event #FBJE11.	F 000		
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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		9/4/16

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

Electronically Signed | 09/02/2016

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F 278	Continued From page 1 Based on observation, record review and interviews with staff, the facility failed to accurately code Preadmission Screening and Resident Review(PASRR) (section A1500) on the Minimum Data Set(MDS) for 1 of 1 sampled resident (Resident # 76). Findings included: Resident # 76 was admitted to the facility on 5/8/2016 with diagnoses which included hypertension,hyperlipidemia,anxiety, depression and manic depression. The annual MDS (Minimum Data Set) dated 5/15/2016 indicated the resident's cognition was intact. The MDS did not indicate the resident received PASRR (Preadmission screening and Resident Review) level II services. On 8/17/2016 at 10:00 AM, the MDS nurse was interviewed. She acknowledged that the resident did have a diagnosis of mental illness and it should have been coded on the MDS under section A1500 because the resident was receiving PASRR services. On 8/17//2016 at 10:30 AM, the Social worker was interviewed. She reported that it was her responsibility to notify the MDS coordinator about the residents at the facility receiving PASRR services. She added that she will make sure in the future she notifies the MDS coordinator about the residents at the facility receiving PASRR services. On 8/17/2016 at 2:00 PM, the Director of Nursing (DON) was interviewed. She acknowledged the annual MDS dated 5/15/2016 should have coded the resident as receiving (PASRR) services. She added her expectation was for MDS nurse to accurately code the MDS information.	F 278	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? Correctly code the PASRR on the MDS set for the sampled resident. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 100% audit of all PASRRs for all active residents and modifications made to those incorrectly coded. Completed by 9/4/16. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur 1.MDS to correctly code all current Level II PASRRs. 2.IDT to bring charts of residents who were newly admitted/readmitted to the facility to the morning meeting the next business day after admission/readmission date and review for Level II PASRR criteria effective 9/4/16. 3.Level II PASRR will be kept along with current admitting FL2 in the resident's chart behind the admission record tab and also in notebook located in Social Workers Office. 4.IDT to review MDS coding of A1500	

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F 278	Continued From page 2	F 278	prior to closing of the comprehensive assessments. 5.In-service MDS nurse and MDS coordinator, Admissions Director and Social worker as to placement of the Level II PASRR in the medical chart by 9/4/16. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. A review of the LEVEL II PASRR will be done weekly x 4, then monthly x 3. All findings will be taken to PI committee monthly x 3. Results of the audits will be presented in QAPI by the MDS director.	