STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 17 residents reviewed (#156). Findings included: Resident #156 had been admitted on 5/17/2014. Diagnoses included dementia, depression, anxiety and cellulitis of the lower extremities. Resident #156's most recent annual assessment dated 11/17/2016 indicated she had moderate cognitive impairment and required supervision with eating and extensive assistance with all other activities of daily living (ADLs). On 11/23/2016 Resident #156 was discharged to the hospital and her return was anticipated. She was readmitted to the facility on 11/25/2016. An observation of the facility's MDS computer program was made on 3/07/2017. An incomplete quarterly MDS with an assessment reference date (ARD) of 2/16/2017 for Resident #156 was noted. The MDS coordinator was unavailable for an interview.	F 276	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. Immediate corrective action taken for this alleged deficient practice includes: 1.Resident # 156 MDS was completed and transmitted on 3/11/2017. Resident with potential to be affected. 1.All residents have the potential to be affected. 2.Residents identified by Minimum Data Set scheduler in American Health Tech system. Measures put into place to assure that the alleged deficient practice does not recur include: 1.On 3/20/17 the Clinical Reimbursement Consultant educated the Case Mix Director / Coordinator on reviewing the	4/5/17

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

Electronically Signed | 03/23/2017

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F 276	Continued From page 1 An interview was conducted with the facility reimbursement consultant on 3/09/2017 at 11:07 AM. The consultant indicated the facility was behind on several MDS assessments. The consultant stated according to the Resident Assessment Instrument (RAI) Manual, assessments need to be completed by the 14th day after the ARD. The consultant stated MDS assessments should be completed and submitted according to the RAI guidelines. An interview was conducted with the director of nursing (DON) on 3/092017 at 11:45 AM. The DON indicated MDS assessments should completed on time.	F 276	Minimum Data Set scheduled for late assessments and / or assessments due for completion. 2.The Case Mix Director / Coordinator reviews the Minimum Data Set scheduler daily to identify late assessments and/or assessments due for completion. 3.The Administrator will review the Minimum Data Set scheduler daily for completion of assessments. Monitoring put in place to assure the alleged deficient practice does not recur includes: 1. The Case Mix Director / Coordinator will present the findings and interventions put in place for MDS completions will be reported in Quality Assurance Performance Improvement Committee Meetings for review of any additional needs monthly until three months of consecutive compliance has been established. Date of Completion 4/5/17	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		4/5/17

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F 278	Continued From page 2 (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 5 of 6 residents (Residents #43, #96, #121, #250 and #353) reviewed for Preadmission Screening and Resident Review (PASRR, a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines). Findings included:	F 278	Immediate corrective action taken for this alleged deficient practice includes: 1.MDS modification competed for Residents # 43, #96, #121, #250 and # 353 on 3/10/17. Resident with potential to be affected. 1.100% audit of all PASRR□s for all active residents and modifications made to	

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F 278	Continued From page 3 1. Resident #43 was admitted on 10/02/2013. Admitting diagnoses included bipolar disorder, schizophrenia and diabetes. Review of Resident #43's PASRR Level II Determination Notification dated 11/13/2015 indicated there was no expiration date. Resident #43's most recent annual MDS assessment dated 4/01/2016 did not indicate he required PASRR Level II. 2. Resident #96 was admitted on 11/15/2010. Admitting diagnoses included dementia, depression, generalized anxiety and bipolar disorder. Review of Resident #96's PASRR Level II Determination Notification dated 10/13/2010 indicated there was no expiration date. Resident #96's most recent annual MDS assessment dated 8/03/2016 did not indicate she required PASRR Level II. 3. Resident #121 was admitted on 5/06/2011. Admitting diagnoses included altered mental status, diabetes and depression. Review of Resident #121's PASRR Level II Determination Notification dated 5/17/2011 indicated there was no expiration date. Resident #121's most recent annual MDS assessment dated 2/07/2017 did not indicate she required PASRR Level II. 4. Resident #250 was admitted on 6/23/2016. Admitting diagnoses included schizophrenia,	F 278	those incorrectly coded. Completed on 3/20/17. Measures put into place to assure that the alleged deficient practice does not recur include: 1.Interdisciplinary Team will bring charts of the newly admitted / readmitted residents to the facility mornings meeting the next business day to review their PASRR criteria. This will occur daily for 7 days, weekly for 3 weeks and monthly thereafter. 2.The Level II PASRR is maintained on the Residents chart under the Social Work section and also in a notebook in the Social Work office. 3.Interdisciplinary team to review the MDS coding at A1500 prior to closing the comprehensive assessments. 4.The Director of Health Services completed educate on March 20, 2017 with the Social Worker, Case Mix Director / Coordinator and Admissions Director as to the placement of the Level II PASRR in the medical record. Monitoring put in place to assure the alleged deficient practice does not recur includes: 1.The Case Mix Director and Social Worker will present their findings and interventions put in place for Level II PASSR to the Quality Assurance	

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F 278	Continued From page 4 depression, hypertension and diabetes. Review of Resident #250's PASRR Level II Determination Notification was observed in her chart and was dated 2/02/2017 with an expiration date of 4/3/2017. Resident #250's admission MDS dated 6/30/2016 did not indicate she required PASRR Level II. 5. Resident #353 was readmitted on 2/16/2017. Admitting diagnoses included bipolar disorder, major depressive disorder and hypertension. Review of Resident #353's PASRR Level II Determination Notification dated 2/17/2017 indicated there was no expiration date. Resident #353's admission MDS dated 2/23/2017 did not indicate she required PASRR Level II. An interview with the social worker (SW) was conducted on 3/08/2017 at 9:05 AM. The SW stated upon admission, the admissions coordinator or the business office would alert the SW that a resident requiring PASRR Level II was being admitted. The SW stated she would obtain the PASRR information and place the PASRR notification letter in the resident's chart. The SW stated this information was also noted on the resident demographic information sheet (face sheet) and the PASRR notification letter would be placed in the resident's chart and available for the MDS nurse to see. The MDS coordinator was unavailable for an interview. An interview was conducted with the facility	F 278	Performance Improvement Committee Meetings for review of any additional needs monthly until three months of consecutive compliance has been established. Date of Completion 4/5/17	

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F 278	Continued From page 5 reimbursement consultant on 3/09/2017 at 11:07 AM. The consultant stated information regarding PASRR Level II was communicated to the MDS nurse by the social worker or the admissions coordinator. The MDS nurse was responsible for making sure the information in the MDS was correct and accurate and the MDS assessment should accurately reflect the resident's condition. The consultant stated the MDS nurse had missed marking the PASRR information on this resident's assessment. An interview was conducted with the director of nursing (DON) on 3/092017 at 11:45 AM. The DON indicated MDS assessments should accurately reflect the resident's condition.	F 278		