STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING _____ B. WING _____	07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

(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 interview the facility failed to code the Minimum Data Set	F 278	F278 Residents #146, 51, 13, and 76 did not	8/16/17

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

Electronically Signed | 08/01/2017

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F 278	Continued From page 1 (MDS) accurately in the areas of hospice and respite (Resident #146), behaviors (Resident #51), medications (Resident #13) and Activities of Daily Living (Resident #76) for 4 of 16 residents reviewed. The findings included: 1. Resident #146 was admitted to the facility on 5/17/17 with diagnoses that included heart disease a chronic obstructive pulmonary disease (COPD). Record review revealed Resident #146 was initially admitted on 5/17/17 for a 5 day respite stay (5/17/17 through 5/21/17). On 5/22/17 Resident #146 converted from respite care to long term care. Resident #146 was also indicated to be on hospice services prior to his admission to the facility on 5/17/17 and he remained on hospice services after his admission to the facility. The admission MDS assessment dated 5/26/17 indicated Resident #146 had moderate cognitive impairment. Section O, the Special Treatments, Procedures, and Programs section, indicated Resident #146 had not received hospice care while not a resident of the facility and within the last 14 days. Section O also indicated Resident #146 had not been on respite care while a resident of the facility and within the last 14 days. An interview was conducted with MDS Nurse #2 on 7/19/17 at 11:20 AM. She verified she completed Section O of Resident #146's admission MDS dated 5/26/17. Section O of Resident #146's MDS dated 5/26/17 that indicated he had not been on hospice care prior to admission and not on respite care after admission was reviewed with MDS Nurse #2.	F 278	Experience any adverse effect related to coding Inaccuracy. All of the residents noted in the Statement of deficiencies had the MDS (Minimum Data Set) Corrected by the MDS coordinator on 7-20-17 Residents with potential. The following was accomplished: 1.The MDS (Minimum Data Set) for residents # 146, 51, 13 and 76 was corrected by the MDS coordinator and re-submitted by 7-20-17. 2.100% of July MDS assessments will be audited for accuracy by 8-16-17 by the Corporate Regional Care Manager and Corporate Regional Nursing Consultant. If any resident assessment is found to have an error in coding, that resident's assessments for May 2017, April 2017 and March 2017 will be audited by the MDS team to ensure accuracy. If any resident assessments' are inaccurate, a modification will be completed by the MDS team and resubmitted when error has been found. Measures put in place: •The interdisciplinary team which includes MDS, Activities, Dietary, Social Worker, Therapy and the business office were educated regarding the assessment process and coding the MDS accurately	

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F 278	Continued From page 2 The medical record documentation that indicated Resident #146 was on hospice care prior to admission and respite care after admission was reviewed with MDS Nurse #2. She revealed she was unaware Resident #146 was admitted on respite care. She additionally revealed she had known he was on hospice services prior to admission and had made an error when she coded the MDS. A follow up interview was conducted with MDS Nurse #2 on 7/19/17 at 12:08 PM. She confirmed Resident #146 was admitted to the facility for respite care on 5/17/17 and the 5/26/17 MDS was inaccurately coded. An interview with the Director of Nursing on 7/20/17 at 10:05 AM indicated she expected the MDS to be coded accurately. 2. Resident #51 was admitted to the facility on 6/5/17 with diagnoses that included dementia with behavioral disturbance and anxiety disorder. The admission MDS dated 6/12/17 indicated Resident #51's cognition was significantly impaired. He was assessed with no behaviors, no wandering, and no rejection of care. Record review of the look back period of the 6/12/17 MDS (6/6/17 through 6/12/17) for Resident #51 indicated the following: - A nursing note dated 6/7/17 indicated Resident #51 had wandering behaviors, refusals of care, combative behaviors, and agitation. - Nursing behavior documentation indicated Resident #51 had wandering behaviors on 5 of 7 days (6/7, 6/8, 6/9, 6/11, and 6/12), yelling/screaming on 2 of 7 days (6/10 and 6/12),	F 278	by the Director of nurses or the Corporate Regional Care Manager on 7-31-17 •The MDS Nurses will be using a pre-assessment tool which includes the following information: Diagnosis, orders, Doctor visits, events for example, falls, skin tears and bruises, progress notes, scanned documents, electronic medical and treatment record, activities of daily living documentation, range of motion, continence record, all items listed on section O, wounds and Pain. This pre-assessment sheet will compare with information keyed on the MDS assessment to ensure accuracy. This tool will be used on a 100% of MDS assessments. • The audit tool will include sections B,C,D,E,Q, F,K,L,G,GG,H,I, J, M,N,O and P. This will ensure that the MDS assessment is coded correctly. Monitoring: Starting on 8-1-17 Corporate Regional Care Manager and Corporate Regional Nurse Consultant will audit 100% of all MDS assessments for one month and 25% of all MDS assessments weekly for 4 months, then 10% of all MDS assessments monthly for 6 months using the Resident assessment accuracy audit tool. The resident assessment accuracy audit tool will ensure accuracy for the following sections B,C,D,E,Q, F,K,L,G,GG,H,I, J, M,N,O and P. If any	

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F 278	Continued From page 3 anxiety on 2 of 7 days (6/11 and 6/12), agitation on 2 of 7 days (6/11 and 6/12), and running into others on 1 of 7 days (6/10). An interview was conducted with the Social Worker (SW) on 7/19/17 at 2:40 PM. She stated she was responsible for completing Section of E, the Behavior Section, of the MDS assessments. Section E of Resident #51's admission MDS dated 6/5/17 that indicated he had no behaviors, no wandering, and no rejection of care was reviewed with the SW. The nursing notes and behavior documentation from the time period of the MDS look back period (6/6/17 through 6/12/17) was reviewed with the SW. She revealed she was unaware of how to find the nursing behavior documentation in the electronic medical records system. She additionally revealed she had not seen the 6/7/17 nursing note. The SW stated the MDS was inaccurately coded for behaviors, wandering, and rejection of care. An interview with the Director of Nursing on 7/20/17 at 10:05 AM indicated she expected the MDS to be coded accurately. 3. Resident #13 was admitted to the facility on 2/17/17 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 6/3/17 indicated that Resident #13 had severe cognitive impairment and he had not received an antianxiety medication during the 7 day assessment period. Resident #13 had a physician's order dated	F 278	coding errors are identified, the MDS will be modified and resubmitted with the accurate coding. The results of any audits will determine the need for further monitoring. QA: All audit information will be brought to monthly QA meeting by the MDS nurses to be analyzed and reviewed by the DON and the QAPI Committee members.	

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5/26/17 for Ativan 0.5 milligrams (mgs) by mouth two times a day for anxiety disorder.

The Medication Administration Records (MARs) for May and June 2017 were reviewed. The MAR revealed that Resident #13 had received Ativan from 5/26 through 6/3/17 on a daily basis.

On 7/19/17 at 11:02 AM, MDS Nurse #1 was interviewed. She reviewed the MAR and the MDS assessment and stated that she missed to code the use of antianxiety medication on the quarterly MDS assessment dated 6/3/17. She added that she would modify the MDS assessment to reflect the use of the antianxiety medication.

On 7/19/17 at 10:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessment to be accurate.

4. Resident #76 was admitted to the facility 6/16/17. Cumulative diagnoses included cerebrovascular accident (CVA) with left sided weakness and muscle weakness.

A fourteen (14) day Minimum Data Set (MDS) dated 6/30/17 indicated Resident #76 was cognitively intact. It was documented that Resident #76 was independent with locomotion on and off the unit.

A review of the ADL (activity of daily living) documentation for the seven day look back period of 6/24/17-6/30/17 revealed that Resident #76 was totally dependent on staff for locomotion on the unit two times on 6/26/17 and off the unit

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F 278	Continued From page 5 6/26/17 and 6/28/17. On 7/19/2017 at 11:00 AM, an interview was conducted with MDS Nurse #2. She stated she reviewed the ADL documentation prior to coding the MDS. MDS Nurse #2 stated she also spoke with the resident and observed Resident #76 wheeling herself in the hallway. She said, if she saw any discrepancies with the ADL documentation and what she observed, she usually would speak to the nursing assistants about the documentation on the ADL sheet. MDS Nurse #2 stated she did not speak with the nursing assistants who coded the locomotion as totally dependent. After reviewing the ADL documentation, MDS Nurse #2 stated locomotion on and off the unit should have been coded as extensive assistance and she must have missed it. On 7/19/17 at 2:46 PM, an interview was conducted with NA #1. She stated she had provided care for Resident #76. NA #1 stated Resident #76 had some weakness on the left side and was not able to move about in her wheelchair independently. She said Resident #76 required extensive assistance of nursing staff with locomotion on and off the unit. On 7/20/17 at 10:04 AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be coded accurately.	F 278		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 322		8/7/17

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F 322	Continued From page 6 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to check the tube placement prior to administering the medications via gastrostomy tube (GT) and failed to administer the medications via gastrostomy tube by gravity for 1 of 1 sampled resident observed (Resident #139). Findings included: Resident #139 was originally admitted to the facility on 5/10/17 and was readmitted on 7/3/17 with multiple diagnoses including congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS) assessment dated 7/11/17 indicated that Resident #139 had moderate cognitive impairment and he had a feeding tube while a resident at the facility.	F 322	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F322 Resident #139 did not experience any adverse effects from not checking gastrostomy tube placement prior to medication administration. Residents with potential The following was accomplished: 1.Resident #139 was assessed for any	

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F 322	Continued From page 7 Resident #139 had a doctor's order dated 6/19/17 to "check tube placement before insertion of formula, medication administration and flushing tube". Resident #139's care plan dated/last updated on 7/11/17 was reviewed. One of the care plan problems was "resident requires tube feeding related to diagnoses of dysphagia." The goal was" resident will not exhibit signs of complications from feeding tube or enteral feeding." The approaches included "check placement and patency of feeding tube before each feeding or medication administration." On 7/19/17 at 8:35 AM, Nurse # 1 was observed to prepare and to administer the medications to Resident #139 via GT. She was observed to administer the medications and water by pushing each medication and water flush into the tube using a syringe. Nurse #1 was not observed to check the tube placement prior to administering the medications nor administer the medications and water flush by gravity. On 7/19/17 at 9:15 AM, Nurse #1 was interviewed. When asked how she checked tube placement she replied, "listen with stethoscope which I didn't do. I forgot." She also stated that she didn't administer the medications by gravity because the GT opening was small. On 7/19/17 at 10:05 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to check tube placement prior to administering medications via GT and to administer medications via GT by gravity.	F 322	adverse reaction, none were noted. 2.No other residents were affected by this alleged deficiency. 3.Nurse #1 was inserviced on Peak Resources Pinelake Policy: Administering Medication through a Gastrostomy Tube on 7-19-17 by the Director of Nursing. 4.Nurse#1 was monitored checking gastrostomy tube placement on 7-19-17 by the Director of Nursing and the action was performed correctly per policy. Measures put in place: 1.All Nursing staff will be in serviced by the SDC(Staff Development Coordinator) on Peak Resources Pinelake Policy: Administering Medication through a Gastrostomy Tube by 8-4-17 2.100% of all nurses that administer medication will be audited by the Director of Nursing or Staff Development Coordinator with the Medication Administration observation Audit Tool giving medication through a Gastrostomy Tube by 8-7-17 3.This audit tool includes the following monitoring. Meds are properly removed from container blister pack, Liquid medication is poured at eye level with palm covering label, Nurse verifies medication and strength with order as transcribed on medication record per facility policy, Resident is observed to ensure medication is swallowed, Adequate and appropriate fluid is offered with	

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F 322	Continued From page 8	F 322	medication, Medication record is signed immediately after administration, Controlled substance record is signed immediately after administration of same, Correct dose is administered, Medication is administered at correct time, Nurse crushes medication according to facility policy and procedures, Eye medication is administered per facility policy and procedure. Infection control technique is acceptable. Medication via gastric tube is administered per facility policy and procedure. Resident is properly positioned. Tube is checked for placement and patency. Tube is flushed before, between, and after medications are administered. Monitoring: 1.The Director Of Nursing and Staff Development Nurse will use the Medication Administration observation Audit Tool to audit 25% of nurses while Administration Medication through a gastrostomy tube weekly for 6 weeks, 10% monthly for 4 months and quarterly thereafter. The results of these audits will determine the need for further monitoring. QA: All audit information will be brought to the monthly QA meeting monthly by the Director of Nursing to be analyzed and reviewed by the QA committee.	
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		8/7/17

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F 332	Continued From page 9 (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 1 of 3 residents observed during medication pass (Resident #139). Findings included: 1a.Resident #139 was originally admitted to the facility on 5/10/17 and was readmitted on 7/3/17 with multiple diagnoses including congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS) assessment dated 7/11/17 indicated that Resident #139 had moderate cognitive impairment. Resident #139 had a doctor's order dated 6/19/17 for Maxitrol (combination of a steroid and antibiotic used to treat eye infection and swelling/redness of the eye) eye ointment-thin layer to left eye twice a day. On 7/19/17 at 8:35 AM, Nurse # 1 was observed to prepare and to administer the Maxitrol eye ointment to Resident #139. She was observed to apply a thin layer of Maxitrol to the resident's right eye.	F 332	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F332 Resident #139 did not experience any adverse effects from this medication error. Residents with potential The following was accomplished: 1.Resident #139 was assessed for any adverse reaction, none were noted. 2.The MD was notified on 7-19-17 by the Director of Nursing 3.No other residents were administered eye drops incorrectly. 4.Nurse #1 was inserviced on Peak Resources Pinelake Policy: Medication Errors and Drug Reactions and Eye Medications Eye Drops and Ointments on 7-19-17 By the Director of Nursing 5.Nurse#1 was monitored By Director of Nursing administering eye drops during her medication administration observation and all medications were given as ordered	

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F 332	Continued From page 10 On 7/19/17 at 9:15 AM, Nurse #1 was interviewed. She acknowledged that she applied the Maxitrol to the right eye instead of the left eye as ordered. She reviewed the physician's orders and verified that the order was for the left eye and not for the right eye. On 7/19/17 at 10:05 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to administer the medications as ordered. b. Resident #139 was originally admitted to the facility on 5/10/17 and was readmitted on 7/3/17 with multiple diagnoses including congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS) assessment dated 7/11/17 indicated that Resident #139 had moderate cognitive impairment. Resident #139 had a doctor's order dated 6/19/17 for Tobramycin ophthalmic (used to treat eye infection) 1 drop to right eye every 2 hours. On 7/19/17 at 8:35 AM, Nurse # 1 was observed to prepare and to administer the Tobramycin ophthalmic to Resident #139. She was observed to instill 2 drops of Tobramycin to the resident's right eye. On 7/19/17 at 9:15 AM, Nurse #1 was interviewed. She acknowledged that she administered 2 drops of Tobramycin to the resident's right eye. She reviewed the physician's	F 332	with no errors on 7-19-17. 6.All medication errors observed during survey were documented and recorded per Peak Resources policy. Measures put in place: 1.All Nursing staff will be in serviced by the SDC(Staff Development Coordinator) on Peak Resources Pinelake Policy: Medication Errors and Drug Reactions and Eye Medications Eye Drops and Ointments by 8-4-17. Any Nursing staff that is unable to attend these inservices by 8-4-17, will be removed from the work schedule until they have attended a one on one inservice with the Staff Development Coordinator. 2.100% of all nurses that administer medication will be audited by the Director of Nursing or Staff Development Coordinator with the Medication Administration observation Audit Tool giving eye drops during their medication pass by 8-7-17. 3.This audit tool includes the following monitoring. Meds are properly removed from container blister pack, Liquid medication is poured at eye level with palm covering label, Nurse verifies medication and strength with order as transcribed on medication record per facility policy, Resident is observed to ensure medication is swallowed, Adequate and appropriate fluid is offered with	

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F 332	Continued From page 11 orders and verified that the order was to administer 1 drop of Tobramycin to the right eye. On 7/19/17 at 10:05 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to administer the medications as ordered.	F 332	medication, Medication record is signed immediately after administration, Controlled substance record is signed immediately after administration of same, Correct dose is administered, Medication is administered at correct time, Nurse crushes medication according to facility policy and procedures, Eye medication is administered per facility policy and procedure. Infection control technique is acceptable. Medication via gastric tube is administered per facility policy and procedure. Resident is properly positioned. Tube is checked for placement and patency. Tube is flushed before, between, and after medications is administered. Monitoring: 1.The Director Of Nursing and Staff Development Nurse will use the Medication Administration observation Audit Tool to audit 25% of nurses while administering eye drops to a resident weekly for 6 weeks, 10% monthly for 4 months and quarterly thereafter. The results of these audits will dictate the need for further monitoring. QA: All audit information will be brought to the monthly QA meeting monthly by the Director of Nursing to be analyzed and reviewed by the QA committee.	
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION	F 356		8/1/17

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F 356	Continued From page 12 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data.	F 356		

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F 356	Continued From page 13 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. (4) Facility data retention requirements. 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 observation, staff interview, and record review, the facility failed to accurately report the resident census and staffing figures on the daily staff posting for 3 of 3 days reviewed (7/17/17 through 7/19/17). The findings included: During the initial tour of the facility on 7/17/17 at 9:15 AM the daily staff posting indicated the census total was blank. The daily staff posting was observed on 7/17/17 at 3:30 PM and the census total was blank. The daily staff posting was observed on 7/18/17 at 10:00 AM and the census total was blank. The daily staff posting was observed on 7/18/17 at 3:00 PM and the census total was blank. The daily staff posting was observed on 7/19/17 at 9:30 AM and the census total was blank. On 7/19/17 at 4:40 PM the daily staff posting from 7/17/17 through 7/19/17 was compared to the daily staff schedule from the same dates. The Registered Nurse (RN) total staffing numbers and RN total hours worked on the daily staff posting was inaccurate based on the daily staff	F 356	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. F356 The corrected nurse staffing information was posted on 7-17-17. The staffing coordinator/nursing will post the nurse staffing information each morning with the correct census and current staffing information. The RN supervisor will update the staffing information as needed. Education will be provided to the staffing coordinator and all nurses by the Staff Development Coordinator/ RN regarding posting the nurse staffing information on a daily basis at the beginning of each shift and updating every shift as needed this will be completed on 8-1-17 An audit tool was developed to monitor posting nurse staffing information to	

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F 356	Continued From page 14 schedules. An interview was conducted with the Facility Scheduler on 7/19/17 at 4:45 PM. She indicated she was responsible for completing the daily staff posting. She stated she had been completing this task every Monday through Friday for about a year. She revealed she filled in the census total at the end of each day. She also revealed she included Minimum Data Set (MDS) Nurse #1, MDS Nurse #2, and the Staff Development Coordinator (SDC) in the RN total staffing numbers and RN total hours worked regardless of whether or not they provided direct care. The Facility Scheduler indicated she was unaware that licensed staff who were not providing direct care were unable to be included in the daily staff posting. She stated she had always included MDS Nurse #1, MDS Nurse #2, and the SDC in the daily staff posting numbers. An interview was conducted with the Director of Nursing (DON) on 7/20/17 at 10:11 AM. She indicated her expectation was for the daily staff posting to be completed accurately and as required.	F 356	include that the nurse staffing information was completed on a daily basis at the beginning of each shift and had current staffing information and census. Audits will be completed for each day during the week by the Ward Clerk weekly for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be brought to QAPI meeting monthly by the Director of Nursing and the results of the audits will be analyzed by the QAPI team monthly.	
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;	F 520		8/1/17

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F 520	Continued From page 15 (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 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility ' s Quality Assessment and Assurance committee (QAA) failed to maintain implemented procedures and monitor these interventions that the committee put into place in July of 2016. This was for one (1) recited deficiency which were originally cited	F 520	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care.	

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F 520	Continued From page 16 on 7/28/16 during the recertification survey, recited on 5/17/17 during a MDS (Minimum Data Set) survey and on the current recertification survey 7/20/17 (F278). The continued failure of the facility during the three federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. F278: Assessment accuracy: Based on record review and staff interview the facility failed to code the Minimum Data Set (MDS) accurately in the areas of hospice and respite (Resident #146), behaviors (Resident #51), medications (Resident #13) and Activities of Daily Living (Resident #76) for 4 of 16 residents reviewed. During the recertification survey of 7/28/16, the facility was cited F278 for failure to accurately code dialysis, cognition and psychotropic medications. On the MDS survey of 5/17/17, the facility was cited F 278 for diagnosis, falls and psychotropic medications. On the current recertification survey of 7/20/17, the facility failed to accurately code the MDS assessment for hospice and respite care, psychotropic medications and ADL's (activity of daily living). On 7/20/17 at 11:02 AM, an interview was conducted with the Administrator. He stated the facility had two previous surveys with F 278 cited. After the survey on 7/26/16, the QAA team put a plan in place with 15% of auditing being done on the MDS. After the survey 5/17/7, the facility did a 100% audit for 2 months for the entire MDS and not just the cited areas. During that time, a lot of	F 520	F520 Corrective actions as described in the Plan of Correction were taken for Resident's # 146, 51, 13 and 76 relative to inaccurate coding on the MDS (Minimum Data Set). Residents with Potential: • Facility QAPI committee members were in-serviced by the Administrator and the Director of Nursing about the Quality Assurance Performance Improvement Committee, program and procedures by 7-31-17. The in-service objective is: •Identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan, as necessary. •The Facility committee members will understand the purpose of the QA program i.e.: to provide a means for a resident(s) care and safety issues to be resolved. •Committee members will understand how the QAPI Committee monitors issues and follows up with unresolved issues that have been identified. Systemic changes: •The QAPI policy was reviewed by the Administrator on 7-31-17, the policy states the facility shall develop, implement and	

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F 520	Continued From page 17 modifications were completed. After that, 10% was audited and there were 1-2 modifications at that time. The Administrator stated the facility was still using the audit tool for ADL ' s, medications, diagnoses, orders, visits, behaviors, falls, wounds and scanned documents. He said there continued to be an ongoing problem and QAA would have to change their plan of action.	F 520	maintain an ongoing program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care and to resolve identified problems. No changes to the policy were necessary. •A tool was developed, titled Self Evaluation. The tool included the following: oDoes the QAPI committee have a current plan in place? oDoes the committee identify who is responsible to oversee the plan/project? oIs the plan working? oIf the plan is not working have changes been put in place to improve? oIs the outcome measurable? oHas the project been successful? oCan the plan be considered resolved? •This tool was developed for a QAPI sub-committee to establish the successfulness of the QAPI projects and make recommendations as necessary. Monitoring: •The Self-Evaluation tool will be completed by the sub-committee at scheduled meetings twice monthly prior to the next scheduled QAPI monthly meeting. •The sub-committee is made up of 4 members of the QAPI general Committee. •Findings of the sub-committee will be addressed at the monthly QAPI meeting when all participants attend. •The Self-Evaluation tool will be utilized for 6 months; ongoing use of the tool will	

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F 520	Continued From page 18	F 520	be determined by the prior 6 months of self-Evaluating the QAPI process. QAPI The results of the self-evaluation tool will be brought to the QAPI meeting monthly by the Administrator and reviewed by the QAPI team. The QAPI Team will make changes if necessary.	