PRINTED: 07/21/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345389	B. WING _			06/	21/2017
	ROVIDER OR SUPPLIER	N	•	110	REET ADDRESS, CITY, STATE, ZIP CODE 11 HARTWELL STREET 1. ARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	was conducted June a facility was not in com- requirements of 42 C.	(MDS) 3.0 Focused Survey 20 and 21, 2017. The apliance with applicable F.R. Part 483, Health hts for Long Term Care					
F 278 SS=D	483.20(g)-(j) ASSESS ACCURACY/COORD		F	278			7/13/17
		esments. The assessment ct the resident's status.					
	(h) Coordination A registered nurse mu each assessment with participation of health						
	(i) Certification (1) A registered nurse the assessment is co	e must sign and certify that mpleted.					
	. ,	no completes a portion of the n and certify the accuracy of sessment.					
	(j) Penalty for Falsifica (1) Under Medicare a who willfully and know	nd Medicaid, an individual					
		and false statement in a is subject to a civil money nan \$1,000 for each					
		dividual to certify a material naresident assessment is					(X6) DATE

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.

Electronically Signed

06/30/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345389	B. WING		06/21/2017	
	ROVIDER OR SUPPLIER	IN .		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529	1 00/2 1/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 278	\$5,000 for each asset (2) Clinical disagreer material and false sta This REQUIREMENT by: Based on record rev facility failed to accur (Minimum Data Set) diagnoses for 1 of 12 and failed to accurate fall for 4 of 12 resider #10) reviewed for acc Findings included: 1. Resident #11 was 6/27/15 with diagnose and Cerebral Vascula Review of resident # coded as a quarterly resident #11 had recomedication for 7 of 7 period, and no active support the use of the A review of the reside had documentation of diagnosis of Psychos During an interview w 6/21/17 at 11:25 am, indicated the assessifurther indicated psychem marked under to fithe MDS dated 4/2	respensity or not more than essment. In ent does not constitute a latement. It is not met as evidenced riews and staff interviews, the rately code the MDS to reflect the active residents (Resident #11), ely code the MDS to reflect a late (Resident #3, #5, #2, and curacy of the MDS. It is admitted to the facility on less that included Pneumonia ar Accident. It is MDS dated 4/21/17, assessment, indicated leived antipsychotic days of the look back of diagnosis was marked to be antipsychotic medication. The includent having a current sist. It is the MDS Coordinator on the MDS Coordinator on the MDS Coordinator ment was inaccurate. She chotic disorder should have the Active Diagnosis section 21/17. She stated the emodified and submitted	F 278	The Laurels of Forest Glenn wishes thave this submitted plan of correction stand as its written allegation of compliance. Our alleged date of compliance is July 13, 2017. Preparation and/or execution of this pof correction does not constitute admission to, nor agreement with, eith the existence of or the scope and sevof any of the cited deficiencies, or conclusions set forth in the statement deficiencies. This plan is prepared an executed to ensure continuing complia with regulatory requirements. F 278 483.20 Assessment Accuracy/Coordination/Certified Corrective Action On June 21, 2017, the MDS (Minimum Data Set) assessment for resident number 11 was corrected to reflect the active diagnosis, and for resident number #2, 3, 5 & 10 the MDS was corrected to reflect a fall. The MDS nurses has submitted the corrections	lan ner erity of d/or ance	
		s admitted to the facility on oses that included Muscle ia. and Dementia.		June 21, 2017. Corrective action for those who have to potential to be affected	he	

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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ROVIDER OR SUPPLIER			ST	REET ADDRESS CITY STATE ZIP CODE	1 00/	21/2017
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(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
Continued From pag	e 2	F:	278			
coded as an annual a resident had one fall admission or previous Review of the facility May 2017 had the rehaving fallen twice of and again at 6:30pm Review of a nursing documentation that refrom bed to floor. Now written at 10:00pm of During an interview of 6/21/17 at 11:46am to the resident had falled Coordinator indicated inaccurate and should include both falls on the assessment would review of the statement of the statemen	assessment, indicated the with no injury since is assessment. It's Incident/Accident log for issident's name listed as in 5/1/17. Once at 7:00am is note dated 5/1/17 had read in part: Resident fell or injuries. The note was in 5/1/17. With the MDS Coordinator on the MDS Coordinator stated an twice on 5/1/17. The MDS did have been coded to 5/1/17. She further stated lid be modified and submitted			the survey, the DON (Director of Nurse and the MDS nurse reviewed the last completed assessment for all current residents that were assessed in the pasix months, reviewing for capturing any falls that may have occurred and capturing of all active diagnosis. Additional necessary corrections will be completed by the MDS nurses by July 2017. Systemic changes The MDS nurses will be re-educated be our Corporate Clinical Resource Specialist for accuracy in coding the M Re-education was completed on June 2017. The MDS nurse will attend the discourse of the MDS nurse will attend the	es) st / e 10, y DS. 21, aily	
4/21/16 with diagnos Mellitus and Dement A review of Resident coded as a discharge resident had 2 or mo fall with major injury assessment. Review of the facility May 2017 had the rehaving fallen on 5/11 and as having fallen tear to her left finger. A review of an incide	tes that included Diabetes ia. #5's MDS dated 6/2/17, et assessment revealed the ire falls with no injury and 1 since admission or previous 's Incident/Accident log for esident's name listed as indicated in a skin on the fall of the			Monitoring The Corporate Clinical Resource Specialist will visit the facility twice a month for the next two months and will review all comprehensive MDS . The Director of Nurses, using a QA auditing tool, will review all MDS for those residents that have had new diagnosis and falls for completeness and accuracy weekly for the next 2 months, and then will review random MDS completed weekly for the next month to ensure the MDS are and continue to be accurate.	e g cy,	
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag Review of Resident of coded as an annual resident had one fall admission or previous Review of the facility May 2017 had the rehaving fallen twice of an again at 6:30 pm Review of a nursing documentation that refrom bed to floor. Now written at 10:00 pm of During an interview of 6/21/17 at 11:46 am to the resident had falled Coordinator indicated in accurate and shou include both falls on the assessment wou before the end of the same o	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 Review of Resident #3's MDS dated 5/1/17, coded as an annual assessment, indicated the resident had one fall with no injury since admission or previous assessment. Review of the facility's Incident/Accident log for May 2017 had the resident's name listed as having fallen twice on 5/1/17. Once at 7:00am and again at 6:30pm. Review of a nursing note dated 5/1/17 had documentation that read in part: Resident fell from bed to floor. No injuries. The note was written at 10:00pm on 5/1/17. During an interview with the MDS Coordinator on 6/21/17 at 11:46am the MDS Coordinator stated the resident had fallen twice on 5/1/17. The MDS Coordinator indicated the assessment was inaccurate and should have been coded to include both falls on 5/1/17. She further stated the assessment would be modified and submitted before the end of the day. 3. Resident #5 was admitted to the facility on 4/21/16 with diagnoses that included Diabetes Mellitus and Dementia. A review of Resident #5's MDS dated 6/2/17, coded as a discharge assessment revealed the resident had 2 or more falls with no injury and 1 fall with major injury since admission or previous	ROVIDER OR SUPPLIER RELS OF FOREST GLENN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 Review of Resident #3's MDS dated 5/1/17, coded as an annual assessment, indicated the resident had one fall with no injury since admission or previous assessment. Review of the facility's Incident/Accident log for May 2017 had the resident's name listed as having fallen twice on 5/1/17. Once at 7:00am and again at 6:30pm. Review of a nursing note dated 5/1/17 had documentation that read in part: Resident fell from bed to floor. No injuries. The note was written at 10:00pm on 5/1/17. During an interview with the MDS Coordinator on 6/21/17 at 11:46am the MDS Coordinator stated the resident had fallen twice on 5/1/17. The MDS Coordinator indicated the assessment was inaccurate and should have been coded to include both falls on 5/11/17. She further stated the assessment would be modified and submitted before the end of the day. 3. Resident #5 was admitted to the facility on 4/21/16 with diagnoses that included Diabetes Mellitus and Dementia. A review of Resident #5's MDS dated 6/2/17, coded as a discharge assessment revealed the resident had 2 or more falls with no injury and 1 fall with major injury since admission or previous assessment. Review of the facility's Incident/Accident log for May 2017 had the resident's name listed as having fallen on 5/11/17 with no apparent injury and as having fallen on 5/16/17 resulting in a skin tear to her left finger. A review of an incident/accident report dated 5/16/17 had documentation that the resident had	ROVIDER OR SUPPLIER RELS OF FOREST GLENN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 Review of Resident #3's MDS dated 5/1/17, coded as an annual assessment, indicated the resident had one fall with no injury since admission or previous assessment. Review of the facility's Incident/Accident log for May 2017 had the resident's name listed as having fallen twice on 5/1/17. Once at 7:00am and again at 6:30pm. Review of a nursing note dated 5/1/17 had documentation that read in part: Resident fell from bed to floor. No injuries. The note was written at 10:00pm on 5/1/17. During an interview with the MDS Coordinator on 6/21/17 at 11:46am the MDS Coordinator stated the resident had fallen twice on 5/1/17. The MDS Coordinator indicated the assessment was inaccurate and should have been coded to include both falls on 5/1/17. She further stated the assessment would be modified and submitted before the end of the day. 3. Resident #5 was admitted to the facility on 4/21/16 with diagnoses that included Diabetes Mellitus and Dementia. A review of Resident #5's MDS dated 6/2/17, coded as a discharge assessment revealed the resident had 2 or more falls with no injury and 1 fall with major injury since admission or previous assessment. Review of the facility's Incident/Accident log for May 2017 had the resident's name listed as having fallen on 5/16/17 resulting in a skin tear to her left finger. A review of an incident/accident report dated 5/16/17 had documentation that the resident had	ROWDER OR SUPPLIER RELS OF FOREST GLENN SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY) STATE PROPOSES, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY) STATE PROPOSES OF THE APPROPRIA (EACH ORDERCTION AND STATEMENT OF DEPICIENCIES (EACH DEPICIENCY) STATE PROPOSES OF THE APPROPRIA CONTINUED From page 2 Review of Resident #3's MDS dated 5/1/17, coded as an annual assessment, indicated the resident had one fall with no injury since admission or previous assessment. Review of the facility's Incident/Accident tog for May 2017 had the resident and fallen twice on 5/1/17. Once at 7:00am and again at 6:30pm. Review of a nursing note dated 5/1/17 had documentation that read in part: Resident fell from bed to floor. No injuries. The note was written at 10:00pm on 5/1/17. The MDS Coordinator stated the resident had fallen twice on 5/1/17. The MDS Coordinator stated the assessment would be modified and submitted before the end of the day. 3. Resident #5 was admitted to the facility on 4/21/16 with diagnoses that included Diabetes Mellitus and Dementia. A review of Resident #5's MDS dated 6/2/17, coded as a fischarge assessment revealed the resident had 2 or more falls with no injury and 1 fall with major injury since admission or previous assessment. Review of the facility's incident/Accident tog for May 2017 had the resident had parent injury and as having fallen on 5/11/17 resulting in a skin tear to her left finger. A review of the facility's incident/Accident tog for May 2017 had the residents and the resident and the resident and had been coded to include both falls on 5/16/17 had the resident and submitted before the end of the day. A ferror of Nurses will be re-educated be our Corporate Clinical Resource Specialist will visit the facility twice a month for the next two months and will review all MDS is for those residents that have had new diagnosis and falls for completeness and accura weekly for the next 2 months, and ther will review of an incident/Accident report dated s	A BUILDING 345389 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HARTWELL STREES, CITY, STATE, ZIP CODE 1101 HARTWELL STREES SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 Review of Resident #3's MDS dated 5/1/17, coded as an annual assessment, indicated the resident had one fall with no injury since admission or previous assessment. Review of the facility's incident/Accident log for May 2017 had the resident's name listed as having fallen to for. No injuries. The note was written at 10:00pm on 5/1/17. During an interview with the MDS Coordinator on 6/2/11/7 at 11-46am the MDS Coordinator on 6/2/11/7 at 11-46am the MDS Coordinator stated the resident had fallen twice on 5/1/17. The MDS Coordinator indicated the assessment was inaccurate and should have been coded to include both falls on 5/1/17. She further stated the assessment would be modified and submitted before the end of the day. 3. Resident #5's was admitted to the facility on 4/2/1/16 with diagnoses that included Diabetes Mellitus and Dementia. A review of Resident #3's MDS dated 6/2/17, coded as a discharge assessment revealed the residents had two on 5/16/17 resulting in a skin tear to her left finger. A review of The facility's Incident/Accident log for May 2017 had the resident's name listed as having fallen on 5/11/17 resulting in a skin tear to her left finger. A review of an incident that seried in the facility in a sparent injury and as having fallen on 5/11/17 resulting in a skin tear to her left finger. A review of an incident that the resident shad in the resident shad the resident shad as a discharge assessment revealed the resident shad in the resident's name listed as having fallen on 5/11/17 resulting in a skin tear to her left finger. A review of an incident that the resident shad in the resident shad in the resident shad in the resident shad as a discharge assessment revealed the resident shad in the resident shad in the res

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NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP COI 1101 HARTWELL STREET GARNER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 278	log for June 2017 had as having fallen on 6 A nursing note was we the resident had a fainjuries were appared. Review of a nursing documentation that the hospital for a fracture 6/1/17. During an interview we 6/21/17 at 11:48am to indicated she was awnot notice the resider she fell on 5/16/17. To indicated the assessishould have been cono injury, one fall with with major injury. She assessment would be before the end of the 4. Resident #2 was 1/21/2017 with diagn Stage Renal Disease Hypertension. Review of Resident #2 coded as an admissist the resident had no for previous assessment. Review of the facility May 2017 had the rehaving fallen on 5/23 Review of a nursing for the series was shown to series with the resident had no for previous assessment.	e facility's Incident/Accident d the resident's name listed /1/17 with no apparent injury. written on 6/1/17 which stated II in the bathroom and no not at that time. Incide dated 6/2/17 had the resident was sent to the e sustained from her fall on with the MDS Coordinator on the MDS Coordinator ware of the three falls, but did not sustained a skin tear when the MDS Coordinator ment was inaccurate and ded to include one fall with the minor injury, and one fall the further stated the emodified and submitted day. It is admitted to the facility on coses that included End et alls since admission or the MDS dated 5/24/17, and assessment, indicated alls since admission or the sident's name listed as 1/17. Incident dated 5/23/17 had dead in part: Resident had a	F 27	(Quality Assurance and Perform Improvement) meeting for an recommendations. The DON responsible to follow-up on a recommendation from the Quality additional training to be the Clinical Resource Special indicated.	ny further I will be Iny A committee provided by	

	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345389	B. WING _			06/	21/2017
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN			1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 HARTWELL STREET GARNER, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278 F 520 SS=D	During an interview w 6/21/17 at 12:58pm, the resident had faller Coordinator indicated inaccurate and should include the fall on 5/2 assessment would be before the end of the 5. Resident #10 wa 4/21/17 with diagnose Fibrillation and History Review of Resident # coded as a 30 day PF System) assessment, not fallen since admis assessment. Review of the facility's May 2017 had the reshaving fallen on 5/13/his left lower leg. A nursing note was w documentation that retoday at 7:45pm. Sm During an interview w 6/21/17 at 1:10pm the the assessment was in been coded to include She further stated the modified and submitted 483.75(g)(1)(i)-(iii)(2)(dii)(2)(dii)(dii)(dii)(dii)(dii	ith the MDS Coordinator on the MDS Coordinator stated on on 5/23/17. The MDS the assessment was dishave been coded to 3/17. She further stated the emodified and submitted day. Is admitted to the facility on the structure of falling. It is shart included Atrial by of falling by of falling. It is shart included Atrial by of falling by of fal		520			7/13/17
	(g) Quality assessme						
	(1) A facility must mai	ntain a quality assessment					

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		345389	B. WING			06/21/2017	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF FOREST GLENN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HARTWELL STREET GARNER, NC 27529		30,21,2011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 520	(iii) At least three oth staff, at least one of administrator, owner individual in a leader (g)(2) The quality ass committee must: (i) Meet at least quar coordinate and evaluate identifying issues with assessment and assinecessary; and (ii) Develop and implication to correct identifying issues of info Secretary may not records of such committee.	rsing services; ctor or his/her designee; er members of the facility's who must be the , a board member or other ship role; and sessment and assurance terly and as needed to late activities such as th respect to which quality	F 52	,			
	section. (i) Sanctions. Good for committee to identify deficiencies will not be sanctions. This REQUIREMENT by: Based on record rev			F 520 483.75 Administration			

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NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
TUE I ALIE	RELS OF FOREST GI	ENN		110	01 HARTWELL STREET			
I TE LAUF	KELS OF FOREST GI	ENN		GA	ARNER, NC 27529			
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F 520	Continued From p	age 6	F 5	520				
	·	to maintain implemented			Corrective Action			
		onitor the interventions that the						
		effect January 2017. This was			On June 21, 2017, the MDS (Minimum	1		
		ficiency which was originally			Data Set) assessment for resident			
		2016 during a recertification			number 11 was corrected to reflect the	;		
	survey and was re			active diagnosis, and for resident				
	Data Set (MDS) 3 and 21, 2017. The			number □s #2, 3, 5 & 10 the MDS was corrected to reflect a fall. The MDS				
	assessments. The			nurses has submitted the corrections	วท			
		surveys of record show a			June 21, 2017.			
	pattern of the facil							
	effective Quality Assurance Program.				Corrective action for those who have t	he		
					potential to be affected			
	The Findings Inclu	ıded:			AG 115 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	This tog is speed r	oformed to:			After notification of errors detected du	-		
	This tag is cross re F 278: Accuracy				the survey, the DON (Director of Nurse and the MDS nurse reviewed the last	55)		
		eviews and staff interviews, the			completed assessment for all current			
		curately code the MDS			residents that were assessed in the pa	ast		
		et) to reflect the active			six months, reviewing for capturing an	у		
		12 residents (Resident #11),			falls that may have occurred and			
		rately code the MDS to reflect a			capturing of all active diagnosis.			
		dents (Resident #3, #5, #2, and			Additional necessary corrections will b			
#10) reviewed for accu		accuracy of the MDS.			completed by the MDS nurse by July 2017.	10,		
		us recertification of 12/09/2016,			Systemic changes			
		ed a deficiency at F278 for			The OADI committee will be in coming	. ما		
		ly code the Minimum Data Set ent's dental status for 1 of 3			The QAPI committee will be in-service by the Administrator by June 30, 2017			
		d for dental status (Resident			the procedure for developing and	, 011		
	#13).	a for derital status (Resident			implementing appropriate plans of acti	on		
	- ,				to correct identified quality concerns.			
					Education will include determining the	root		
	An interview with t	the Director of Nursing and the			cause of the identified concern,			
		conducted on 6/21/2017 at			identifying, implementing and monitori			
	_	this interview, the Administrator			the corrective action plan and recogniz	zing		
		ssessments monitoring for			when an action plan may need to be			
	accuracy was ong	oing.			revised. The MDS/Care Plan Nurse ar	ıd		

Facility ID: 923173

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F 520	Continued From pag	e 7	F5	administrative nurses will have re-educated on June 21, 20 Corporate Clinical Resource regarding coding accuracy. The MDS nurses will attend clinical meeting to ensure the new diagnosis are captural appropriately. Monitoring The Corporate Clinical Resespecialist will visit the facility month for the next two mone review all comprehensive Monitoring and tool, will review all MDS residents that have had never new antipsychotic medication and/or UTI s, for complete accuracy, weekly for the new and then will review random completed weekly for the new and then will review random completed weekly for the new and then will review random completed will be reported by the DONe monthly QAPI (Quality Assesper formance Improvement) any further recommendation will be responsible to follow recommendation from the C with additional training to be the Clinical Resource Specindicated.	ource ty twice a auditing for those w diagnosis, ons, falls, ness and ext 2 months, n MDS sext month to d continue to . The results I, to the urance and) meeting for ns. The DON r-up on any QA committee e provided by	;		