STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	**8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 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. (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	F 278	For Resident # 37: • On May 4, 2017, MDS Coordinator	5/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/12/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING ______ B. WING ______	05/04/2017

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F 278	Continued From page 1 Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 residents (Residents #37) identified as a Level II PASRR resident. Findings included: Resident #37 was admitted to the facility on 12-19-11 with diagnoses which included unspecified intellectual disabilities. Review of Resident #37's PASARR level II, dated on 05-23-11, revealed that the resident had a permanent number. Review of the Significant Change MDS, dated on 02/02/17, indicated Resident #37 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. During an interview with the MDS Coordinator on 05/04/17 at 9:00 a.m., the MDS Coordinator stated it was an oversight. During an interview with the Administrator on 05/04/17 at 9:25 a.m., the Administrator stated it was her expectation Section A of the MDS be coded completely and accurately.	F 278	completed a modification change to reflect the Level II PASRR. • MDS Coordinator in-serviced on May 4, 2017 by Administrator on ensuring Section A of the MDS is coded completely and accurately. For Resident # 37 and all other residents: • MDS Coordinator in-serviced on May 4, 2017 by Administrator on ensuring Section A of the MDS is coded completely and accurately. • Effective May 4, 2017, Audit initiated by Administrator to be conducted by MDS Coordinator/Designee for review of all current residents most recent MDS assessment focusing on Section A to ensure PASRR level is coded completely and accurately. Random audit of 25% most recent Section A of the MDS assessment to continue weekly times four weeks to total 100% and monthly thereafter by MDS Coordinator/Designee. • For continued monitoring, random selection of 5 resident's most recent Section A of MDS assessment to be reviewed by Director of Nursing/Designee in weekly "IDT" meeting for verification of accurate PASRR Level coding. • Results of Section A of the MDS assessment audit and "IDT" meeting notes to be presented at next scheduled Quality Assurance Committee Meeting for review and again at the following quarterly Quality Assurance Committee Meeting with determination at that time for continued need for monitoring.	