STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345566	A. BUILDING _____ B. WING _____	C 09/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

DHSR L & C Black Mountain ORO Received OCT 07 2016 by: SKH

(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 There were no deficiencies cited as a result of the complaint investigation survey. Event ID R1BP11.	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	For the resident affected, on September 29, 2016, the MDS Coordinator requested her most recent Minimal Data Set (MDS) be reopened and the correct box checked indicating the resident had a history of falls in the last 6 months as directed by the Resident Assessment Instrument (RAI). It was closed on the same date and resubmitted. For those residents with the potential of being affected, two audits were conducted by the Director of Nursing (RN) to determine if any other residents were affected. Audit #1 included reviewing all MDS assessments with anyone that had had fallen in the last 6 months at the facility against all readmission assessments. Audit #2 included auditing all previous residents readmitted to ensure the correct box was checked if the person had any falls in the last 2 to 6 months at the facility.	9/29/16 10/5/16

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

ADMINISTRATOR 10/6/16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345566	A. BUILDING _____ B. WING _____	C 09/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

(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 278	Continued From page 1 Based on record review and staff interview, the facility failed to accurately code a quarterly Minimum Data Set (MDS) assessment in the area of falls for 1 of 11 sampled residents (Resident # 43). The findings included: Resident # 43 was admitted to the facility on 02/18/2016 with diagnoses including but not limited to: Peripheral Vascular Disease, History of Falls, Hypertension, Diabetes Mellitus, Vascular Dementia, Failure to Thrive, and Altered Mental Status. Review of a Quarterly MDS assessment dated 08/05/2016 revealed the resident was moderately cognitively impaired. The assessment indicated resident #43 required extensive assistance with one person physical assistance for bed mobility, locomotion, dressing, eating, toileting, and personal hygiene. The resident required extensive assistance with two plus person physical assistance for transferring and walking in room. The assessment also indicated the resident had no falls in the last 2-6 months prior to admission/re-entry. Review of an MDS dated 7/27/16, coded as a discharge assessment - return anticipated, revealed the resident was discharged from the facility on 7/27/16. Review of an MDS dated 7/30/16, coded as an Entry tracking MDS, revealed the resident re-entered the facility on 7/30/16. A review of nursing notes and incident reports revealed that the resident had falls on the following dates: 5/5/16, 5/6/16, 5/30/16, and 6/22/16 indicating that the resident had fallen in the last 2-6 months prior to admission/re-entry. An interview was conducted with MDS coordinator # 1 on 9/28/16 at 10:48 AM. During this interview she stated the Quarterly MDS dated	F 278	On September 29, 2016, the MDS nurses were inserviced by the administrator on the need to check the box (J1700A and J1700B) if their assessment indicates the resident has fallen as per the RAI and the box should be checked to indicate a recent history of falls. All readmission, admission and quarterly assessment will be audited for proper coding by the Director of Nursing daily for two weeks and then prn monthly for three months. Results of the audits will be presented to the Quality Assurance and Performance Improvement (QAPI) committee by Director of Nursing or Administrator for recommendations and changes as indicated and will continue as needed until sustainable compliance is achieved	9/29/16 10/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345566	A. BUILDING _____ B. WING _____	C 09/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

(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 278	Continued From page 2 08/05/16 was coded for no falls in the 2-6 months prior to admission/re-entry. She stated, " I guess I was thinking re-entry started the whole process over again. Let me check the Resident Assessment Instrument (RAI) manual for clarification. " After consulting the RAI manual MDS coordinator # 1 indicated that the MDS assessment should have been coded as yes, that the resident did have falls in the 2-6 months since admission/re-entry. An interview conducted with the Director of Nursing (DON) on 9/28/16 at 10:57 AM revealed she expected the MDS assessments to be coded per the RAI manual. An interview conducted with the Administrator on 09/28/16 at 12:45 PM revealed that he expected the MDS to be coded per the RAI manual.	F 278		