STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

(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 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		10/6/16

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

Electronically Signed | 09/30/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to completely assess residents on the comprehensive assessment in the areas of mental status, mood, and pain for 2 of 13 sampled residents (Residents #45 and #83). The findings included: 1. Resident #45 was initially admitted to the facility on 3/17/16 and readmitted on 5/30/16 with multiple diagnoses including a fracture of the upper end of left humerus, anxiety disorder, and dementia. A nursing progress note dated 5/31/16 indicated Resident #45 was alert and verbal with confusion noted at times. Nursing progress notes dated 6/1/16, 6/2/16, and 6/3/16 indicated Resident #45 was alert and oriented times three (person, place, and time). Nursing progress notes dated 6/3/16 and 6/4/16 indicated Resident #45 was alert and verbal with confusion noted at times. Nursing progress notes dated 6/5/16 and 6/6/16 indicated Resident #45 was alert with some confusion and was able to make her needs known. 1a. The admission Minimum Data Set (MDS) assessment dated 6/6/16 indicated Resident #45 had clear speech, she was usually understood and she sometimes understood others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #45.	F 272	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility'□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident(s) Affected On 9/26/16, Resident # 45, and #83 Minimum Data Set (MDS) assessments were reviewed by the MDS Regional Consultant. Resident #45□s MDS assessment was updated. Resident #83□s medical record had been closed due to discharge; therefore, no changes made. All identified issues were corrected and completed by 09/30/16. Corrective Action for Residents Potentially Affected All residents have the potential to be affected by this practice. On 9/26/16, the Regional MDS Consultant and Regional Registered Nurse (RN) Nurse Consultant began auditing the most current comprehensive MDS assessments. 10% of the most current comprehensive MDS assessments were audited. They were all found to be out of compliance. To ensure that resident interviews are attempted,	

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F 272	Continued From page 2 Question C0100 was coded to indicate Resident #45 was rarely/never understood and the brief interview for mental status (questions C0200 through C0500) was not conducted. An interview was conducted on 9/7/16 at 4:55 PM with the MDS Nurse and MDS Consultant. Section C of the admission MDS dated 6/6/16 for Resident #45 was reviewed with the MDS Nurse and MDS Consultant. Resident #45's medical record documentation for the review period of the 6/6/16 MDS was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated the previous social worker who no longer worked at the facility had completed this section of the 6/6/16 MDS for Resident #45. The MDS Nurse stated she was responsible for reviewing the MDS assessments for completeness and accuracy. She revealed the medical record documentation contradicted the coding of Question C0100 that indicated Resident #45 was rarely/never understood. She stated the brief interview for mental status should have been attempted with Resident #45. An interview was conducted with the Director of Nursing (DON) on 9/8/16 at 9:40 AM. She indicated her expectation was for residents to be comprehensively assessed in all areas of the MDS. A follow up interview was conducted with the MDS Nurse and MDS Consultant on 9/8/16 at 11:53 AM. The MDS Consultant indicated that the brief interview for mental status was required to be attempted even if a resident had some confusion. 1b. The admission MDS assessment dated	F 272	conducted and keyed into the current MDS assessments on the Assessment Reference Date(ARD) or the day before the ARD, the Director of Nursing (DON) and/or the Licensed Practical Nurse (LPN) MDS Support Nurse will review the current MDS ARDs with the Interdisciplinary Team (IDT) during morning meeting, Monday through Friday, in order to ensure that the interviews are completed timely. On 9/26/16 the Regional MDS Consultant conducted a direct re-education with the IDT team that included Social Services Director, Nurse Supervisors and Unit Managers, DON and Activities Director who are responsible for conducting resident interviews for mental status, mood, pain and Customary Routine. Re-education emphasized that all interviews must be attempted unless the resident has a comatose health condition; they are never / rarely understood; or they do not communicate in English and there is no available interpreter. The only other interview exception are the Customary Routine as these can be conducted with resident□s spouse or family member if the resident is not able. On 09-26-16, the Regional MDS Consultant conducted a direct re-education with the Social Services Director to ensure that she is conducting the interviews per Resident Assessment Instrument (RAI) requirements and guidelines. Systemic Changes On 09/09/16, the MDS Coordinator	

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F 272	Continued From page 3 6/6/16 indicated Resident #45 had clear speech, she was usually understood and she sometimes understood others. Section D, the Mood section, was not comprehensively assessed for Resident #45. Questions D0100 was coded to indicate Resident #45 was rarely/never understood and the resident mood interview (questions D0200 through D0300) was not conducted. An interview was conducted on 9/7/16 at 4:55 PM with the MDS Nurse and MDS Consultant. Section D of the admission MDS dated 6/6/16 for Resident #45 was reviewed with the MDS Nurse and MDS Consultant. Resident #45's medical record documentation for the review period of the 6/6/16 MDS was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated the previous social worker who no longer worked at the facility had completed this section of the 6/6/16 MDS for Resident #45. The MDS Nurse stated she was responsible for reviewing the MDS assessments for completeness and accuracy. She revealed the medical record documentation contradicted the coding of Question D0100 that indicated Resident #45 was rarely/never understood. She stated the resident mood interview for should have been attempted with Resident #45. An interview was conducted with the DON on 9/8/16 at 9:40 AM. She indicated her expectation was for residents to be comprehensively assessed in all areas of the MDS. A follow up interview was conducted with the MDS Nurse and MDS Consultant on 9/8/16 at 11:53 AM. The MDS Consultant indicated that the resident mood interview was required to be attempted even if a resident had some confusion.	F 272	resigned her position. Facility is currently recruiting for an MDS Coordinator. In the interim, The LPN MDS support nurse will assist, as appropriate, the MDS process to support the Regional MDS Consultant so as to complete the facility MDS Assessments accurately and timely; further ensuring that resident□s care plans are accurate and that proper interventions are identified and implemented to the care plans timely. Once a new MDS RN Coordinator is identified and hired, the Regional MDS Consultant will train new Coordinator on accurately and comprehensively assessing residents in a face-to-face interview, conduct direct observation and a thorough review of the medical record during any MDS assessment or look-back period so that accurate MDS coding is maintained at all times. Direct focus will include: Section C Mental Status (BIMS Interview): Social Services Director will ensure that all BIMS interviews are attempted and questions (C0100 to C0500) are accurately completed and coded based upon a face-to-face interview with the resident. The only times when the interview cannot be conducted for residents that are comatose, never / rarely understood; or they do not talk, understand or communicate in English. Any contradictions noted in nursing documentation will be immediately resolved by the MDS Coordinator and the DON to ensure accurate coding of section	

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F 272	Continued From page 4 1c. The admission MDS assessment dated 6/6/16 indicated Resident #45 had clear speech, she was usually understood and she sometimes understood others. Section J, the Health Conditions section, was not comprehensively assessed for Resident #45. Question J0200 was coded to indicate Resident #45 was rarely/never understood and the resident pain assessment interview (questions J0300 through J0600) was not conducted. An interview was conducted on 9/7/16 at 4:55 PM with the MDS Nurse and MDS Consultant. Section J of the admission MDS dated 6/6/16 for Resident #45 was reviewed with the MDS Nurse and MDS Consultant. Resident #45's medical record documentation for the review period of the 6/6/16 MDS was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated she completed Section J of the 6/6/16 MDS for Resident #45. She revealed the medical record documentation contradicted the coding of Question J0200 that indicated Resident #45 was rarely/never understood. She stated that she was unable to recall if she had attempted to complete the resident pain assessment interview with Resident #45. She indicated that according to the medical record documentation the resident pain assessment interview should have been attempted with Resident #45. An interview was conducted with the DON on 9/8/16 at 9:40 AM. She indicated her expectation was for residents to be comprehensively assessed in all areas of the MDS. A follow up interview was conducted with theMDS Nurse and MDS Consultant on 9/8/16 at 11:53	F 272	C at all times. Section D Mood: Social Services Director will ensure that all Mood Interview are attempted and questions (D0100 to D0500) are accurately completed and coded based upon a face-to-face interview with the resident. The only times when the interview cannot be conducted for residents that are comatose, never / rarely understood; or they do not talk, understand or communicate in English. Any contradictions noted in nursing documentation will be immediately resolved by the MDS Coordinator and the DON to ensure accurate coding of section D at all times. Section J Health Condition: MDS Coordinator will ensure that all questions (J0200 to J0600) are accurately completed and coded based upon a face-to-face interview with the resident. The only times when the interview cannot be conducted for residents that are comatose, never / rarely understood; or they do not talk, understand or communicate in English. Direct observation and a thorough review of the medical record will be completed. Any contradictions noted in nursing documentation will be immediately resolved by the MDS Coordinator and the DON to ensure accurate coding of section J at all times. This information has been integrated into the standard orientation training for MDS Coordinator and in the required in-service	

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F 272	Continued From page 5 AM. The MDS Consultant indicated that the resident pain assessment interview was required to be attempted even if a resident had some confusion. 2. Resident #83 was admitted to the facility on 5/16/16 with multiple diagnoses including a fracture of the right hip, anxiety disorder, and dementia. Nursing notes dated 5/17/16 and 5/20/16 indicated Resident #83 was alert, oriented to self, had some confusion, and was able to make some needs known to staff. A physician progress note dated 5/20/16 indicated Resident #83 had moderately impaired cognition. Nursing notes dated 5/21/16 and 5/22/16 indicated Resident #83 was alert and oriented to self. 2a. The admission Minimum Data Set (MDS) assessment dated 5/23/16 indicated Resident #83 had clear speech, he was usually understood and he usually understood others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #83. Question C0100 was coded to indicate Resident #83 was rarely/never understood and the brief interview for mental status (questions C0200 through C0500) was not conducted. An interview was conducted with the Director of Nursing (DON) on 9/8/16 at 9:40 AM. She indicated her expectation was for residents to be comprehensively assessed in all areas of the MDS.	F 272	refresher courses for all employees involved in this process will be re-educated by the Quality Assurance (QA) Team to verify that the change has been implemented. Quality Assurance The Regional MDS Consultant, the DON or the Executive Director will audit three resident MDS assessments for accuracy of section C, D and J per week and compliance documented on corresponding QA tools (Pain Interview, Mood Interview, BIMS Interview). This will be done weekly for one month starting 9/23/16 then monthly for two months or until resolved by Quality Assurance Committee. Reports will be presented to the Executive Director or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, Health Information Manager (HIM), Dietary Manager and the Executive Director.	

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F 272	Continued From page 6	F 272		

An interview was conducted on 9/8/16 at 11:53 AM with the MDS Nurse and MDS Consultant. Section C of the admission MDS dated 5/23/16 for Resident #83 was reviewed with the MDS Nurse and MDS Consultant. Resident #83's medical record documentation for the review period of the 5/23/16 MDS was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated the previous social worker who no longer worked at the facility had completed this section of the 5/23/16 MDS for Resident #83. The MDS Nurse stated she was responsible for reviewing the MDS assessments for completeness and accuracy. She revealed the medical record documentation contradicted the coding of Question C0100 that indicated Resident #83 was rarely/never understood. She stated the brief interview for mental status should have been attempted with Resident #83. The MDS Consultant indicated that the brief interview for mental status was required to be attempted even if a resident had some confusion.

2b. The admission MDS assessment dated 5/23/16 indicated Resident #83 had clear speech, he was usually understood and he usually understood others. Section D, the Mood section, was not comprehensively assessed for Resident #45. Questions D0100 was coded to indicate Resident #45 was rarely/never understood and the resident mood interview (questions D0200 through D0300) was not conducted.

An interview was conducted with the DON on 9/8/16 at 9:40 AM. She indicated her expectation was for residents to be comprehensively assessed in all areas of the MDS.

An interview was conducted on 9/8/16 at 11:53

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F 272	Continued From page 7	F 272		

AM with the MDS Nurse and MDS Consultant. Section D of the admission MDS dated 5/23/16 for Resident #83 was reviewed with the MDS Nurse and MDS Consultant. Resident #83's medical record documentation for the review period of the 5/23/16 MDS was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated the previous social worker who no longer worked at the facility had completed this section of the 5/23/16 MDS for Resident #83. The MDS Nurse stated she was responsible for reviewing the MDS assessments for completeness and accuracy. She revealed the medical record documentation contradicted the coding of Question D0100 that indicated Resident #83 was rarely/never understood. She stated the resident mood interview for should have been attempted with Resident #83. The MDS Consultant indicated that the resident mood interview was required to be attempted even if a resident had some confusion.

2c. The admission MDS assessment dated 5/23/16 indicated Resident #83 had clear speech, he was usually understood and he usually understood others. Section J, the Health Conditions section, was not comprehensively assessed for Resident #45. Question J0200 was coded to indicate Resident #45 was rarely/never understood and the resident pain assessment interview (questions J0300 through J0600) was not conducted.

An interview was conducted with the DON on 9/8/16 at 9:40 AM. She indicated her expectation was for residents to be comprehensively assessed in all areas of the MDS.

An interview was conducted on 9/8/16 at 11:53

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F 272	Continued From page 8 AM with the MDS Nurse and MDS Consultant. Section J of the admission MDS dated 5/23/16 for Resident #83 was reviewed with the MDS Nurse and MDS Consultant. Resident #83's medical record documentation for the review period of the 5/23/16 MDS was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated she completed Section J of the 5/23/16 MDS for Resident #83. She revealed the medical record documentation contradicted the coding of Question J0200 that indicated Resident #83 was rarely/never understood. She stated that she was unable to recall if she had attempted to complete the resident pain assessment interview with Resident #45. She indicated that according to the medical record documentation the resident pain assessment interview should have been attempted with Resident #83. The MDS Consultant indicated that the resident pain assessment interview was required to be attempted even if a resident had some confusion.	F 272		
F 278 SS=E	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.	F 278		10/6/16

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F 278	Continued From page 9 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: Based on medical record review, resident interview, and staff interview the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of life expectancy (Resident #45), behaviors (Resident #45), falls (Resident #45), pressure ulcers (Resident #94), medications (Residents #62, #34, and #12), range of motion (Residents #58 and #77), and diagnoses (Resident #12 and #18) for 8 of 13 sampled residents. The findings included: 1a. Resident #45 was initially admitted to the facility on 3/17/16 and readmitted on 5/30/16 with multiple diagnoses including heart failure. A physician order dated 7/15/16 indicated Resident #45 was admitted to hospice. The significant change Minimum Data Set (MDS) dated 7/22/16 indicated Resident #45 was on hospice. Section J, the Health Conditions section, had not indicated Resident #45 had a life	F 278	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident(s) Affected On 9/26/16, Resident #45, #94, #62, #34, #12, #58, #77 and #18 MDS assessments were reviewed by the MDS consultant. All identified issues were recorded correctly on the MDS Assessments via modifications and were completed on 09/28/16. For Resident #45, a Significant Correction to Prior Comprehensive	

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F 278	Continued From page 10 expectancy of six months or less (Question J1400). An interview was conducted on 9/7/16 at 4:55 PM with the MDS Nurse and MDS Consultant. Section J of the significant change MDS dated 7/22/16 for Resident #45 was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated she completed this section of the 7/22/16 MDS for Resident #45. She revealed she had coded question J1400 incorrectly. She indicated she was going to complete a modification that indicated Resident #45 had a life expectancy of six months or less. An interview was conducted with the Director of Nursing on 9/8/16 at 9:40 AM. She indicated her expectation was for the MDS to be completed accurately. 1b. Resident #45 was initially admitted to the facility on 3/17/16 and readmitted on 5/30/16 with multiple diagnoses including dementia and anxiety. A nursing progress note dated 7/16/16 indicated Resident #45 was agitated, non-compliant, and was trying to bite the nurse. The significant change MDS dated 7/22/16 indicated Resident #45 had no behaviors during the seven day look back period (7/16/16 through 7/22/16). An interview was conducted on 9/7/16 at 4:55 PM with the MDS Nurse and MDS Consultant. The behavior section of the 7/22/16 significant change MDS for Resident #45 was reviewed with the MDS Nurse and MDS Consultant. The medical	F 278	Assessment was opened for the IDT team to re-assesse and code correctly areas that had not been assessed or mis-coded. These areas included; the mental status (BIMS), Mood, Pain interviews, the behaviors that had been missed, appropriate coding of life expectancy prognosis and falls. Corrective Action for Resident(s) Potentially Affected All residents have the potential to be affected by this practice. On 09/27/16, the most current MDS of current residents were re-assessed by the Regional MDS consultant and the RN Nurse consultant for coding accuracy of life expectancy, behaviors, falls, pressure ulcers, medications, range of motion, and active diagnoses. Eight Comprehensive Assessments were audited and three were identified as non-compliant and were corrected/modified by 10/05/16. The DON and Nursing supervisors completed a full audit of all residents who have had a fall in the last 6 months. They ensured that any intervention that the team had initiated for each fall was accurately reflected on the residents□ care plan. On 9/26/16 the Regional MDS Consultant conducted a direct re-education with the Interdisciplinary Team (IDT) team that included Social Services Director, Nurse Supervisors and Unit Managers, Director of Nursing (DON) and Activities Director who are responsible for conducting resident interviews for mental status, mood, pain and Customary Routine.	

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F 278	Continued From page 11 record documentation for the look back period of the 7/22/16 MDS for Resident #45 was reviewed with the MDS Nurse and MDS Consultant. The MDS Nurse indicated she completed this section of the 7/22/16 MDS for Resident #45. She revealed she had coded the MDS incorrectly. She stated she must have missed the 7/16/16 nursing note when she completed the 7/22/16 MDS for Resident #45. An interview was conducted with the Director of Nursing on 9/8/16 at 9:40 AM. She indicated her expectation was for the MDS to be completed accurately. 1c. Resident #45 was initially admitted to the facility on 3/17/16 and readmitted on 5/30/16 with multiple diagnoses including a fracture of the upper end of left humerus and a history of falling. A review of Resident #45's medical record from 6/7/16 through 7/22/16 revealed four falls since the admission MDS dated 6/6/16. These four falls included two with minor injuries (7/1/16 and 7/15/16) and two without injury (7/10/16 and 7/16/16). The significant change MDS dated 7/22/16 indicated Resident #45 had zero falls with no injury, two or more falls with minor injury, and two or more falls with major injury. An interview was conducted on 9/7/16 at 4:55 PM with the MDS Nurse and MDS Consultant. The 7/22/16 significant change MDS for Resident #45 was reviewed with the MDS Nurse and MDS Consultant. The medical record documentation of falls from 6/7/17 through 7/22/16 for Resident #45 was reviewed with the MDS Nurse and MDS	F 278	Re-education emphasized that all interviews must be attempted unless the resident has a comatose health condition; they are never / rarely understood; or they do not communicate in English and there is no available interpreter. The only other interview exception are the Customary Routine as these can be conducted with resident□s spouse or family member if the resident is not able. On 09-26-16, the Regional MDS Consultant conducted a direct re-education with the Social Services Director to ensure that she is conducting the interviews per RAI requirements and guidelines. Systemic Changes On 09/09/16, the MDS Coordinator resigned her position. Facility is currently recruiting for an MDS Coordinator. In the interim, The LPN MDS support nurse will assist, as appropriate, the MDS process to support the Regional MDS Consultant so as to complete the facility MDS Assessments accurately and timely; further ensuring that resident□s care plans are accurate and that proper interventions are identified and implemented to the care plans timely. Once a new MDS RN Coordinator is identified and hired, the Regional MDS Consultant will train new Coordinator on accurately and comprehensively assessing residents in a face-to-face interview, conduct direct observation and a thorough review of the medical record during any MDS assessment or look-back period so that accurate MDS coding is	

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F 278	Continued From page 12 Consultant. The MDS Nurse indicated she completed this section of the 7/22/16 MDS for Resident #45. She revealed she had coded the MDS incorrectly. She indicated Resident #45's 7/22/16 MDS should have indicated she had zero falls with major injury, two or more falls with minor injury, and two or more falls with no injury. An interview was conducted with the Director of Nursing on 9/8/16 at 9:40 AM. She indicated her expectation was for the MDS to be completed accurately. 2. Resident # 94 was admitted to the facility on 7/22/16 with multiple diagnoses including cellulitis left upper limb. The admission Minimum Data Set (MDS) assessment dated 7/29/16 indicated that Resident #94 had 5 unstageable pressure ulcers that were present on admission. The hospital discharge summary dated 7/22/16 was reviewed. The discharge summary indicated that Resident #94 had a fall at home and sustained lacerations to her left elbow, bilateral knees and right foot. The weekly wound assessment dated 7/22/16 indicated that Resident #94 had no pressure ulcer. The assessment indicated that the resident had an abscess on her left elbow. On 9/6/16 at 4:47 PM, Resident #94 was interviewed. She stated that when she fell at home she sustained skin tears on her elbow, knees and legs. On 9/7/16 at 9:05 AM, Nurse #1 was interviewed. She stated that Resident #94 has wounds on her	F 278	maintained at all times. MDS Coordinator will ensure that questions relating to a resident□s life expectancy, behaviors, falls, pressure ulcers, range of motion (or lack thereof), cognition, dementia, pain measurement and management, medication use (antipsychotic, diuretic, antibiotic, hypertension, anemia, etc.,) and days of administration of the medications accurately counted and coded based upon a face-to-face interview, direct observation and/or a thorough review of the medical record. If necessary, the resident Care Plan will be accurately updated within 24 hours of change in a noted health condition by the MDS Coordinator. The care plans should be updated daily and on as needed basis whenever a new intervention for any issue is added for the resident. This information has been integrated into the standard orientation training for the MDS Coordinator and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Regional MDS Consultant will audit three resident MDS for accuracy in behaviors, falls, pressure ulcers, medications, range of motion, and diagnosis and compliance documented on the MDS Coding Accuracy QA Tool. This	

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F 278	Continued From page 13 elbow, knees and legs but were not pressure ulcers. The resident sustained the wounds from her fall at home. On 9/8/16 at 8:50 AM, the MDS Nurse was interviewed. The MDS Nurse indicated that the wound assessment indicated that the wounds on the resident's elbow, left and right knee and ankle were deep tissue injury and she interpreted that as pressure ulcer. On 9/8/16 at 11:50 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate. 3. Resident # 77 was admitted to the facility on 3/8/16 with multiple diagnoses including chronic lymphocytic leukemia. The admission MDS assessment dated 3/15/16 indicated that Resident #77 had no limitation in range of motion. The 14 day MDS assessment dated 3/22/16 indicated that Resident #77 had limitation in range of motion on both sides of the lower extremities. The Physical Therapy (PT) notes from 3/15-3/22/16 were reviewed. The notes indicated that PT was working with the resident on ambulation. The notes did not indicate that the resident had limitation in range of motion (ROM) on both lower extremities. On 9/8/16 at 8:30 AM, the MDS Nurse was interviewed. The MDS Nurse stated that the resident had no limitation in ROM on both lower extremities and she coded the MDS assessment wrong. On 9/8/16 at 11:50 AM, the Director of Nursing	F 278	will be done weekly until the new MDS Coordinator has 1 month of 100 % compliance on the audit or until resolved by Quality Assurance Committee. Reports will be presented to the Executive Director or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Executive Director.	

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(DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate.

4. Resident #62 was admitted to the facility 8/11/16. Cumulative diagnoses included: Depression, Sexually inappropriate conduct disorder and Dementia without behavioral disturbance.

An Admission Minimum Data Set (MDS) dated 8/20/16 indicated Resident #62 had short term and long term memory impairment and was severely impaired in cognition. Medications administered during the 7 day assessment look back period was documented as follows: 7 antidepressant and 7 anticoagulant. Antipsychotic medication was documented as "0" .

Physician admission orders dated 8/11/16 was reviewed and an order was noted for Seroquel (antipsychotic medication) 12.5 milligrams by mouth daily.

A review of the Medication Administration Record (MAR) for the look-back period from 8/14/16--8/20/16 revealed Resident #62 received Seroquel 12.5 milligrams on 8/14/16. Seroquel was not coded on the MDS.

On 9/8/16 at 7:48AM, an interview was conducted with the MDS Nurse. She stated she made a copy of the MAR for Resident #62 and reviewed the medications administered during the 7 day look back period and coded the MAR from that information. The MDS Nurse reviewed Resident #62's MAR and stated she should have coded a "1" for the antipsychotic medication. She must have overlooked it.

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On 9/08/2016 at 11:49AM, an interview was conducted with the Director of Nursing. She stated she expected the MDS to be accurate.

5. Resident #58 was admitted to the facility 6/13/16. Cumulative diagnoses included: Dementia, Lumbar spine stenosis with back pain and sciatica (compression of nerves in the lower back and with pain radiating down the leg) and remote history of cerebrovascular accident (CVA).

An Admission Minimum Data Set (MDS) dated 6/20/16 indicated Resident #58 was moderately impaired in cognition. No impairment in functional limitation in range of motion was indicated for the upper or lower extremities.

A 14 day MDS dated 6/27/16 indicated Resident #58 was cognitively intact. Limitation in range of motion was noted for both lower extremities.

On 9/8/16 at 7:48AM, an interview was conducted with the MDS Nurse. She stated she looked at two areas when she was coding range of motion. If a resident had trouble walking, she would code the resident as having limitation in range of motion. Also, a diagnosis such as stroke would be a factor in coding functional limitation in range of motion.

On 9/08/2016 at 8:15 AM, an interview was conducted with the Rehabilitation director. She stated she was familiar with Resident #58 and had worked with her during her stay at the facility. She stated Resident #58 had no functional limitation in her range of motion of all extremities. She said Resident #58 had a lot of back pain issues and that was one of the limiting factors in

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her progress in therapy but had improved prior to her discharge to the hospital.

On 9/08/2016 8:36:03 AM, the MDS Nurse was re- interviewed. She stated she had been looking at the question regarding functional range of motion wrong and thought if they had difficulty walking, it would be coded as limitation. She stated she coded the section incorrectly.

On 9/08/2016 at 11:49AM, an interview was conducted with the Director of Nursing. She stated she expected the MDS to be accurate.

6. Resident #34 was admitted to the facility 11/18/13. Cumulative diagnoses included: Dementia and Hypertension.

An Annual MDS dated 4/8/16 indicated Resident #34 was cognitively intact. Medications administered during the 7 day assessment look back period was documented as follows: 7 antidepressant and 7 diuretic.

Physician orders were reviewed and revealed an order for HCTZ (hydrochloriazide--a diuretic) 12.5 milligrams by mouth QOD (every other day).

A review of the Medication Administration Record (MAR) for the look back period of 4/2/16 through 4/8/16 revealed HCTZ was administered on 4/2/16, 4/4/16, 4/6/16, and 4/8/16 (4 days).

On 09/08/2016 at 9:00AM, an interview was conducted with the MDS Nurse who stated she reviewed Resident #34's MAR when she coded the MDS for medications. She reviewed the MAR and stated Resident #34 received diuretic medication 4 days and she coded diuretics

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wrong. She stated it must have been an oversight.

On 9/08/2016 at 11:49AM, an interview was conducted with the Director of Nursing. She stated she expected the MDS to be accurate.

7a. Resident #12 was admitted 11/10/15 and last readmitted 5/31/16 and had multiple diagnoses including hypertension and history of Urinary Tract Infection (UTI).

The 8/26/16 Quarterly Minimum Data Set (MDS) was reviewed and revealed antibiotic use was coded as occurring for 3 of the 7 days during the look back period (8/20/16 - 8/26/16).

The Medication Administration Record (MAR) and Physician Orders for 8/20/16 - 8/26/16 were reviewed and revealed Resident #12 received Keflex (an antibiotic) for cellulitis for 3 of 7 days during the look back period and Nitrofurantoin (an antibiotic) for UTI prophylaxis for 7 of 7 days during the look back period.

On 9/8/16 at 9:28 AM the MDS Nurse was interviewed. She stated she was aware that Resident #12 had orders for and was taking Nitrofurantoin on an ongoing basis and that she had it for 7 of 7 days during the look back period. She acknowledged that the MDS was incorrectly coded and should have indicated 7 of 7 days as opposed to 3 of 7 days.

On 9/8/16 at 11:15 AM the Director of Nursing was interviewed. She acknowledged that the MDS had been incorrectly coded for antibiotic medication use and that her expectation was that the MDS would be accurate.

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7b. Resident #12 was admitted 11/10/15 and last readmitted 5/31/16 and had multiple diagnoses including hypertension and history of Urinary Tract Infection (UTI).

The 8/26/16 Quarterly Minimum Data Set (MDS) was reviewed for active diagnoses and revealed hypertension was not listed as an active diagnoses for Resident #12.

The Medication Administration Record (MAR) and Physician Orders for 8/20/16 - 8/26/16 were reviewed and revealed Resident #12 received coreg for hypertension during this look back period.

On 9/8/16 at 9:28 AM the MDS Nurse was interviewed. She indicated that since Resident #12 was prescribed and received a medication for hypertension during the look back period and that hypertension should therefore have been listed as one of the resident ' s active diagnoses on the 8/26/16 MDS.

On 9/8/16 at 11:15 AM the Director of Nursing was interviewed. She acknowledged that the MDS had been incorrectly coded for active diagnoses, as hypertension should have been included, and that her expectation was that the MDS would be accurate.

8. Resident #18 was admitted 3/25/16 and had multiple diagnoses including anemia.

The 6/23/16 Quarterly Minimum Data Set (MDS) was reviewed for active diagnoses and revealed anemia was not listed as an active diagnoses for Resident #18.

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F 278	Continued From page 19 The Medication Administration Record (MAR) and Physician orders for 6/17/16 - 6/23/16 were reviewed and revealed Resident #18 received ferrous sulphate for anemia during this look back period. On 9/18/16 at 9:28 AM the MDS Nurse was interviewed. She acknowledged that Resident #18 was prescribed and received a medication for anemia during the look back period and that anemia should therefore have been listed as one of Resident #18 ' s active diagnoses on the 6/23/6 MDS. On 9/8/16 at 11:15 AM the Director of Nursing was interviewed. She acknowledged that the MDS had been inaccurately coded, as anemia should have been included, and that her expectation was that the MDS would be accurate.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		10/6/16

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F 280	Continued From page 20 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to revise care plans after falls for 2 of 3 residents (Residents #45 and #83) reviewed for falls. The findings included: 1. Resident #45 was initially admitted to the facility on 3/17/16 and readmitted on 5/30/16 with multiple diagnoses including a fracture of the upper end of left humerus, hip fracture, anxiety disorder, and dementia. The Risk Assessment dated 5/30/16 indicated Resident #45 had a fall within the last month and a fall within the last 2 to 6 months. Resident #45 was indicated to be chairfast (ability to walk was severely limited or non-existent), mobility was very limited (made occasional slight changes in body or extremity position, but unable to make frequent or significant changes independently), unable to independently stand, and exhibited a loss of balance while standing. The plan of care for Resident #45, with an initiated date of 5/30/16, included the focus area of an actual fall with risk for further falls. The risk factors indicated were an unsteady gait, psychoactive drug use, history of falls, pain, poor safety awareness, and a history of anemia. The interventions initiated on 5/30/16 included: - Encourage me to call for assistance prior to	F 280	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□'s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident(s) Affected On 9/26/16, Resident #45, and #83 MDS assessments and Care Plans were reviewed by the MDS consultant. Resident #45□s Care Plan was updated to include new interventions. Resident #83□s medical record had been closed due to discharge; therefore, no changes made. All identified issues were corrected and completed by 09/30/16. Corrective Action for Resident(s) Potentially Affected All residents have the potential to be affected by this practice. On 09/26/16 and 09/27/16, 100% of current residents were re-assessed by the DON, RN Clinical	

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F 280	Continued From page 21 transfers. - Encourage me to wear non slip socks when not wearing shoes. - Have [Physical Therapy] evaluate me as needed. - Keep frequently used objects in my reach. - Keep my call light in my reach. - Make sure that I have non-slip shoes that fit appropriately. - Observe me for possible side effects from medications that may affect my gait and balance and report to nurse if I have change in my gait or balance. - Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bedbound. - [Physical Therapy consultation] for strength and mobility. - Reinforce safety reminders frequently. The admission Minimum Data Set (MDS) assessment dated 6/6/16 indicated Resident #45 had significant cognitive impairment and required extensive assistance with all activities of daily living. She was indicated to have had a fall within the last month prior to admission as well as a fall within the last 2 to 6 months prior to admission. The Care Area Assessment (CAA) for the 6/6/16 MDS indicated Resident #45 remained at risk for falls due to her confusion and restlessness. She was indicated to be dependent on staff for mobility and transfers. Resident #45 demonstrated no safety awareness and needed frequent observations by staff. She was indicated to attempt to get out of bed without assistance, she had difficulty maintaining sitting balance, and had impaired balance during transfers. Resident #45 was on antidepressant medications,	F 280	Supervisor, and RN Supervisor for Care Plan accuracy and to ensure that proper interventions were identified and appropriately documented on said Care Plans. Sixty three Care Plans were audited; 28 were found out of compliance were modified by 10/04/16. On 9/26/16 the Regional MDS Consultant conducted a direct re-education with the Interdisciplinary Team (IDT) team that included Social Services Director, Nurse Supervisors and Unit Managers, Director of Nursing (DON) and Activities Director who would be responsible for updating the resident Care Plans and ensuring that said Care Plans are appropriately updated each and every time new interventions are determined at the daily morning meetings each Monday through Friday with the inter-disciplinary team. Said interventions will be transferred to the resident□s Care Plan within 24 hours of said meeting. This would include any intervention for falls, pressure ulcers, behaviors, communication, life expectancy, range of motion (or lack thereof), behaviors, ADL assistance that may enhance a resident□s quality of life or prevent further incidents based upon an incident, change in condition or direct observation. Systemic Changes On 09/09/16, the MDS Coordinator resigned her position. Facility is currently recruiting for an MDS Coordinator. In the interim, The LPN MDS support nurse will assist, as appropriate, the MDS process to support the Regional MDS Consultant	

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F 280	Continued From page 22 antianxiety medications, and diuretics. A nursing progress note dated 7/1/6 indicated Resident #45 fell out of her bed and sustained a skin tear to her left arm and a bruise to her forehead. The fall investigation report dated 7/4/16 indicated staff continued to keep Resident #45's bed in the lowest position and continued their frequent monitoring of Resident #45. There were no new interventions added to Resident #45 ' s care plan. A nursing progress note dated 7/10/16 indicated Resident #45 fell out of her bed. No injury was sustained. The fall investigation report dated 7/11/16 indicated Resident #45 was unable to retain safety information. Staff were reminded to keep Resident #45's bed in the lowest position and to provide frequent safety checks. Resident #45's care plan was updated with the intervention, "Anticipate my needs as much as possible" on 7/11/16. A nursing progress note dated 7/15/16 indicated Resident #45 fell out of her bed and sustained two skin tears to her right arm. The fall investigation report dated 7/16/16 indicated staff continued to keep Resident #45's bed in the lowest position and provided frequent monitoring. There were no new interventions added to Resident #45's care plan. A nursing progress note dated 7/16/16 indicated Resident #45 fell out of her bed. No injury was sustained. The fall investigation report dated 7/25/16 indicated preventative measures included a winged mattress and bed in the lowest position. Resident #45 ' s care plan was updated with the intervention, "Winged mattress to provide	F 280	so as to complete the facility MDS Assessments accurately and timely; further ensuring that resident□s care plans are accurate and that proper interventions are identified and implemented to the care plans timely. Once a new MDS RN Coordinator is identified and hired, the Regional MDS Consultant will train new Coordinator on accurately and comprehensively assessing residents in a face-to-face interview, conduct direct observation and a thorough review of the medical record during any MDS assessment or look-back period so that accurate MDS coding is maintained at all times. The MDS Coordinator or DON will ensure that Care Plans are appropriately updated each and every time new interventions are determined at the daily morning meetings each Monday through Friday with the inter-disciplinary team. Said interventions will be transferred to the resident□s Care Plan within 24 hours of said meeting. This would include any intervention for falls, pressure ulcers, behaviors, communication, life expectancy, range of motion (or lack thereof), behaviors, ADL assistance that may enhance a resident□s quality of life or prevent further incidents based upon an incident, change in condition or direct observation. This information has been integrated into the standard orientation training for MDS Coordinator and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance	

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F 280	Continued From page 23 reminders for boundaries, define parameters of bed" on 7/26/16. A nursing progress note dated 8/25/16 indicated Resident #45 fell out of her chair. No injuries were sustained. Resident #45 was not wearing her non-slip socks. Staff were indicated to be educated on the use of non-slip socks. The fall investigation report dated 8/28/16 indicated Resident #45's chair was going to be removed from her room, staff continued with frequent monitoring, and her bed in the low position. There were no new interventions added to Resident #45's care plan. A nursing progress note dated 9/2/16 indicated Resident #45 fell out of her bed. No injuries were sustained. The fall investigation report was not provided. As of 9/6/16 no new interventions were added to Resident #45's care plan. An interview was conducted with the MDS Nurse on 9/7/16 at 4:55 PM. She indicated she completed the care plans and reviewed and revised interventions. She stated she was responsible for adding interventions for residents who were fall risks and/or who had sustained actual falls. The MDS Nurse indicated that falls were reviewed during the daily morning meeting that occurred every Monday through Friday. She stated the Director of Nursing (DON), Nursing Supervisor, and herself attended the meeting. The MDS Nurse stated that new interventions for were discussed in that meeting and she was responsible for adding the interventions to the care plan. The medical record and fall investigation reports for Resident #45's 6 falls were reviewed with the MDS Nurse. She revealed there were some interventions	F 280	Process to verify that the change has been sustained. Quality Assurance The DON will audit three residents medical records for accuracy of the residents Care Plans per week and compliance documented on the Care Plan & Falls Interventions QA Tool. This will be done weekly for one month then monthly for two months or until resolved by Quality Assurance Committee. Reports will be presented to the Executive Director or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Executive Director.	

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mentioned in the fall investigation reports for Resident #45 that she had not added to the care plan. These interventions included Resident #45's bed being in the lowest position and frequent monitoring by staff. The MDS Nurse stated she should have added these interventions to the care plan the day they were discussed. She additionally indicated she had difficulty developing new interventions that were effective for Resident #45 as the resident was not able to retain safety information. The MDS Nurse stated, "I just didn't know what to do for [Resident #45]".

On 9/7/16 the following intervention were initiated to Resident #45's care plan for falls:
- Check for possibility of [urinary tract infection] with repeated falls.
- Check on me frequently as I forget to use my call bell.
- Please keep me clean and dry to lower my restlessness.
- Bed low

An interview was conducted with the DON on 9/8/16 at 9:30 AM. The DON indicated there was a daily morning meeting held each Monday through Friday. She stated the Nursing Supervisor, Assistant Director of Nursing (ADON), MDS Nurse, and herself attended the meeting. She indicated this meeting was where falls were reviewed and investigations were completed. The DON reported the purpose of the meeting was to review interventions, develop interventions, and/or revise interventions for falls. She stated that new interventions and/or revisions to existing interventions that were discussed in the meeting were expected to be added to the plan of care by the MDS Nurse the same day. She indicated that if the interventions were not

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carried over to the care plan then the meeting had not served its purpose. She revealed she became aware of interventions not being added to care plans as of 9/7/16. She indicated the facility was already working on this and have added care plan interventions to Resident #45's care plan for falls as of yesterday (9/7/16).

2. Resident #83 was admitted to the facility on 5/16/16 with multiple diagnoses that included a hip fracture, history of falling, and dementia.

A nursing note dated 5/16/16 indicated Resident #83 was found lying on the floor of his room yelling for help. No injuries were noted. The fall investigation report indicated Resident #83's room was moved closer to the nursing station and resident was educated on the importance of using his call bell.

The plan of care for Resident #83, with an initiated date of 5/16/16, included the focus area of an actual fall with risk for further falls. The risk factors indicated were an unsteady gait, psychoactive drug use, poor communication and comprehension, fall risk, poor safety awareness. The interventions initiated on 5/16/16 included:
- Anticipate my needs as much as possible.
- Encourage me to call for assistance prior to transfers.
- Encourage me to lock my brakes before standing up.
- Encourage me to use my walker when ambulating.
- Encourage me to wear non-slip socks when not wearing shoes.
- Have [Physical Therapy] evaluate me as needed, keep frequently used objects in my reach.

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- Keep frequently used objects in my reach.
- Keep my call light in my reach.
- Make sure that I have non-slip shoes on that fit appropriately.
- Monitor/document/report PRN x 72 hours to [physician] for [signs and symptoms of] pain, bruises, change in mental status, with new onset of confusion, sleepiness, inability to maintain posture, agitation.
- Observe me for possible side effects from medications that may affect my gait and balance and report to nurse if I have change in my gait or balance.
- Pharmacy [consultation] to evaluate medications.
- Provide activities that promote exercise and strength building where possible. Provided [one on one] activities if bedbound.

The admission Minimum Data Set (MDS) assessment dated 5/23/16 indicated Resident #83 had significant cognitive impairment. He was indicated to require extensive assistance with bed mobility, transfers, toileting, dressing, and hygiene. He was additionally indicated as requiring limited assistance with locomotion on and off the unit. Resident #83 had impaired balance, he was only able to stabilize with staff assistance, and had a functional limitation in range of motion on one side of his lower extremities. He was indicated to have had 1 fall with a fracture within 1 month prior to his admission and one fall with no injury since his admission.

A nursing progress note dated 6/14/16 indicated Resident #83 was found sitting on the floor of his room in front of his wheelchair. No injuries were noted. The fall investigation report indicated the

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intervention of keeping Resident #83 near the nurses' station while he was up in wheelchair. Staff were indicated to provide frequent monitoring while Resident #83 was in his room. There were no new interventions added to Resident #83's care plan.

An interview was conducted with the MDS Nurse on 9/7/16 at 4:55 PM. She indicated she completed the care plans and reviewed and revised interventions. She stated she was responsible for adding interventions for residents who were fall risks and/or who had sustained actual falls. The MDS Nurse indicated that falls were reviewed during the daily morning meeting that occurred every Monday through Friday. She stated the Director of Nursing (DON), Nursing Supervisor, and herself attended the meeting. The MDS Nurse stated that new interventions for falls were discussed in that meeting and she was responsible for adding the interventions to the care plan.

An interview was conducted with the DON on 9/8/16 at 9:30 AM. The DON indicated there was a daily morning meeting held each Monday through Friday. She stated the Nursing Supervisor, Assistant Director of Nursing (ADON), MDS Nurse, and herself attended the meeting. She indicated this meeting was where falls were reviewed and investigations were completed. The DON reported the purpose of the meeting was to review interventions, develop interventions, and/or revise interventions for falls. She stated that new interventions and/or revisions to existing interventions that were discussed in the meeting were expected to be added to the plan of care by the MDS Nurse the same day. She indicated that if the interventions were not

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F 280	Continued From page 28 carried over to the care plan then the meeting had not served its purpose. She revealed she became aware of interventions not being added to care plans as of 9/7/16. A follow up interview was conducted with the DON on 9/8/16 at 11:00 AM. Resident #83 ' s medical record and care plan for falls was reviewed with the DON. She confirmed that no new care plan interventions were added after Resident #83's fall on 6/14/16.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to implement effective interventions and ensure the interventions in place were followed to reduce the risk of falls for a resident who sustained 6 falls (7/1/16, 7/10/16, 7/15/16, 7/16/16, 8/25/16, 9/2/16) in a 64 day timeframe (Resident #45) for 1 of 3 residents reviewed for falls. The findings included: Resident #45 was initially admitted to the facility on 3/17/16 and readmitted on 5/30/16 with multiple diagnoses including a fracture of the upper end of left humerus, hip fracture, anxiety	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility'□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	10/6/16

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F 323	Continued From page 29 disorder, and dementia. The Risk Assessment dated 5/30/16 indicated Resident #45 had a fall within the last month and a fall within the last 2 to 6 months. Resident #45 was indicated to be chairfast (ability to walk was severely limited or non-existent), mobility was very limited (made occasional slight changes in body or extremity position, but unable to make frequent or significant changes independently), unable to independently stand, and exhibited a loss of balance while standing. The plan of care for Resident #45, with an initiated date of 5/30/16, included the focus area of an actual fall with risk for further falls. The risk factors indicated were an unsteady gait, psychoactive drug use, history of falls, pain, poor safety awareness, and a history of anemia. The interventions initiated on 5/30/16 included: - Encourage me to call for assistance prior to transfers. - Encourage me to wear non slip socks when not wearing shoes. - Have [Physical Therapy] evaluate me as needed. - Keep frequently used objects in my reach. - Keep my call light in my reach. - Make sure that I have non-slip shoes that fit appropriately. - Observe me for possible side effects from medications that may affect my gait and balance and report to nurse if I have change in my gait or balance. - Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bedbound. - [Physical Therapy consultation] for strength and mobility.	F 323	Corrective Action for Resident Affected On 9/26/16, In reference to resident #45, MDS assessments and Care Plans were reviewed by the Regional MDS consultant. Resident #45□s Care Plan was updated to include new interventions on each documented fall. All identified issues were corrected and completed by 09/30/16. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this practice. On 09/26/2016 through 09/29/2016, a 6 month look back review was completed of current residents falls and reviewed by the Director of Nursing and RN Clinical Supervisors for Care Plan accuracy to ensure that proper interventions were identified and appropriately documented on all residents Care Plans. Results of the audit: Resident Care Plans that were noted unsatisfactory was 28 out of 63 documented falls were identified. All the modifications were completed by the Regional MDS Consultant, DON and RN Clinical Supervisors by 10/04/16. On 09/27/16, the RN Nurse Consultant conducted an in-service with the IDT [IDT consists of the DON, MDS Coordinator, Therapy, RN Supervisors, Activities and Dietary) on appropriate fall interventions to assist with Care Planning. Such interventions may include, but may not be limited to: Therapy to screen for gait, safety, cognition, environmental evaluation and need for assistive devices;	

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F 323	Continued From page 30 - Reinforce safety reminders frequently. The admission Minimum Data Set (MDS) assessment dated 6/6/16 indicated Resident #45 had significant cognitive impairment and required extensive assistance with all activities of daily living. She was indicated to have had a fall within the last month prior to admission as well as a fall within the last 2 to 6 months prior to admission. The Care Area Assessment (CAA) for the 6/6/16 MDS indicated Resident #45 remained at risk for falls due to her confusion and restlessness. She was indicated to be dependent on staff for mobility and transfers. Resident #45 demonstrated no safety awareness and needed frequent observations by staff. She was indicated to attempt to get out of bed without assistance, she had difficulty maintaining sitting balance, and had impaired balance during transfers. Resident #45 was on antidepressant medications, antianxiety medications, and diuretics. A nursing progress note dated 7/1/6 indicated Resident #45 fell out of her bed and sustained a skin tear to her left arm and a bruise to her forehead. The fall investigation report dated 7/4/16 indicated staff continued to keep Resident #45's bed in the lowest position and continued their frequent monitoring of Resident #45. There were no new interventions added to Resident #45's care plan. A nursing progress note dated 7/10/16 indicated Resident #45 fell out of her bed. No injury was sustained. The fall investigation report dated 7/11/16 indicated Resident #45 was unable to retain safety information. Staff were reminded to keep Resident #45's bed in the lowest position	F 323	Pharmacy to conduct medication review for potential interactions, and potential adverse effects; MD to evaluate for change of conditions, new diagnoses, physician referrals. When a patient has a fall, the IDT will review the incident report and determine appropriate interventions based upon the root cause, history of the resident and nature of the fall. The interventions listed above may be appropriate for the resident. If interventions cannot be identified, the IDT should contact the medical provider for further evaluation. Systemic Changes The DON and/or RN Clinical Supervisor, will ensure that new fall interventions that are determined at the daily morning meetings each Monday through Friday (weekend incidents will be reviewed on Monday mornings) with the inter-disciplinary team. All fall interventions are then transferred to the resident□s care plan within 24 hours of said meeting. Once interventions are transferred to the Care Plan, the DON and/or RN Clinical Supervisor will make direct observation of resident, with access to Care Plan and within 24 hours of transfer, to ensure interventions have been implemented/initiated. Quality Assurance The Regional RN Clinical Consultant will audit three resident Care Plans per week to verify that falls interventions have been identified and implemented for each fall. Compliance will be documented on the	

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F 323	Continued From page 31 and to provide frequent safety checks. Resident #45's care plan was updated with the intervention, "Anticipate my needs as much as possible" on 7/11/16. A nursing progress note dated 7/15/16 indicated Resident #45 fell out of her bed and sustained two skin tears to her right arm. The fall investigation report dated 7/16/16 indicated staff continued to keep Resident #45's bed in the lowest position and provided frequent monitoring. There were no new interventions added to Resident #45's care plan. A nursing progress note dated 7/16/16 indicated Resident #45 fell out of her bed. No injury was sustained. The fall investigation report dated 7/25/16 indicated preventative measures included a winged mattress and bed in the lowest position. Resident #45's care plan was updated with the intervention, "Winged mattress to provide reminders for boundaries, define parameters of bed" on 7/26/16. A nursing progress note dated 8/25/16 indicated Resident #45 fell out of her chair. No injuries were sustained. Resident #45 was not wearing her non-slip socks. Staff were indicated to be educated on the use of non-slip socks. The fall investigation report dated 8/28/16 indicated Resident #45's chair was going to be removed from her room, staff continued with frequent monitoring, and her bed in the low position. There were no new interventions added to Resident #45's care plan. A nursing progress note dated 9/2/16 indicated Resident #45 fell out of her bed. No injuries were sustained. The fall investigation report was not	F 323	Weekly QA Monitor Tool; thus validating the accuracy of the Care Plan. This will be done weekly until for one month and then bi-weekly for two months or until resolved by Quality Assurance Committee. Reports will be presented to the Executive Director or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Executive Director.	

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F 323	Continued From page 32	F 323		

provided. As of 9/6/16 no new interventions were added to Resident #45's care plan.

An interview was conducted with the MDS Nurse on 9/7/16 at 4:55 PM. She indicated she completed the care plans and reviewed and revised interventions. She stated she was responsible for adding interventions for residents who were fall risks and/or who had sustained actual falls. The MDS Nurse indicated that falls were reviewed during the daily morning meeting that occurred every Monday through Friday. She stated the Director of Nursing (DON), Nursing Supervisor, and herself attended the meeting. The MDS Nurse stated that new interventions for falls were discussed in that meeting and she was responsible for adding the interventions to the care plan. The medical record and fall investigation reports for Resident #45's 6 falls were reviewed with the MDS Nurse. She revealed there were some interventions mentioned in the fall investigation reports for Resident #45 that she had not added to the care plan. These interventions included Resident #45's bed being in the lowest position and frequent monitoring by staff. The MDS Nurse stated she should have added these interventions to the care plan the day they were discussed. She additionally indicated she had difficulty developing new interventions that were effective for Resident #45 as the resident was not able to retain safety information. The MDS Nurse stated, "I just didn't know what to do for [Resident #45]" .

On 9/7/16 the following intervention were initiated to Resident #45's care plan for falls:
- Check for possibility of [urinary tract infection] with repeated falls
- Check on me frequently as I forget to use my

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F 323	Continued From page 33 call bell - Please keep me clean and dry to lower my restlessness - Bed low An interview was conducted with the DON on 9/8/16 at 9:30 AM. The DON indicated there was a daily morning meeting held each Monday through Friday. She stated the Nursing Supervisor, Assistant Director of Nursing (ADON), MDS Nurse, and herself attended the meeting. She indicated this meeting was where falls were reviewed and investigations were completed. The DON reported the purpose of the meeting was to review interventions, develop interventions, and/or revise interventions for falls. She stated that new interventions and/or revisions to existing interventions that were discussed in the meeting were expected to be added to the plan of care by the MDS Nurse the same day. She indicated that if the interventions were not carried over to the care plan then the meeting had not served its purpose. She revealed she became aware of interventions not being added to care plans as of 9/7/16. She indicated the facility was already working on this and have added care plan interventions to Resident #45's care plan for falls as of yesterday (9/7/16).	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		10/6/16

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F 356	Continued From page 34 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to post the nurse staffing information that was complete and accurate and on a daily basis at the beginning of each shift for 2 of 2 days observation. Findings included: On 9/6/16 at 8:30 AM and 4:30 PM, tour of the facility was conducted. There was no nurse staffing information posted. On 9/7/16 at 12:30 PM and 3:30 PM, a nurse staffing information was observed posted on	F 356	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility'□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	

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F 356	Continued From page 35 station 1 dated 9/6/16. The posting had 4 Registered Nurses (RNs) listed on 7A-7P shift. The information for 7P-7A was blank. On 9/7/16 at 3:32 PM, Nurse #2 was interviewed. Nurse #2 stated that it was the responsibility of the nurse to complete the nurse staffing information daily and to post it. The nurse indicated that he normally completed the form before he left at 7 PM. He added that he was the one who completed the form for 9/6/16 and he would complete the 9/7/16 before the end of his shift and post it. The nurse acknowledged that the 7 P- 7A shift nurse did not complete the information on the form for 9/6/16. Nurse #2 further stated that the 4 RNs were the Director of Nursing (DON), MDS Nurse, Assistant DON and the RN supervisor. On 9/7/16 at 12:35 and 3:45 PM, a nurse staffing information was observed posted on station 2 dated 9/7/16. The posting had 4 RNs and 3 Licensed Practical Nurses (LPNs) listed. On 9/7/16 at 3:45 PM, Nurse #3 was interviewed. Nurse #3 stated that she completed the form and the 4 RNs were the DON, MDS Nurse, ADON and RN supervisor and the 3 LPNS were Nurse #2, Nurse #3 and Nurse #4 who was on her first day orientation. On 9/7/16 at 11:50 AM, the DON was interviewed. The DON stated that the nurses worked 12 hour shift. The day shift nurse was responsible for completing the nurse staffing information for 7A-7P and the night shift nurse was responsible for the 7P-7A. The DON indicated that the form should be completed at the start of the shift. The	F 356	Corrective Action On 9/9/16, all licensed nursing staff were in-serviced on properly completing the Nurse Staffing Information Sheet for every shift each day. This Nurse Staffing Information is posted at each Nurse□s Station at the start of each shift by the Nursing Supervisor. The Nursing Staffing Sheet is clear, in readable format and posted in a prominent place readily accessible to residents and visitors. The facility will maintain the posted daily nurse staffing data for a minimum of 18 months as required by state law. Systemic Changes On 09/09/16, all licensed nursing staff were in-serviced on properly completing the Nurse Staffing Information Sheet for every shift each day and then posted at each Nurse□s Station at the start of each shift. In-service for current licensed staff was completed on 09-16-16 by the Director of Nursing. Any new licensed staff will be in-serviced during orientation on the proper completion and posting of Nurse Staffing Information Sheet. Quality Assurance The Director of Nursing, Executive Director and/or RN Clinical Supervisors will verify that the accurate Nurse Staffing Information is posted each day at the beginning of each shift including weekends. This will be completed three times a week for one month then weekly for one month or until resolved by Quality	

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F 356	Continued From page 36 DON further stated that DON, MDS Nurse and Nurse #4 should not be counted on the nurse staffing data form. The DON stated that she expected the nurse staffing information to be complete, accurate and posted on the daily basis at the start of the shift.	F 356	Assurance Committee. The ongoing monitoring will be completed by the Director of Nursing and the RN Clinical Team. Reports will be presented to the Executive Director or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Executive Director.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review the facility failed to label and date and discard expired foods from freezer and to discard expired foods from refrigerator, and failed to keep milk products at 41 degrees F (Fahrenheit) or below. The findings included: 1. Review of the facility precedure number B006 "Food and Supply Storage Procedures", revised 1/14 revealed "Remove from storage any items	F 371	The statements mane on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility'□s allegation of	10/6/16

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F 371	Continued From page 37 for which the expiration date has expired." Review of the facility policy "Sanitation and Food Handeling Procedures" (undated) revaled "Food not in it's original packaging should be lables wrapped and dated". On 9/6/16 at 8:00 AM the walk in freezer located outside the facility was observed with Chef #1. The following expired items were observed in the freezer: 1 bag turkey cutlets--expired 8/8/6 1 bag stuffed peppers--expired 8/14/16 1 bag mushroom gravy--expired 7/8/16 1 bag chicken and dumplings --expired 8/16/16 (also unlabeled) 1 bag chicken and dumplings--expired 8/14/16 1 bag salmon patties--expired 8/11/16 1 bag salmon patties--expired 7/15/16 1 bag stuffed pepper mix--expired 6/21/16 1 bag tuna-expired 4/29/16 1 bag asparagus soup--expired 7/15/16 1 bag mushroom soup--expired 5/7/16 2 bags cream of chicken soup--expired 8/10/16 In addition the following unlabeled and/or undated items were observed: 1 bag of tortellini's--wrapped in cellophane, unlabeled and undated 1/2 bag of potato pancakes-opened and undated (ice crystals in the bag) 1 bag with 8 frozen biscuits-- undated (ice crystals in the bag) On 9.6.16 at 8:20 AM the walk in refrigerator was observed with Chef #1. The following items were observed to be past their discard by date but not yet discarded:	F 371	compliance such that all alleged deficiencies cited have been or will be corrected by the date or dated indicated. Corrective Action for Area Affected: On 9/6/2016, State Surveyor noted facility failed to label, date and discard expired food items in the refrigerator. On 9/6/2016, all items that were not labeled, dated or had expired in the walk-in cooler and freezer were immediately discarded. Systemic Changes On 09/07/16, the Director of Dietary Services in-serviced dietary staff on proper labeling and dating of items, as well as the appropriate shelf life of food products that are received, stored and prepared. The Director of Dietary Services will also conduct a formalized, mandatory Communication Health and Training (CHAT training) with dietary staff members on 09/28/16 that will address Morrison□s guidelines and policies and procedures for proper food and storage items. Packaged food label information must include: The common name of the food; or, absent a common name, an adequately descriptive identity statement. Items will be labeled with a Date In date for all items, boxed or unboxed, in refrigerator, freezer or dry storage. Prepared items, i.e., glasses of tea, milk, etc., will have a Use By label date adhered to the side of glass/cup. Any cups of dressing, poured from larger	

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F 371	Continued From page 38 9 pieces Boston cream pie dated as prepared on 8/30/16 with an expiration/use by date of 9/3/16 3 brownies dated as prepared on 8/31/16 with an expired/use by date of 9/4/16 2 pieces of chocolate cake dated as prepared on 8/31/16 with an expired/use by date of 9/4/16 On 9/6/16 at 8:25 AM interview with Chef #1 revealed that all dietary staff were expected to check for expiration dates and discard expired foods/foods past their use by date and that no one staff member was responsible. On 9/7/16 at 10:40 AM the Dietary Manager was interviewed. He indicated that his staff had told him about the expired food items in the freezer and that they had been removed but he had not yet heard about the desserts in the refrigerator that were past their use by date. He said he thought the reason for these items still being in the freezer and refrigerator could have had to do with hoarding which was one of the issues he had been brought in to resolve but that he had not been in his position very long. On 9/8/16 at 12:30 PM the Administrator was interviewed and stated that she expected expired foods to be discarded and food items to be properly labeled and dated. 2. Review of the facility procedure number B006, "Food and Supply Storage Procedures" revised 1/14 revealed "Milk will be refrigerated immediately upon receipt. A with all refrigerated storage, temperatures must be maintained at 41 (degrees) F (Fahrenheit) or below." On 9/7/16 at 11:15 AM Chef #1 was observed to	F 371	bottle, will have Use By label date adhered to top of serving cup. Large boxes of desserts will have a Use By label on top of box; any sliced dessert will have Use By label on cellophane wrap. Any item that does not have a Date In, Use By, manufacturer□s expiration, or other allowable food label that accurately identifies a date opened, and a date to use by will immediately be deemed expired and thusly discarded. Quality Assurance: The Director of Dietary Services or Sous Chef will audit on alternating shifts the reach-in, walk-in refrigerator and freezer to ensure that all items are appropriately labeled with a Date In, a manufacturer□s expiration date and/or a Use By date, three times per week with periodic weekend audits and compliance documented on the Food Safety & Sanitation Audit. This will be completed and documented 3 times per week for 6 weeks; then one time per week for 8 weeks; then bi-weekly for 2 months or until resolved by the Quality Assurance Committee. Reports will be presented weekly to the Executive Director or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Executive Director.	

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F 371	Continued From page 39 use a calibrated thermometer to measure the temperature of a single serving carton of milk taken out of the reach in refrigerator located directly behind the steam table. This was milk that was available to be put on a resident's tray during the lunch service tray line. The temperature of the milk was 44 degrees F (Fahrenheit). The temperature reading for this refrigerator, according to the digital temperature indicator display outside the refrigerator, was 43 degrees F at this time. The temperature reading on the thermometer inside the refrigerator was not observed. Chef #1 then measured the temperature of two more single serving cartons of milk and they both registered 44 degrees F. A box of single serving cartons of milk was then obtained from another chiller across the room (not observed) and Chef #1 measured the temperature of one of these cartons and it registered 42 degrees F. The Dietary Manager stated that he was surprised it did not register a lower temperature because the chiller it was obtained from had a temperature reading of 32 degrees F and the milk had been delivered yesterday and stored in that chiller since then. The Dietary Manager acknowledged the reach in refrigerator behind the steam table was exposed to the heat of the steam table and was being opened frequently as that was where most of the cold drinks that were being put on the lunch trays, including milk water and iced tea, were being stored for use. On 9/8/16 at 12:30 PM the Administrator was interviewed and stated that she expected milk products to be maintained and served at temperatures under 41 degrees F.	F 371	Corrective Action for Area Affected: On 9/6/2016, State Surveyor observed that dairy products specifically milk did not maintain a proper temperature below 41 degrees. Milk products were immediately placed in ice bath to bring below required 41 degrees. Upon re-inspection, milk maintained a temperature of below 41 degrees. Any milk product that was above the minimum 41 degrees was immediately discarded. Systemic Changes: On 9/6/2016, the Director of Dietary Services in-serviced the dietary staff ad-hoc on the importance of proper temperatures for all food products, but specifically milk products. As of 09-06-16, all milk products are placed in an ice bath before meal service to insure proper temperature is reached before placement on meal trays. Temperatures are then randomly checked once meal carts left dietary department. On 09/07/16, the Dietary Services Director conducted a formalized in-service for all dietary staff on proper temperature safe zones and approximate thresholds for diary, produce, protein, hot held, and cold held items. Dietary staff were also trained on completing the temperature monitoring sheets each day to ensure temperature safety zones are maintained on all of products, inclusive of checking and documenting the internal temperature of our walk-in and reach-in coolers. The Director of Dietary Services will also hold a formalized, mandatory CHAT training	

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F 371	Continued From page 40	F 371	with dietary staff members on 9/28/2016. Quality Assurance: The Director of Dining Services or Sous Chef will randomly audit the reach-in, walk-in and tray line service ice bath container to ensure that proper milk temperatures are achieved and maintained. This will be completed and documented 3 times per week for 6 weeks; then one time per week for 8 weeks; then bi-weekly for 2 months or until resolved by the Quality Assurance Committee. Reports will be presented weekly to the Executive Director or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Executive Director.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520		10/6/16

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F 520	Continued From page 41 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 10/1/15 recertification survey. This was for a recited deficiency in the area of assessment accuracy (F278). This deficiency was cited again on the current recertification survey of 9/8/16. The continued failure during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: F278 - Assessment Accuracy: Based on medical record review, resident interview, and staff interview the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of life expectancy (Resident #45), behaviors (Resident #45), falls (Resident #45), pressure ulcers (Resident #94), medications	F 520	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility'□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected Resident #45- Behaviors and falls; Resident #94-pressure ulcers; Resident #62, #34, #18 and #12-Medications; Resident #58 and #77-Range of Motions; and Resident #18-Diagnoses. The MDS Nurse Consultant reviewed and corrected the MDS of the residents affected via modification.	

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F 520	Continued From page 42 (Residents #62, #34, #18, and #12), range of motion (Residents #58 and #77), and diagnoses (Resident #18) for 8 of 13 sampled residents. During the recertification survey of 10/1/15 the facility was cited F278 for failing to accurately assess residents in the areas of pressure ulcer and hydration on the MDS. On the current recertification survey of 8/19/16, the facility failed to accurately assess residents in the areas of Preadmission Screening and Resident Review (PASRR), medications, falls, and dental status. On 9/08/2016 at 1:24PM, an interview was conducted with the Administrator. She stated the facility had a Quality Assurance and Performance Improvement process (QAPI) that reviewed the citation last year and put a plan of action into place that was effective until recently. The Director of Nursing and the Regional MDS Coordinator monitored the MDS for accuracy. The Administrator said there was a transition in the regional team which might have affected the process (a new Director of Nursing in March and Regional MDS Coordinator in June). Monitoring of the MDS no longer occurred. She said the facility felt the problem was resolved because they had seen significant improvement. They had not observed any trends of inaccuracy in the coding.	F 520	Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this practice. See other plans of corrections cited for F278. On 09/29/2016, the QA Nurse Consultant in-serviced the Administrator and Director of Nursing. Topics included: The need to continue all plan of correction quality assurance monitors until full compliance is sustained for 3 months. Once sustained for 3 months the survey monitor will be completed quarterly until after the next survey cycle to ensure compliance on the next survey. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The QA Nurse Consultant will monitor this issue using the QA Survey Tool. Quality Assurance Audit tools identified in this plan of correction will be reviewed monthly to ensure that corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	