STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. BUILDING _____ B. WING _____	09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB AND HC CTR AT VILLAGE GR	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of 09/29/16. Event ID# LHYT11.	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		10/21/16

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

Electronically Signed | 10/14/2016

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F 278	Continued From page 1 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the medications received during the 7 day look back period for 1 of 5 residents (Resident #84) reviewed for unnecessary medications and failed to accurately code the MDS to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 residents (Resident #28) identified as a Level II PASRR resident. Findings included: 1. Resident #84 was readmitted to the facility on 07/22/16 with diagnoses including depression and Parkinson's disease. Review of the Quarterly MDS dated 09/05/16 indicated Resident #84 received zero antidepressant medications during the seven day look back period. Review of the Medication Administration Records (MAR) revealed Resident #84 received 2 different antidepressant medications during the look back period. One medication was received six times and the other was received seven times. In an interview on 09/29/16 at 10:38 AM the MDS Coordinator stated her assistant gathered the data and she input the information into the MDS. She indicated her assistant missed that Resident #84 was taking two antidepressant medications. The MDS Coordinator stated the assessment was inaccurate and that it was her expectation that inaccuracies would not happen again. In an interview on 09/29/16 at 10:45 AM the Director of Nursing (DON) stated it was his expectation that the MDS be coded accurately. 2. Resident #28 was admitted to the facility on 02/10/16 with a diagnosis history that included Major Depressive Disorder and Bipolar Disorder. Review of the PASRR Level II number for	F 278	F 278: 483.20(g) – (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 1) Actions taken for Residents #84, #28: A. With regards to resident #84, the MDS was immediately corrected to accurately reflect the 2 antidepressant medications received during the look back period. B. With regards to resident #28, the MDS was immediately corrected to accurately reflect this resident as a state Level II PASRR. 2) Actions taken for all residents due to the potential for being affected: A. On/before 10/12/2016, the MDS Coordinator, appropriate designee, audited all MDS back to July 1, 2016 for medication coding and did not find any other miscoded data. The MDS Coordinator also audited all residents currently in the facility with a state Level PASSR II for proper coding in the MDS. All residents were properly coded in the MDS. B. On 10/12/2016 all MDS nursing staff were re-inserviced by MDS Coordinator regarding: (1) The importance of capturing medication coding properly for MDS/Care Planning. (2) Trained on the proper use of the MDS 3.0 Drug Class Index. (3) How to determine the proper drug class for coding purposes. 3) Actions taken to prevent further recurrence: A. MDS Coordinator, or designee, will audit all Initial MDS Assessment Sheets	

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F 278	Continued From page 2 Resident #28 revealed that the resident had a permanent number, dated 10/07/11. Review of Resident #28's two most recent annual MDS, dated 02/23/16 and 03/18/15, indicated the resident was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review were used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for servicing to help develop an individual's plan of care. In an interview on 09/29/16 at 10:37 AM with the MDS Coordinator, she revealed that it was an oversight that the resident was not coded as a Level II PASRR. In an interview on 09/29/16 at 10:45AM with the DON, he revealed that it was his expectation that the MDS Coordinator make sure the PASRR Level II residents were coded accurately.	F 278	2X week for 4 weeks for proper PASSR II and medication coding. B. Checking for proper PASSR II coding and medication coding in the MDS on an on-going basis has been assigned to the MDS Coordinator C. Following Step 3A, MDS Coordinator, designee, will conduct random monthly audits X 2 months, followed by quarterly X 2 quarters, and as needed for compliance with both PASSR II and medication coding in the MDS Any non-compliance will be addressed by the MDS Coordinator, designee, as soon as practical. 4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee: A. MDS Coordinator, designee, will bring results of audits to morning administrative team meeting for review, weekly X 4 weeks. B. Results of all audits will be brought to the facility QAA meeting by the MDS Coordinator, designee, and reviewed by the QAA committee monthly X 2 months, quarterly X 2 quarters, and as needed. C. Any non-compliance with established plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised. D. Discussion, interventions, and/or revisions to established plan will be included in the meeting minutes. E. Any adjustment to the established plan, through revision and/or interventions for non-compliance will require re-inservicing of the applicable staff by the MDS Coordinator, or appropriate	

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F 278	Continued From page 3	F 278	designee. F. Any revision to the established plan will require the monitoring to begin again at Step 4A and continue as outlined.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement ordered nutritional interventions and laboratory studies for 1 of 3 residents (Resident #70) who was reviewed for pressure ulcers. Findings included: Review of Resident #70's Quarterly Minimum Data Set (MDS) dated 07/19/16 revealed an admission date of 03/04/16 and diagnoses of peripheral vascular disease, diabetes, and physical debility. Resident #70 was moderately cognitively impaired. The MDS showed Resident #70 had no pressure ulcers but did have Moisture Associated Skin Damage (MASD). Review of Resident #70's Care Plan dated 07/19/16 revealed a stage 3 pressure ulcer to the sacrum. Interventions included: wound care as ordered by the physician and a weekly evaluation of wound healing.	F 314	F 314: 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 1) Actions taken for Residents #70: A. On 9/29/2016, a Physician's Telephone Order was received to add Prostat 30ml by mouth twice each day to aid in wound healing. An audit of the pre-albumin level will be conducted by the TX nurse or designee every 2 weeks until the order is discontinued or until there is an upward trend of 3 data points. 2) Actions taken for all residents due to the potential for being affected: A. On/before 10/20/2016, the DON or appropriate designee, will review medical records for all residents with wounds to check for pre-albumin orders and compliance with standing orders.	10/21/16

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F 314	Continued From page 4 Review of the Wound Assessment Report dated 08/19/16 revealed Resident #70 had a stage 3 pressure ulcer to the sacrum measuring 3.8 x 2.8 x 0.20 cm (centimeters). Review of the Physician's Telephone Orders dated 08/30/16 revealed an order to check Resident #70's pre-albumin level (a test used to monitor nutritional status.) If the pre-albumin was <20 (less than 20), 30 mls (milliliters) of prostat (a protein supplement) was to be given twice each day. Resident #70's pre-albumin level was to be checked every two weeks until there was a continuous upward move of three data points. Review of the laboratory results dated 08/31/16 showed a pre-albumin level of 13.0 mg/dL (milligrams per deciliter). Review of the daily Laboratory Book showed no orders for pre-albumin laboratory draws for Resident #70 in September 2016. Review of the Physician's Telephone Orders dated 09/29/16 revealed a repeat order to add prostat 30ml by mouth twice each day to aid in wound healing. Review of the September 2016 Medication Administration Record (MAR) revealed no order for prostat 30ml twice each day until 09/29/16. In an interview on 09/29/16 at 2:40 PM the Director of Nursing (DON) confirmed that no pre-albumin laboratory levels were completed for Resident #70 in September 2016. In an interview on 09/29/16 at 3:35 PM the Medical Records clerk stated when a telephone order was taken, the process was for the nurse to enter it in the computer. The 11-7 nurse was required to do a 24 hour chart check to make sure all the orders were either entered or discontinued as ordered. She indicated that one copy of the telephone order was placed in the physician's box and one copy went to medical	F 314	B. On/before 10/20/2016, a log of all residents with wounds and a pre-albumin order will be created and used as a tool for the DON or designee to audit bi-weekly pre-albumin labs. This tool will also be used to assure that new prostat orders are implemented as per standing orders. C. On/before 10/21/2016 all licensed nursing staff will be in-serviced by SDC regarding: (1) Activating standing orders as necessary. (2) Wound protocol. (3) How to handle an order containing labs. (4) Any nursing personnel not in attendance will be contacted by the DON, or appropriate designee, and given the information prior to the employee's next scheduled shift. 3) Actions taken to prevent further recurrence: A. DON, or designee, will audit pre-albumin log 2X week for 4 weeks to ensure labs are being drawn as ordered and for activation of appropriate standing orders. B. Checking new daily physicians' orders on a routine, on-going basis has been assigned to the Clinical Care Coordinator or appropriate designee. C. Following Step 3A, DON, designee, will conduct random monthly audits X 2 months, followed by quarterly X 2 quarters, and as needed for compliance with above stated plan for the pre-albumin log audits and for activation of appropriate physician orders. Any non-compliance	

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F 314	Continued From page 5 records and she passed the copy on to the DON to be discussed in the morning clinical meeting. In an interview on 09/29/16 at 3:45 PM the DON stated the order had just been missed. He indicated the order was a physician's standing order that had been initiated by the Treatment Nurse. The DON stated he expected the Treatment Nurse to follow-up on any orders she initiated to make sure they were carried out. He indicated he expected the 11-7 nurses to do the 24 hour chart checks to make sure no orders were missed. He stated the order fell through the cracks. In an interview on 09/29/16 at 4:55 PM the Treatment Nurse indicated she had initiated the order for prostat and laboratory studies for Resident #70 but had not followed up to make sure the order was carried out. In a telephone interview on 09/29/16 at 5:00 PM Nurse #1, who signed off the 24 hour check the day the order was written, stated she did not remember the order and could not say whether or not she had seen the order.	F 314	will be addressed by the DON, designee, as soon as practical. 4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee: A. DON, designee, will bring results of pre-albumin log audits to morning administrative team meeting for review, weekly X 4 weeks. B. Results of pre-albumin log audits as stated in 3A and 3C will be brought to the facility QAA meeting by the DON, designee, and reviewed by the QAA committee monthly X 2 months, quarterly X 2 quarters, and as needed. C. Any non-compliance with established plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised. D. Discussion, interventions, and/or revisions to established plan will be included in the meeting minutes. E. Any adjustment to the established plan, through revision and/or interventions for non-compliance will require re-inservicing of the applicable staff by the DON, or appropriate designee. F. Any revision to the established plan will require the monitoring to begin again at Step 4A and continue as outlined.	