STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345552	A. BUILDING _____ B. WING _____	C 06/09/2017

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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, staff interviews, and observations, the facility failed to accurately code	F 278	The facility corrected the coding of the active diagnosis and the range of motion	7/7/17

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

Electronically Signed | 07/10/2017

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F 278	Continued From page 1 the Minimum Data Set (MDS) for 1 (Resident #11) of 38 sampled residents regarding active diagnoses and physical range of motion limitations. Findings included: Resident #11 was readmitted to the facility on 6/15/2016 following an acute care admission to the hospital. Diagnoses on admission included CVA (cerebrovascular accident - stroke) with left sided hemiparesis (weakness), left hand contracture, anemia (low red blood cells), hypertension (high blood pressure), urinary tract infection, diabetes mellitus, thyroid disorder, depression, psychotic disorder, and macular degeneration (an eye disease that causes vision loss). A review of the Comprehensive MDS Assessment for resident dated for 6/22/2017 coded as an admission assessment listed anemia (low red blood cells), hypertension (high blood pressure), urinary tract infection, diabetes mellitus, thyroid disorder, depression, psychotic disorder, and macular degeneration (an eye disease that causes vision loss) as active diagnoses. It failed to list CVA (cerebrovascular accident - stroke) with left sided hemiparesis (weakness) and left hand contracture. In addition, it also coded the resident had no functional limitation in range of motion for both upper and lower extremities. Review of resident #11's active care plan dated for 2/25/17, originally initiated on 12/20/2016 revealed a care plan was in place for potential for skin breakdown related to the resident's total care needs, immobility, bowel incontinence, indwelling catheter placement, left hand contracture, CVA	F 278	limitations which were identified during the annual survey process. The MDS assessments in question were corrected by the MDS department on 7/7/17. The facility audited 100% of the completed and transmitted comprehensive MDS assessments of residents currently residing in the building. The audit went back to the time that the deficient practice was identified and focused on the coding accuracy of active diagnosis and range of motion limitations. This was completed on 7/7/17 and any issues were corrected at that time. The facility has created a new internal procedure for verifying the accuracy of MDS coding specific to active diagnosis (section I) and range of motion limitations (section G). A Unit Coordinator (a licensed administrative nurse) has since been trained by the MDS department, utilizing the RAI manual as a guideline. This has allowed the facility to add an additional quality review of the areas in question. Moving forward and effective immediately, the Unit Coordinator (designated by the facility administrator) will audit 100% of the comprehensive MDS assessments specific to the areas identified in the 2017 annual survey. The designated Unit Coordinator will utilize a newly created QA tool, The MDS Accuracy Coding Check off QA Tool, to both guide and to record the results of these MDS audits. This will ensure that 100% of future MDS assessments are coded correctly (specific to this plan of	

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F 278	Continued From page 2 with left sided weakness. Resident was also care planned for total assist with activities of daily living (ADLs) due to functional decline and psychiatric admission. During an interview and observation on 06/08/2017 at 12:29:02 PM resident #11 was observed being fed by staff during meal time. Resident #11 was able to move her right hand and arm but no movement was observed in her left side. When asked about the level of assistance needed for resident #11, the NA feeding the resident stated that she required extensive to total assistance due to her left sided weakness, contracture, and blindness. She also stated that the resident required physical therapy for help with her left hand contracture. When asked about range of motion requirements, she stated that NAs are required to perform ROM for residents that have contractures and are bedridden. She stated that during baths and daily care NAs gently move joints and extremities for ROM as well. During an interview with the MDS coordinator on 6/9/2017 at 2:30 PM, when asked if the resident was admitted to the facility following the CVA and development of the left hand contracture, she stated that she was admitted with both. When shown the active diagnoses and physical range of motion limitations areas on the MDS from 6/22/2017 and asked if this was coded correctly, she stated no and that the previous MDS coordinator had entered it incorrectly. During an interview with the administrator on 6/9/2017 at 6:25 PM, when asked what his expectations were for accurate MDS coding, he stated that he expected his MDS coordinator to	F 278	correction). The MDS audit in question will be completed by the designated Unit Coordinator prior to the MDS assessments being submitted. The MDS audit will be introduced at the 7/6/17 session of the weekly Administrative Nursing Quality Initiative meeting. After this informative session on 7/6/17, the results of the weekly MDS audits will be reported and reviewed each week, starting with the 7/13/17 Administrative Nursing Quality Initiative meeting. The monitoring and oversight of the interventions listed in this plan of correction will be directed by the newly formed MDS/ Care Plan QA Team which consists of the Nursing Home Administrator, Assistant Administrator, Director of Nursing, a Unit Coordinator and at least one MDS department representative. Additional team members can be added or removed as needed and additional interventions can be taken at the discretion of the Administrator as needed to ensure ongoing compliance. The QA team responsible for this plan of correction met most recently on 7/3/17 and will continue to meet to review the weekly MDS audits at least monthly, for a minimum of 1 year. This QA team will report directly to the Executive QA Committee which meets quarterly. The next meeting of the Executive QA Committee is scheduled for 7/19/17. The facility alleges full compliance with this plan of correction as of 7/7/17.	

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F 278	Continued From page 3 complete the MDS based on each resident's needs and diagnoses.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 280		7/7/17

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F 280	Continued From page 4	F 280		

strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

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F 280	Continued From page 5 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to update the Care Plans of 2 of 5 sampled residents reviewed for unnecessary drugs (Residents #24 and #140) and 1 of 1 resident reviewed for dialysis (Resident #75). Findings included: 1. Resident #24 was admitted to the facility on 1/3/17 with diagnoses which included: diabetes mellitus, deep vein thrombosis, edema, cellulitis, and depression. Review of the quarterly Minimum Data Set (MDS) dated 3/29/17 indicated Resident #24 was cognitively intact, and received antidepressant, anticoagulant, and diuretic medications. Review of the Care Plan dated 3/29/17 revealed Resident #24 had the continued problem of frequent pain in her lower extremities due to cellulitis and immobility, and frequent pain in her right knee. Approaches included: administer resident's pain medication as ordered; and, monitor for worsening of resident's pain symptoms and report to physician. The recommendation of the Pain Management Consult dated 4/12/17 was for Resident #24 to receive .5mg (milligrams) of Ativan (antianxiety medication) due to insomnia and anxiety.	F 280	The care plans in question on the 2567 were corrected by the MDS Department on 6/9/17. Members of the MDS/ Care Plan QA Team audited all current resident care plans to ensure any resident taking Ativan or any resident with a fluid restriction were care planned accordingly. Any care plans that needed to be corrected were corrected by 7/7/17. The facility has created a new process and QA tool (The Care Plan Accuracy QA Tool) for checking care plans of any resident who receives Ativan or who has a fluid restriction. These specific care plan areas will now be reviewed for accuracy by a Unit Coordinator Administrative Nurse who has been internally trained to complete the care plan audits. This designee by the facility administrator will work directly with the MDS department to help verify the accuracy of the MDS assessment/care planning process specific to this plan of correction. This audit/review will be done following the initial completion of the MDS assessment and prior to final completion of the updated care plan. The Unit Coordinator will utilize a newly created weekly report from our pharmacy provider to ensure ongoing accuracy and compliance. This	

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F 280	Continued From page 6 The review of the Physician's Order dated 4/12/17 revealed Resident #24 was to receive .5mg of Ativan by mouth every night. The Medication Administration Records (MARs) indicated Ativan was administered to the resident at night beginning 4/12/17 and the medication was included on the Behavior Sheets. During an interview on 6/9/17 at 4:17 p.m., the MDS Coordinator stated that the Unit Managers would give her a copy of the Physician's telephone orders during the facility's daily stand-up meetings or bring them to her during the day so that she could update a resident's care plan with any new orders. She revealed she did not know how, but stated this order of Ativan was missed. 2. Resident #140 was admitted to the facility on 2/15/17 with diagnoses which included: diabetes mellitus, hemiplegia following cerebral infarction affecting right dominant side, and repeated falls. The review of the Physician's Order dated 4/7/17 revealed Resident #140 was to receive .5mg (milligrams) of Ativan every eight hours whenever needed for anxiety/agitation. The Medication Administration Records (MARs) indicated Ativan was administered to the resident beginning 4/8/17 and the medication was included on the Behavior Sheets. Review of the quarterly Minimum Data Set (MDS) dated 4/28/17 indicated Resident #140 was severely, cognitively impaired; had wandering behaviors; and received antianxiety and antidepressant medications.	F 280	report will be automatically generated from the pharmacy orders and will be provided and updated weekly for the facility to reflect any new Ativan activity/changes. In like manner, all residents who are on a fluid restriction will now be reviewed at the weekly Administrative Nursing Quality Initiative meeting to ensure any changes with a fluid restriction are captured and recorded timely on the care plan. The monitoring and oversight of the interventions listed in this plan of correction (MDS audits, QI meeting notes, weekly pharmacy report activity) will be directed by the newly formed MDS/ Care Plan QA Team which consists of the Nursing Home Administrator, Assistant Administrator, Director of Nursing, a Unit Coordinator and at least one MDS department representative. Additional team members can be added or removed as needed and additional interventions can be taken at the discretion of the NHA as needed to ensure ongoing compliance. This QA team met most recently on 7/3/17 to finalize their actions surrounding this plan of correction and will meet to review the weekly MDS audits at least monthly, for a minimum of 1 year. This QA team will report directly to the Executive QA Committee which meets quarterly. The next meeting of the Executive QA Committee is scheduled for 7/19/17. The facility alleges full compliance with this plan of correction as of 7/7/17.	

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F 280	Continued From page 7	F 280		

Review of the Care Plan dated 5/12/17 revealed Resident #140 was at risk for elopement due to her cognition; and was a high risk for falls related to increased weakness and recurrent falls at home.

Resident #140's Care Plan was not updated to include the resident receiving Ativan for anxiety/agitation.

3. Resident #75 was admitted to the facility on 8/22/16 with diagnoses which included: end-stage renal disease, dementia, and congestive heart failure.

The review of the facility's Diet Order and Communication Record dated 12/20/16 revealed Resident #75's diet was changed to no added salt, limited foods high in potassium, and a 1500ml (milliliter) fluid restriction per day.

Review of the quarterly Minimum Data Set (MDS) dated 5/11/17 indicated Resident #75 was severely, cognitively impaired and received dialysis treatments.

Review of the Care Plan dated 5/24/17 revealed Resident #75 was at risk for altered nutrition and significant weight variances related to end-stage renal disease and cardiac disease. Approaches included: Registered Dietician to evaluate and follow up as recommended; and, weigh resident every month or per Physician's orders.

Resident #75's Care Plan was not updated to include his fluid restrictions or his non-compliance with the fluid restriction.

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F 280	Continued From page 8 During an interview on 6/9/17 at 10:00 a.m., The Administrator acknowledged Resident #75's fluid restriction and his non-compliance with his fluid restriction should have been documented in the resident's Care Plan. During an interview on 6/9/17 at 11:47 a.m., The MDS Coordinator stated Resident #75's care plan was not updated to include fluid restrictions and his being non-compliant with the fluid restrictions because dialysis residents were not discussed in the weekly Quality Indicator meetings.	F 280		
F 372 SS=F	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the area surrounding 1 of 1 trash dumpster was free of refuse, debris, and a container of standing water. Findings included: During an observation on 6/5/17 at 11:40 am, accompanied by the Certified Dietary Manager (CDM), there was one garbage dumpster, one cardboard dumpster, and a closed container of used cooking oil surrounded by a wooden fence. The ground within the fenced-in area was littered with wet refuse and debris which included: plastic gloves, plastic cup lids, pieces of plastic, soda cans, pieces of cardboard. There was also a pink, plastic washbasin full of standing water (it had rained earlier that morning). The CDM	F 372	The area/issues surrounding the dumpster which were identified on the morning of 6/5/17 were corrected that same morning and have not been an issue since that time. To address and to prevent future issues in this area, the facility increased the contractual frequency of the “pickups” by the waste management service responsible for the dumpster. Effective 6/9/17, the dumpster is now emptied 3 times each week. The facility also increased the monitoring of cardboard storage and the frequency of cardboard removal. The maintenance director or designee will now make 2 trips per week to dispose of stored cardboard with additional trips made if necessary. The	7/7/17

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F 372	Continued From page 9 acknowledged the area surrounding the dumpster consisted of multiple pieces of wet debris on the ground and stated that the area would be immediately cleared of the debris.	F 372	grease trap storage unit has also been replaced with a newer unit as well. In-services were initiated with the housekeeping and dietary departments to review Administrator expectations for upkeep of the area in question around the dumpster. The housekeeping and dietary departments are the two departments which utilize the dumpster. The in-service will be for 100% of the employees in these departments. Any employee in either of these departments, who has not been in-serviced by 7/7/17, will be in-serviced upon returning to the facility for their next scheduled shift. Future new hires in these departments will also receive this in-service as part of their general orientation process. The Maintenance Director, or designee, will be responsible for logging their checks of the dumpster/refuse area in question. Starting 7/7/17, the dumpster area will be checked at least 4 times per week to ensure proper function, storage and usage. The person completing the inspection of this area will document the results of their monitoring on a QA tool, The External Facility Dumpster QA Monitoring Tool. The facility formed a new QA team, which is being led by the Assistant Administrator, to monitor and ensure ongoing compliance with this plan of correction. The QA team, referred to as the Dumpster Control QA Team, met most recently on 7/3/17 and includes the Administrator, Assistant Administrator, Maintenance	

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F 372	Continued From page 10	F 372	Director, Dietary Manager/Chef and the Housekeeping Supervisor. This QA team will continue to meet at a minimum of monthly for the next year and will document their efforts (including monitoring of this area, in-services and preventative interventions which may be required to ensure ongoing compliance). The documentation from these monthly QA meetings will be reported to the Executive Quarterly QA meeting as well; the next Executive Quarterly QA meeting is scheduled for 7/19/17. The facility alleges full compliance with this plan of correction as of 7/7/17.	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		7/7/17

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F 441	Continued From page 11 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHANNON GRAY REHABILITATION & RECOVERY CENTER	2005 SHANNON GRAY COURT JAMESTOWN, NC 27282

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F 441	Continued From page 12 spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews a) one (NA #1) of two NAs (nurse assistant) observed failed to wash hands between disposing of dirty linen and picking up clean linen and b) two of two NAs (NA #1 and NA #2) observed failed to transport the clean linen without holding it against their bodies while performing linen tasks on 600 hall during one of one observations. Findings included: 1a) Review of the infection control policy revealed that staff are required to wash their hands for ten to fifteen seconds using antimicrobial or non-antimicrobial soap and water after handling items potentially contaminated with blood, body fluids, or secretions. 2b) Review of the infection control policy revealed staff is expected to handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions, in a manner that prevents skin and mucous membrane exposures, contaminating of clothing, and avoids transfer of microorganisms to other residents and environments. 2a) On 06/06/2017 11:41 AM NA #1 was observed walking down the hall with soiled linen bags, wearing no gloves, and disposed of linens in the soiled utility room. After leaving the dirty linen room she walked directly across the hall to	F 441	The employee(s) in question were addressed at the time the facility was made aware of the issue referenced in the 2567. To prevent future compliance issues, the facility created and implemented a 100% in-service with nurses, nursing assistants and medication aides specific to linen handling and hand washing in between handling soiled linen. Any nursing employee who provides care and handles linen who has not been in-serviced by 7/7/17 will be in-serviced when they return to work for their next scheduled shift. Future employees in this department will receive this in-service as part of their orientation training. To ensure ongoing compliance, the facility has increased the frequency of this in-service topic. It has now been added to the scheduled in-service calendar and will be in-serviced at least 2 times each year in addition to the ongoing in-service referenced in this plan of correction. To confirm nursing staff awareness and understanding, the facility's administrative staff will complete random audits/observations of the nursing staff specific to linen handling and hand washing. The observation(s) will begin	

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F 441	Continued From page 13 the clean linen room. During an interview on 06/06/2017 with NA #1 at 11:48 AM, when asked what the facility's policy was for changing linens she stated that she would remove the soiled linens, place them directly into a plastic bag, and put them into the soiled linen room. When asked what she needed to do next she stated she should have washed her hands prior to picking up the clean linen and should have transported the clean linen to the resident's room using the linen cart. She stated she was educated by the facility and knew she was expected to follow the infection control policy in place regarding hand washing and handling linens. 2b) 06/06/2017 11:42 AM NA #1 and NA #2 were observed walking out of clean linen room with clean linen placed directly against their uniforms. NA #1 did not wash hands prior to picking up the clean linen and taking it to the room. When asked if there was a sink in the dirty linen room or the clean linen room she said no. Attempted to interview NA #2, but she had left the facility prior to obtaining the interview. During an interview with the administrator on 06/09/2017 at 6:28 PM, when asked what his expectations were for staff handling linens and hand washing, he stated he expected that staff follow the policies in place for infection control. He also stated that staff was educated on the infection control policies when hired and throughout the year as needed.	F 441	the week of 7/7/17. The facility can/will also conduct return demonstrations at the discretion of the Director of Nursing who is designated by the Administrator to direct this Quality Initiative. The facility expects to complete 100+ random observations/return demonstrations over the next 12 months. Any confirmed non-compliant nursing staff employee will receive additional in-service training and/or disciplinary actions specific to this plan of correction. The monitoring and oversight of the interventions listed in this plan of correction (in-service, observations, return demonstrations) will be directed by a new Quality Assurance Team, The Clean QA Team, which consists of the Nursing Home Administrator, Assistant Administrator, Director of Nursing, a Unit Coordinator and at least one other member of the nursing department. Additional team members can be added or removed as needed and additional interventions can be taken at the discretion of the Director of Nursing to ensure ongoing compliance. The QA team responsible for this plan of correction met initially on 7/3/17 and will continue to meet at least monthly for a minimum of 1 year. This QA team will report to the Executive QA Committee which meets quarterly. The next meeting of the Executive QA Committee is scheduled for 7/19/17. The facility alleges full compliance with this plan of correction as of 7/7/17.	

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F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality	F 520		7/7/17

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F 520	Continued From page 15 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 07/08/2016 certification survey. This was for a recited deficiency in the area of assessment accuracy (F278). The deficiency was cited again on the current recertification survey on June 9, 2017. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings include: This tag is cross referenced to: F278-Assessment Accuracy: Based on record review, staff interviews, and observations, the facility failed to accurately code the Minimum Data Set (MDS) for 1 (Resident #11) of 38 sampled residents regarding active diagnoses and physical range of motion limitations. During the recertification survey of 07/08/16 the facility had failed to include active diagnosis of depression on the facility's comprehensive assessment tool and the minimum data set (MDS) for 1 of 6 sampled residents reviewed for medication and active diagnoses. On the current recertification survey of 06/09/17, the facility failed to accurately document medication and active diagnosis in the comprehensive assessment.	F 520	The facility has corrected areas of deficient practice as identified during the most recent annual survey process. The facility has created new Quality Assurance Teams where needed to both obtain and maintain regulatory compliance of the areas cited specific to the 2567. The facility has increased their Quality Assurance efforts as evidenced by increased Quality Assurance teams and Quality Initiatives (referenced in this document). This increase is intended to not only obtain regulatory compliance but to prevent regulatory non-compliance issues in the areas referenced in this plan of correction. Moving forward, the facility has proactively started the process of assessing and determining the need for additional QA/QI efforts as outlined in Phase 2 of the CMS Requirements of Participation. The facility will complete and document a facility assessment of strengths and weaknesses no later than November 27, 2017. The documented results of this facility assessment, including resulting QAPI efforts, will be communicated to the corporate board managing the facility by the end of November 2017. At that time, the corporate team will review, direct and provide approval of the final version of the facility assessment for 2017. This should	

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F 520	Continued From page 16 An interview was conducted with the Administrator on 06/08/17 at 9:00am. He stated that he was the head of the QAA Committee. Other committee members included the President, Vice President, CEO, the Medical Director, Director of Nursing and departmental managers. The committee meets quarterly, The Administrator reported that management meets with the departments individually regarding their own issues and brings them to the QAA meeting for discussion and planning. He revealed that they recently have reviewed the call bell response time and that many staff and managers have assisted in observing and logging the response time. Additionally, the Administrator stated that he expected all staff be responsible to responded to call bells for resdients.	F 520	occur at a minimum of annually starting with November 2017 unless documented or directed otherwise by the Executive Quarterly QA Team or regulatory entities. The facility alleges compliance with this plan of correction as of 7/7/17.	