DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				SURVEY PLETED
		345187	B. WING			10/	/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	EIGHTS HEALTH & REH			1	09 FOOTHILLS DRIVE		
GILACE II	LIGHTS HEALING KEN			N	IORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272 SS=D	ASSESSMENTS		F	272			11/16/17
	(b) Comprehensive A	ssessments					
	<ul> <li>must make a compreresident's needs, streepreferences, using thinstrument (RAI) spectassessment must incepreferences, using thinstrument (RAI) spectassessment must incepreferences, using thinstrument (RAI) spectassessment must incepreferences, using the advite pattern (iv) Communication.</li> <li>(i) Identification and (ii) Customary routin (iii) Cognitive pattern (iv) Communication.</li> <li>(v) Communication.</li> <li>(v) Vision.</li> <li>(vi) Mood and behave (vii) Psychological week (viii) Psychological week (viii) Physical fun problems.</li> <li>(ix) Continence.</li> <li>(x) Disease diagnos (xi) Dental and nutrit (xii) Skin Conditions.</li> <li>(xiii) Activity purs (xiv) Medications (xv) Special treatment (xvi) Discharge p (xvii) Documentation (xvi) Documentation (xvi) Discharge p (xvii) Discharge p (xv</li></ul>	lude at least the following: d demographic information he. hs. rior patterns. ell-being. ctioning and structural is and health conditions. ional status. uit. ts and procedures. lanning. ion of summary information hal assessment performed triggered by the completion					
	assessment. The ass include direct observation	ion of participation in sessment process must a and communication with as communication with					
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

**Electronically Signed** 

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.

11/06/2017

PRINTED: 11/09/2017

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/09 FORM APPR OMB NO. 0938	ROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
		345187	B. WING		10/19/201	7
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GRACE H	EIGHTS HEALTH & REH	AB CTR	109 FOOTHILLS DRIVE			
CITACE II	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPL	ETION
F 272	Continued From page non-license on all shifts.	e 1 ed direct care staff members	F 27	2		
	observation and com as well as communic non-licensed direct cashifts. This REQUIREMENT by: Based on record rev facility failed to comp that addressed under contributing factors for urinary incontinence residents (Resident # The findings included 1. Resident #62 was 12/15/10 with current and diabetes. Review of the signific Set (MDS) dated 11/3 was severely cognitive make her needs know revealed Resident #6 medication during the Review of the Care A Summary for Psycho 12/06/17 revealed it w Nurse #1. The CAA s #62 had a diagnoses	or psychotropic drug use and for 3 of 20 sampled t62, #49 and #94). I: admitted to the facility on t diagnoses of depression cant change Minimum Data 30/16 revealed Resident #62 vely impaired and able to		1.MDS nurse that completed M resident #62 is no longer emplo Current MDS Nurse #1 & MDS did not understand that the requ should be included in the CAA a have received training since ME completed as followed; Attende training by Mary Mass on 9/20/ 9/21/17 and attended MDS cert class sponsored by AANAC 10/11/17-10/13/17. A significan correction MDS will be complete 11/8/17 by MDS Nurse #1 or MI #2. The Director of Nursing or desig complete an MDS audit for MDS accuracy, completion date and summary on a random sample residents monthly for 3 months quarterly using the MDS Audit F verify compliance for 3 quarters The Director of Nursing is the p responsible for implementing th acceptable plan of correction ar ensure audit results and correct	yyed. Nurse #2 Jired detail area and DS was d MDS 17 & ification t ed by DS Nurse gnee will S CAA of 10 and then Form to a. erson e hd shall	
	Review of the Care A Summary for Psycho 12/06/17 revealed it v Nurse #1. The CAA s #62 had a diagnoses antidepressant medic and medications were and potential side eff	rea Assessment (CAA) tropic Medication Use dated was completed by MDS summary indicated Resident of depression and took an		residents monthly for 3 months quarterly using the MDS Audit F verify compliance for 3 quarters The Director of Nursing is the p responsible for implementing th acceptable plan of correction ar	and then Form to erson e nd shall tive actions Quality vement	

Facility ID: 943407

If continuation sheet Page 2 of 9

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345187	B. WING		10/19/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	
GRACE HEIGHTS HEALTH & REHAB CTR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				109 FOOTHILLS DRIVE MORGANTON, NC 28655	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO
F 272	Continued From page	e 2	F 27	2	
	activities. The CAA so there had been any a attempted dose reduc	ctions. The CAA did not state		ensure corrective actions are achi and maintained.	eved
	received psychiatric s An interview conduct with MDS Nurse #1 m MDS for six years. SI Certified and has also MDS class. She repo MDS summary it was stated she was not an include how the MDS the resident's day to o 2. Resident # 49 was 12/21/12 with current non-Alzheimer's dem depression. Review of the annual	ed on 10/19/17 at 2:39 PM evealed she has been doing ne stated she is MDS to attended the State-offered rted when she wrote an a recap of the MDS. She ware the summary should c Care Area Trigger affected day life and activities. admitted to the facility on diagnoses of		<ul> <li>2.For Resident #49, the MDS nurse not understand that the required d should be included in the CAA are have received training since MDS completed as followed; Attended I training by Mary Mass on 9/20/17 9/21/17 and attended MDS certific class sponsored by AANAC 10/11/17-10/13/17. A significant correction MDS will be completed 11/8/17 by MDS Nurse #1 or MDS #2.</li> <li>The Director of Nursing or designed complete an MDS audit for MDS accuracy, completion date and CA summary on a random sample of residents monthly for 3 months and quarterly using the MDS Audit For</li> </ul>	etail a and was MDS & cation by Nurse ee will AA 10 d then
	her needs known. Th Resident #49 receive and antidepressant m assessment period. Review of the Care A Summary for Psycho 08/11/17 revealed it w Nurse #1. The CAA s #49 had a diagnoses with psychosis (schiz psychotropic medicat	y impaired but could make e MDS further revealed d antipsychotic, antianxiety nedications during the 7 day rea Assessment (CAA) tropic Medication Use dated vas completed by MDS summary indicated Resident of depression; dementia ophrenia) and anxiety. Takes ions which are monitored for tential side effects. The CAA		verify compliance for 3 quarters. The Director of Nursing is the pers responsible for implementing the acceptable plan of correction and ensure audit results and corrective taken are presented at monthly Qu Assurance Performance Improver (QAPI) meetings. The QAPI team ensure corrective actions are achi and maintained.	shall e actions uality nent shall eved

Facility ID: 943407

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		MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED		
		345187	B. WING		10/19/2017		
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
GRACE HEIGHTS HEALTH & REHAB CTR				109 FOOTHILLS DRIVE MORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO		
F 272		day to day function and	F 27	should be included in the CAA are			
	there had been any a attempted dose reduc	ctions. The CAA did not state ssary or if Resident #49 had		have received training since MDS completed. Attended MDS training Mary Mass on 9/20/17 & 9/21/17 attended MDS certification class sponsored by AANAC 10/11/17-10 A significant correction MDS will b	g by and D/13/17.		
	with MDS Nurse #1 r MDS for six years. Sh Certified and has also MDS class. She repo	o attended the State-offered rted when she wrote an		completed. The Director of Nursing or design complete an MDS audit for MDS accuracy, completion date and C/	AA		
	stated she was not av	a recap of the MDS. She ware the summary should Care Area Trigger affected day life and activities.		summary on a random sample of residents monthly for 3 months ar quarterly using the MDS Audit For verify compliance for 3 quarters. The Director of Nursing is the per-	nd then rm to		
	06/02/17 with diagnos dementia, arthritis, ar			responsible for implementing the acceptable plan of correction and ensure audit results and corrective taken are presented at monthly Q	e actions uality		
	(MDS) dated 06/09/1 was cognitively intact	sion Minimum Data Set 7 revealed Resident #94 The MDS further revealed casionally incontinent of		Assurance Performance Improver (QAPI) meetings. The QAPI team ensure corrective actions are achi and maintained.	shall		
	06/15/17 for urinary in by MDS Nurse #1. Th Resident #94 was inc bowel and was on a t reported incontinence CAA did not analyze	rea Assessment dated ncontinence was completed ne CAA Summary indicated continent of bladder and colleting program. Resident e was a long time issue. The how the urinary incontinence day to day function and					
		ed on 10/19/17 at 2:39 PM evealed she has been doing					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '	NG	COMPLETED
		345187	B. WING _		10/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE
GRACE H	EIGHTS HEALTH & REH	AB CTR		109 FOOTHILLS DRIVE MORGANTON, NC 28655	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
F 272	Continued From page	24	F 2	272	
	MDS for six years. Sh				
		attended the State-offered			
		rted when she wrote an			
	MDS summary it was a recap of the MDS. She stated she was not aware the summary should include how the MDS Trigger affected the resident's day to day life and activities.				
F 273			F 2	273	11/16/17
SS=D	ASSESSMENT 14 D	AYS AFTER ADMIT			
	(b)(2) When required	Subject to the timeframes			
		I3(b) of this chapter, a facility			
		rehensive assessment of a			
		e with the timeframes			
	this section. The time	hs (b)(2)(i) through (iii) of			
		hapter do not apply to CAHs.			
		days after admission,			
	-	ns in which there is no the resident's physical or			
		r purposes of this section,			
		a return to the facility			
		absence for hospitalization			
	or therapeutic leave.)				
		is not met as evidenced			
	by: Based on record revi	iew and staff interviews, the		Resident #189 was a ne	ew admission that
	facility failed to compl			was listed on the MDS li	
	comprehensive asses	ssment within the required		but not moved to the MD	
		1 of 20 sampled residents		for other disciplines. An	
	· ·	on of the Minimum Data Set sment (Resident #94).		care plan was completed Nurse #1 & MDS Nurse	
		$\frac{1}{2}$		facility for MDS training a	
	The findings included	:		MDS had not been comp returned. All disciplines	pleted when they
		dmitted to the facility on		the MDS needed comple	etion on 10/16/17.
	09/25/17 with diagnos	ses of hypertension and		The MDS was complete	d and transmitted

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Facility ID: 943407

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(¥2) MI II TIDI	LE CONSTRUCTION	(V2)	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	MPLETED
		345187	B. WING		1	0/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	PCODE	
GRACE HEIGHTS HEALTH & REHAB CTR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			REHAB CTR 109 FOOTHILLS DRIVE MORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 273	Continued From page	e 5	F 27	3		
	Alzheimer's disease.			on 10/20/17. No other reading affected.	sidents were	
	assessment reference of the MDS revealed that had not been con 2:40 PM. In addition to for the triggered area An interview conduct with MDS Nurse for six aware Resident #189 been completed within admission. She state her know when MDS she placed Resident list due to being admi source, overlooking h stated she had sent a that had not complete complete them today An interview conduct Nursing on 10/19/17	ed on 10/19/17 at 2:39 PM evealed she had worked as a years. She stated she was 's admission MDS had not n 14 days after her d she made a list that lets assessmwnts were due and #189 on the bottom of the itted under a different payer her MDS due date. She a reminder today to all staff ed their sections to please ed with the Director of at 3:50 PM revealed it was I MDS to be completed		The IDT including nursing activities, therapy, and di in-serviced on 11/6/17 by regarding RAI guidelines admission MDS assessm is required 14 days from MDS Nurse #1 & MDS N completed online training utilize MDS analyzing so on approaching completion The Director of Nursing of complete an MDS audit f accuracy, completion dat summary on a random sa residents monthly for 3 m quarterly using the MDS verify compliance for 3 qu The Director of Nursing is responsible for implement acceptable plan of correct ensure audit results and taken are presented at m Assurance Performance (QAPI) meetings. The Q/ ensure corrective actions	ietary were MDS Nurse #1 stating nent completion admission date. Iurse #2 g on 11/2/17 to ftware for alerts on dates. or designee will for MDS te and CAA ample of 10 nonths and then Audit Form to uarters. s the person nting the ction and shall corrective actions nonthly Quality Improvement API team shall	
F 278 SS=D		SMENT DINATION/CERTIFIED	F 27	and maintained. 8		11/16/17
		ssments. The assessment ct the resident's status.				
	(h) Coordination					
		ust conduct or coordinate				

Facility ID: 943407

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CENTER STATEMENT C	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			FORM OMB NC (X3) DATE	D: 11/09/2017 1 APPROVED 0. 0938-0391 SURVEY LETED
		345187	B. WING			10/	19/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GRACE H	EIGHTS HEALTH & REH	ABCTR					
				IV	IORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	the assessment is con (2) Each individual whassessment must sign that portion of the ass (j) Penalty for Falsifica (1) Under Medicare a who willfully and know (i) Certifies a material resident assessment penalty of not more thassessment; or (ii) Causes another in and false statement in subject to a civil mone \$5,000 for each asses (2) Clinical disagreem material and false sta This REQUIREMENT by: Based on record revi facility failed to accura Data Set (MDS) for da	<ul> <li>a the appropriate professionals.</li> <li>a must sign and certify that mpleted.</li> <li>ano completes a portion of the n and certify the accuracy of sessment.</li> <li>ation nd Medicaid, an individual vingly-</li> <li>and false statement in a is subject to a civil money han \$1,000 for each</li> <li>dividual to certify a material n a resident assessment is ey penalty or not more than ssment.</li> <li>bent does not constitute a tement.</li> <li>is not met as evidenced</li> <li>ews and staff interviews, the ately code the Minimum ental status (Resident #92) ce (Resident #94) for 2 of 20</li> </ul>	F	278	1. For resident #92, the MDS nurse wa not aware that she could check all that apply in LO200 and only checked unab to examine due to resident refusing examination during the look back perio A dental consult note on 4/13/17 could have been used to confirm resident wa	le d.	
	-	admitted to the facility on			edentulous.	5	

Event ID: JPAF11

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		MEDICAID SERVICES			OMB NO. 0938	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		345187	B. WING		10/19/201	17
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
GRACE H	EIGHTS HEALTH & REH	AB CTR		109 FOOTHILLS DRIVE MORGANTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMP TO THE APPROPRIATE D	X5) PLETIC ATE
F 278	Continued From page	e 7	F 27	8		
	09/16/14 with diagnost Review of Resident # revealed a dental not indicated she was ed The annual MDS date #92 with severe impa oral/dental status sec as "unable to examin An interview conduct with MDS Nurse #1 re on the MDS by inform to the resident or their examining the resider explained she did not information listed on the might not indicate if the such as pain, trouble gum. MDS Nurse #1 was edentulous and a should have been con- edentulous. An interview was con PM with the Director was her expectation for coded.	ses that included dementia. 492's medical record te dated 04/13/17 which entulous (having no teeth). ed 04/27/17 coded Resident airment in cognition. The ction of the MDS was coded e." ed on 10/19/17 at 2:40 PM evealed she coded Section L nation gathered from talking ir family member and nt's mouth. MDS Nurse #1		MDS nurse that comple resident #62 is no longe Current MDS Nurse #1 have received training s completed as followed; training by Mary Mass of 9/21/17 and attended M class sponsored by AAN 10/11/17-10/13/17. A si correction MDS will be of 11/8/17 by MDS Nurse a #2. The Director of Nursing complete an MDS audit accuracy, completion da summary on a random s residents monthly for 3 quarterly using the MDS verify compliance for 3 of The Director of Nursing responsible for impleme acceptable plan of correc ensure audit results and taken are presented at n Assurance Performance (QAPI) meetings. The O ensure corrective action and maintained.	er employed. & MDS Nurse #2 ince MDS was Attended MDS on 9/20/17 & DS certification VAC gnificant completed by #1 or MDS Nurse or designee will for MDS ate and CAA sample of 10 months and then S Audit Form to quarters. is the person enting the ection and shall d corrective actions monthly Quality e Improvement DAPI team shall	
	dementia, hemiplegia Review of the admiss (MDS) dated 06/09/1 was cognitively intact	ses of non-Alzheimer's a and depression. sion Minimum Data Set 7 revealed Resident #94 t. The MDS further revealed casionally incontinent of		2.For Resident #94 a clo made with the incorrect Nurse #1 has been edu each section after comp moving to the next secti	box marked. MDS cated to review letion before	

Event ID: JPAF11

Facility ID: 943407

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345187			10/19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1
GRACE HEIGHTS HEALTH & REHAB CTR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				109 FOOTHILLS DRIVE MORGANTON, NC 28655	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 278	Review of the bowel 06/02/17 through 06/ was incontinent of bla continence was chec An interview conduct with MDS Nurse #1 r H on the MDS for bla and bladder reports. bowel and bladder re 06/09/17 with the sur #94 was incontinent of stated she should ha incontinent of bladde An interview conduct with the Director of N	and bladder reports from 03/17 revealed Resident #94 adder each time bladder ked. ed on 10/19/17 at 2:39 PM evealed she coded Section dder by reviewing the bowel MDS Nurse #1 reviewed the ports from 06/02/17 through veyor and agreed Resident of bladder on those days and ve been coded as always	F 278	<ul> <li>MDS Nurse #1 &amp; MDS Nurse #2 har received training since MDS was completed as followed; Attended MI training by Mary Mass on 9/20/17 &amp; 9/21/17 and attended MDS certificate class sponsored by AANAC 10/11/17-10/13/17. A significant correction MDS will be completed by 11/8/17 by MDS Nurse #1 or MDS N #2.</li> <li>The DON or designee will complete audit for MDS accuracy, completion and CAA summary on a random sar of 10 residents monthly for 3 months then quarterly using the MDS Audit to verify compliance. The QAPI com will monitor this process for effective quarterly.</li> <li>Preparation and/or execution of this of correction does not constitute admissions or agreement by the proof the truth of the facts alleged or conclusions set forth in the statement the deficiencies. The Plan of Correct prepared in/or executed solely becat the provision of the Federal and Star require it.</li> </ul>	DS tion y Jurse MDS date mple s and Form mittee eness plan plan plan tof tion is use

Facility ID: 943407

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