STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(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 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a comprehensive significant change assessment on a resident after a fall for 1 of 15 residents reviewed for comprehensive assessments (Resident #20). Findings included: Resident #20 was admitted to the facility on 8/26/2017 with diagnoses to include heart failure, weakness and vascular dementia. The quarterly Minimum Data Set (MDS) was completed on 11/26/2017 and assessed the resident to be severely cognitively impaired and required one-person assistance with transfers, mobility, as well as the use of a rollator walker for mobility, one-person extensive assistance with toileting, hygiene and bathing activities. A review of the resident ' s chart revealed the resident experienced a fall on 12/25/2017, resulting in a fracture of her right humerus bone	F 637	F 637 Comprehensive Assessment After Significant Change The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is on or before March 15, 2018. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. Corrective Action Minimum Date Set (MDS) Coordinator corrected Resident #20□s Quarterly Assessment originally completed on 1/8/2018 to accurately code it as a	3/15/18

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

Electronically Signed | 03/13/2018

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F 637	Continued From page 1 (right upper arm). The quarterly MDS completed on 1/8/2018 assessed her to require one-person extensive assistance with transfers, locomotion on and off the unit, dressing and hygiene, and two-person extensive assistance with toileting and total assistance of one person for bathing. The resident was no longer able to ambulate with the rollator due to the fracture of her upper right arm. An interview was conducted with Certified Occupational Therapist Assistant (COTA) on 2/22/2018 at 1:29 PM. The COTA reported the resident had been on therapy since her admission on 8/26/2017 and she had walked with a rolling walker prior to her fall on 12/25/2017. The COTA further reported the resident was unable to ambulate because she was non-weightbearing on her right arm and was unable to use the rolling walker without the use of the right arm. The COTA concluded that the resident was on the caseload for therapy and they continued to work with her to maintain her strength. An interview was conducted with the MDS coordinator on 2/22/2018 at 1:40 PM. She reported the quarterly MDS with the date 1/8/2018 was triggered by therapy and she was not aware a comprehensive change of status assessment should have been completed after the fall. The Director of Nurses was interviewed on 2/22/2018 at 1:58 PM. She reported it was her expectation that comprehensive assessments after a significant change of status were completed when required.	F 637	Significant Change. Corrective Action for those having the potential to be affected MDS Coordinator reviewed all other current long-term care residents most recent quarterly or annual MDS assessment to ensure all other status assessments were coded correctly. No other issues were identified. Systematic Changes Laurel Health Care Company's Regional Clinical Resource Specialist will re-educate facility MDS Coordinator/MDS Staff, Director of Nursing, and Assistant Director of Nursing on proper coding of status assessments on MDSs. Clinical interdisciplinary team, led by Director of Nursing, will review all physician orders 5 times per week in order to identify any significant changes in resident condition. Director of Nursing and MDS Coordinator will initiate Significant Change assessments as identified. Monitoring Director of Nursing, Assistant Director of Nursing, and/or Regional Clinical Resource Specialist will utilize a Quality Assurance monitoring tool to review all quarterly and annual assessments weekly x 4 weeks. For ongoing compliance, Director of Nursing, Assistant Director of Nursing, and/or Regional Clinical Resource Specialist will utilize the Quality Assurance monitoring tool to review 5 assessments monthly x 3 months to ensure proper assessments are coded	

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F 637	Continued From page 2 The Administrator was interviewed on 2/22/2018 at 2:16 PM. He reported it was his expectation that MDS assessments were completed as required.	F 637	and immediately notify Administrator and MDS Coordinator of any errors. Continued compliance will be monitored through the facility□s Quality Assurance and Process Improvement Plan and Quality Assurance Program for 4 months. Additional education and monitoring will be initiated for any individual concerns.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 15 residents. Resident #112 was coded inaccurately as to not having had a fall, Resident #32 was coded inaccurately as to having received an anticoagulant, and Resident #7 was coded inaccurately as to not receiving hospice services. Findings included: 1. Resident #112 was admitted on 2/9/18 whose cumulative diagnoses included: Heart Failure, abnormal heart rhythm, history of falling, generalized weakness, and dementia. Review of Resident #112's most recent Minimum Data Set (MDS) assessment revealed a comprehensive admission assessment with an Assessment Reference Date (ARD) of 2/16/18. The resident was coded as having had no falls since admission.	F 641	F 641 Accuracy of Assessments The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is on or before March 15, 2018. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. Corrective Action Minimum Data Set (MDS)Coordinator corrected respective MDS Assessments to accurately capture the fall for Resident #112, to remove the anticoagulant coding for Resident #32, and to accurately	3/15/18

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F 641	Continued From page 3 A review of Resident #112's care plan, which was initiated on 2/10/18, revealed the resident was care planned for being at risk for falls related to unsteady gait, impaired mobility, and a history of falls. The resident had an intervention with an initiation date of 2/12/18 for non-slip material being placed on the seat of the resident's wheelchair A review of the resident's electronic medical record (EMR) for Resident #112 revealed a nurses' note dated 2/10/18 and timed 3:41 PM revealed the resident was documented as sitting at the nurses' station on 2/10/18 at approximately 2:20 PM. The note stated the resident the resident leaned forward and slid out of her wheelchair onto her buttocks. The intervention listed was the addition of non-slip material to the seat of the resident's wheelchair. An interview conducted with Nurse #1 on 2/22/18 at 10:51 AM revealed he was the nurse for Resident #112. The nurse stated the resident had a fall on 2/10/18. The nurse stated he had documented the fall in the resident's nurses' notes. The nurse further stated the intervention put into place after the fall was the addition of non-slip material being placed on the seat of the resident's wheelchair. During an interview conducted with the Director of Nursing (DON) on2/22/18 at 1:45 PM she stated Resident #112 had a fall on 2/10/18 at approximately 2:20 PM. The DON stated the fall was witnessed and documented by Nurse #1. An interview was conducted with the Registered Nurse MDS Coordinator on 2/22/18 at 2:01 PM. The MDS Coordinator stated she had missed	F 641	capture the Hospice services being provided for Resident #7. Corrective Action for those having the potential to be affected Director of Nursing and MDS Coordinator reviewed fall log for the past three months to ensure all residents falls were accurately captured on respective MDS assessments. MDS Coordinator reviewed all residents that were currently prescribed aspirin to ensure accurate coding on respective MDS assessments. MDS Coordinator reviewed all residents currently receiving Hospice services within the last 6 months to ensure Hospice was accurately captured on all MDS assessments. No other issues were identified. Systematic Changes Laurel Health Care Company□s Regional Clinical Resource Specialist will re-educate facility MDS Coordinator/MDS Staff, Director of Nursing, and Assistant Director of Nursing on the accuracy of assessments in order to ensure resident status is correctly coded on each MDS assessment. Focused direction will be provided regarding fall coding, anticoagulant coding, and Hospice services coding. Monitoring Director of Nursing, Assistant Director of Nursing, and/or Regional Clinical Resource Specialist will utilize a Quality Assurance monitoring tool to review all 5 assessments per week x 6 weeks. For	

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F 641	Continued From page 4 coding the resident's fall which had taken place on 2/10/18 on the admission assessment with an ARD of 2/16/18. During an interview with the DON on 2/21/18 at 2:44 PM she stated it was her expectation for the MDS assessments to be coded correctly. During an interview with the Administrator on 2/22/18 at 2:26 PM he stated it was his expectation for the MDS assessments to be coded correctly. 2. Resident #32 was originally admitted on 10/1/15 and most recently readmitted on 1/12/18. The resident's cumulative diagnoses included: high blood pressure, slow heartbeat, heart murmur, and high cholesterol. Review of Resident #32's most recent MDS assessment revealed a quarterly assessment with an ARD of 1/19/18. The resident was coded as having had received an anticoagulant (blood thinner) medication each day of the seven day assessment period. A review of the Medication Administration Record (MAR) for Resident #32 from the assessment period of 1/13/18 through 1/19/18 revealed no record of the resident having received an anticoagulant medication. An interview was conducted with the MDS Coordinator on 2/21/18 at 11:35. During the interview the MDS Coordinator stated she had coded Resident #32 as having received an anticoagulant due to her having received a daily dose of a 325 milligram (mg) aspirin. Upon reviewing the Resident Assessment Instrument (RAI) manual, a guide for completing the MDS	F 641	ongoing compliance, Director of Nursing, Assistant Director of Nursing, and/or Regional Clinical Resource Specialist will utilize the Quality Assurance monitoring tool to review 2 assessments monthly x 3 months to ensure accuracy of assessments and immediately notify Administrator and MDS Coordinator of any errors. Continued compliance will be monitored through the facility□s Quality Assurance and Process Improvement Plan and Quality Assurance Program for 4 months. Additional education and monitoring will be initiated for any individual concerns.	

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F 641	Continued From page 5	F 641		

assessments, the MDS Coordinator stated she had coded the MDS assessment incorrectly due to aspirin not being classified as an anticoagulant per the manual.

During an interview with the DON on 2/21/18 at 2:44 PM she stated it was her expectation for the MDS assessments to be coded correctly.

During an interview with the Administrator on 2/22/18 at 2:26 PM he stated it was his expectation for the MDS assessments to be coded correctly.

3. Resident #7 was admitted to the facility on 2/15/2017 and readmitted on 6/21/2017 with diagnoses to include non-ST elevation MI, end-stage renal failure and gait abnormality.

A review of the resident ' s chart revealed a hospice admission form dated 7/10/2017.

The significant change MDS dated 7/10/2017 was coded "no" for section O 0100K hospice services while a resident.

The quarterly MDS dated 12/27/2017 was coded "no" for section O 0100K hospice services while a resident.

The MDS coordinator was interviewed on 2/21/2018 at 2:33 PM. She reported she completed the significant change MDS dated 7/10/2017 because the resident was admitted to hospice on that date. The MDS coordinator further reported she had completed the MDS quarterly assessment of 12/27/2017. The MDS coordinator reported that it was a coding oversight and a correction would be completed.

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F 641	Continued From page 6 The Director of Nursing was interviewed on 2/21/2018 at 2:44 PM. She reported it was her expectation that MDS assessments are coded correctly. The Administrator was interviewed on 2/22/2018 at 2:26 PM. He reported it was his expectation that MDS assessments are coded correctly.	F 641		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(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. §483.35(g)(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. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		3/15/18

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F 732	Continued From page 7 written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(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 record reviews and staff interviews, the facility failed to correctly report the skilled nursing home census for 97 out of 97 daily staffing sheets reviewed, failed to correctly report hours worked for licensed staff for 61 out of 97 daily staffing sheets reviewed, failed to correctly report hours worked for unlicensed staff 34 out of 97 daily staffing sheets reviewed, and failed to distinguish between skilled nursing home staff hours and assisted living staff hours for 97 out of 97 daily staffing sheets reviewed. Findings included: 1. The Administrator reported the census as 72 upon entrance to the facility on 2/19/2018 at 10:36 AM, with 56 residents in skilled care and 16 residents in the assisted living section of the facility. The staffing reporting sheet for 2/19/2018 was in the front lobby. Census listed for 2/19/2018 at 11:23 AM was 72. The staffing reporting sheet for 2/20/2018 was observed on 2/20/2018 at 8:13 AM, and the posted census was 71.	F 732	F 732 Posted Nursing Staffing The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is on or before March 15, 2018. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. Corrective Action Administrator created new daily staffing sheet with facility name, current date, total number and actual hours worked by licensed and unlicensed staff directly responsible for resident care per shift, registered nurses, licensed practical nurses, certified nursing aides, and resident census. Statement added to new daily staffing sheet that reads Census and hours are reported for beds licensed as Skilled Nursing Facility (Rooms 101-404).	

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F 732	Continued From page 8 A review of the daily staff posting from November 19, 2017 through February 19, 2018 was conducted and revealed the total census listed for all staffing sheets included the assisted living residents. The Administrator and Director of Nursing (DON) were interviewed on 2/20/2018 at 4:11 PM. The DON explained the census was completed by a night shift nurse and updated during the day. The Administrator added that the daily staff reporting sheet had not excluded assisted living resident census in the past. The Administrator was interviewed on 2/22/2018 at 2:16 PM and he reported his expectations for the daily staffing sheets were to have the skilled nursing census accurately reported and assisted living census to be excluded from the skilled nursing census. 2. A review of the daily staff posting from November 19, 2017 through February 19, 2018 was conducted and revealed the licensed staff reporting was including the DON and Assistant DON (ADON) in the totals for direct resident care hours provided. An interview was conducted with the DON on 2/20/2018 and she reported that she did not know the DON and ADON should not be included in the totals for direct resident care hours. The Administrator was interviewed at the same time and he reported it was his expectation the care hours were accurately reported. 3. A review of the daily staff posting from November 19, 2017 through February 19, 2018	F 732	Only includes staff directly responsible for resident care each shift, and excludes certain other nursing positions within facility. Corrective Action for those having the potential to be affected Director of Nursing (DON), Assistant Director of Nursing, and Nursing Staff Employees will complete staffing sheets daily with updates made at the start of each shift and as needed. Systematic Changes Administrator and Director of Nursing will re-educate all licensed nursing staff with regard to information to be included in daily posted nurse staffing information as required by F732 which includes facility name, current date, total number and actual hours worked by licensed and unlicensed staff directly responsible for resident care per shift, registered nurses, licensed practical nurses, certified nursing aides, and resident census. Only census and labor hours for skilled nursing beds will be reported. All Adult Care Home information will be excluded from the postings. Monitoring Director of Nursing, Assistant Director of Nursing, and/or other Nurse Managers will utilize a Quality Assurance monitoring tool to review daily staffing sheets daily x 2 weeks, and weekly x 3 months to ensure accuracy with regard to number of staff, hours worked, and census reported. Any discrepancies will be immediately reported	

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F 732	Continued From page 9 was conducted and revealed the unlicensed staff reporting was calculated incorrectly. An interview was conducted with the DON on 2/20/2018 and she reported that she thought the hours had not included orienting staff on some days and miscalculation on other days. The Administrator was interviewed at the same time and he reported it was his expectation the care hours were accurately reported. 4. A review of the daily staff posting from November 19, 2017 through February 19, 2018 was conducted and revealed the care hours included hours provided for the assisted living residents. An interview was conducted with the DON on 2/20/2018 and she reported that she was not aware the hours provided for the assisted living resident should not be included on the daily staff posting. The Administrator was interviewed at the same time and he reported it was his expectation the care hours were accurately reported.	F 732	to Administrator. Continued compliance will be monitored through the facility□s Quality Assurance and Process Improvement Plan and Quality Assurance Program for 3 months. Additional education and monitoring will be initiated for any identified concerns.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		3/15/18

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F 812	Continued From page 10 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to date and label multiple items discovered in the milk cooler, the stock room, the walk in cooler, and the walk in freezer during one of two observations. The facility failed to maintain clean and fresh water in 5 of 5 bays of the steam table. Findings Included: 1. An observation of the kitchen conducted on 2/19/18 at 10:07 AM revealed the following undated and unlabeled items: a. An undated and unlabeled clear plastic container of liquid was discovered in the milk cooler. The Dietary Manager (DM) reported it was nectar thickened tea. b. An opened and undated bag of elbow macaroni and an opened undated bag of egg noodles were both discovered in the stock room. c. An undated and unlabeled plastic bag containing six hard boiled eggs and a tray containing 12 undated and unlabeled plastic single use plastic soufflé cups with apple sauce were discovered in the walk in cooler. d. An undated and unlabeled plastic bag	F 812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is on or before March 15, 2018. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. Corrective Action The container of nectar thickened tea, the bag of elbow macaroni, the bag of egg noodles, the plastic bag of six hard boiled eggs, the tray of 12 single use plastic souffle cups with apple sauce, and the single frozen pizza were all discarded on or before 2/22/18. Steam table bays were all drained and cleaned and refilled with	

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F 812	Continued From page 11 containing one small, approximately 6 inch wide, frozen pizza was discovered in the walk in freezer. 2. Further observation of the kitchen was conducted on 2/19/18 at 10:07 AM. The further observation revealed five of five steam table bays were observed to have water which appeared to be cloudy and had visible sediment in the water. An interview was conducted with the Dietary Manager (DM) on 2/19/18 at 10:07 AM. The DM stated the steam table water was usually changed once per week, on Sunday. The DM stated the steam table water had not been changed on Sunday, 2/18/18, due to the facility having had a power outage. The DM stated the water in the steam table did appear cloudy and have visible sediment and needed to clean water. An interview was conducted with the DM on 2/22/18 at 11:00 AM. The DM stated it was her expectation for opened food items to be dated and labeled. The DM further stated it was her expectation for the water in the steam table bins to be exchanged for clean-fresh water routinely and when the water in the steam table appeared cloudy and/or had visible sediment in it. During an interview conducted on 2/22/18 at 3:10 PM the Administrator stated it was his expectation for opened food to be dated and labeled. The Administrator further stated it was expectation for steam table water to be exchanged for clean-fresh water routinely and when the water in the steam table appeared cloudy and/or had visible sediment in it.	F 812	clean water on 2/19/18. Corrective Action for those having the potential to be affected Dietary Manager inspected all other food storage areas in the facility and found no other items stored improperly. Systematic Changes Dietary Manager and Assistant Director of Nursing will utilize Relias Learning Training computer module titled Safe Food Handling to educate all Dietary Department employees with regard to storing, preparing, distributing and serving food in accordance with professional standards for food service safety. Additionally, Kitchen Daily Cleaning list was updated to include steam table bays being drained and cleaned after evening meal and as needed, and inspected (and drained and cleaned as needed) prior to morning meal. Monitoring Dietary Manager and/or Cook(s) will utilize a Quality Assurance monitoring tool to review all food storage areas and steam table bays daily x 2 weeks, and weekly x 3 months to ensure compliance with all standards. Any issues will be immediately reported to Administrator. Continued compliance will be monitored through the facility□s Quality Assurance and Process Improvement Plan and Quality Assurance Program and for 3 months. Additional education and monitoring will be initiated for any identified concerns.	

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	345428	A. BUILDING _____ B. WING _____	02/22/2018

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F 865	Continued From page 12	F 865		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(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 record review, observations, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 2/9/17 recertification survey. This was for two deficiencies in the areas of: Comprehensive assessments after a significant change and Minimum Data Set (MDS) assessment accuracy. These deficiencies were recited again on the current recertification survey of 2/22/18. The continued failure of the facility during sequential federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program.	F 865	F 865 QAPI Program/Plan, Disclosure/Good Faith Attempt The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is on or before March 15, 2018. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements.	3/15/18

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F 865	Continued From page 13 The findings included: This tag is cross referenced to: 483.20-Based on record review and staff interviews, the facility failed to complete a comprehensive significant change assessment on a resident after a fall for 1 of 15 residents reviewed for comprehensive assessments (Resident #20). In addition the facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 15 residents. Resident #112 was coded inaccurately as to not having had a fall, Resident #32 was coded inaccurately as to having received an anticoagulant, and Resident #7 was coded inaccurately as to not receiving hospice services. During the recertification survey of 2/9/17 the facility was cited for failing to complete a significant change in status assessment for 2 of 32 sampled residents and the facility failed to accurately code an annual comprehensive Minimum Data Set (MDS) assessment to reflect that a resident was taking an antipsychotic for 1 of 5 sampled residents reviewed for unnecessary medications. An interview was conducted with the Administrator on 2/22/18 at 3:10 PM. The Administrator stated the facility had a Quality Assurance (QA) Committee. The QA Committee consisted of the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Medical Director, Rehabilitation Manager, Business Office Manager, Medical Records/Central Supply Manager, Maintenance Director, Dietary Manager, Social Worker,	F 865	Corrective Action Minimum Data Set (MDS) Coordinator corrected Resident #20□s Quarterly Assessment originally completed on 1/8/2018 to accurately code it as a Significant Change. MDS Coordinator corrected respective MDS Assessments to accurately capture the fall for Resident #112, to remove the anticoagulant coding for Resident #32, and to accurately capture the Hospice services being provided for Resident #7. Corrective Action for those having the potential to be affected MDS Coordinator reviewed all other current long-term care residents□ most recent quarterly or annual MDS assessment to ensure all other status assessments were coded correctly. No other issues were identified. Director of Nursing (DON)and MDS Coordinator reviewed fall log for the past three months to ensure all residents falls were accurately captured on respective MDS assessments. MDS Coordinator reviewed all residents that were currently prescribed aspirin to ensure accurate coding on respective MDS assessments. MDS Coordinator reviewed all residents currently receiving Hospice services and within the last 6 months to ensure Hospice was accurately captured on all MDS assessments. No other issues were identified. Systematic Changes Laurel Health Care Company□s Regional	

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F 865	Continued From page 14 Minimum Data Set (MDS) Coordinator, Housekeeping Director, and the Pharmacist. The Administrator stated the QA Committee met monthly and discussed identified deficiencies and had put into place a Quality Assurance Process Improvement program as part of the QA process. The Administrator further stated the identified deficient practices from the recertification survey which ended on 2/9/17 had been reviewed during subsequent monthly QA meetings. As part of the QA process there were monitoring tools put into place regarding MDS accuracy and initiating of significant change assessments. The monitoring tools were reviewed during the monthly QA meetings for 3-6 months and it had been determined the issue had been resolved and there was no further need for review in the QA Committee meetings.	F 865	Clinical Resource Specialist will re-educate facility MDS Coordinator/MDS Staff, Director of Nursing, and Assistant Director of Nursing on proper coding of status changes on MDS assessments. Clinical interdisciplinary team, led by Director of Nursing, will review all physician orders 5 times per week in order to identify any significant changes in resident condition. Director of Nursing and MDS Coordinator will initiate Significant Change assessments as identified. Laurel Health Care Company□s Regional Clinical Resource Specialist will also re-educate facility MDS Coordinator/MDS Staff, Director of Nursing, and Assistant Director of Nursing on the accuracy of assessments in order to ensure resident status is correctly coded on each MDS assessment. Focused direction will be provided regarding fall coding, anticoagulant coding, and Hospice services coding. Administrator and/or Director of Nursing will educate Quality Assurance and Process Improvement (QAPI) Committee on the facility□'s Quality Assurance policy and procedure and Quality Assurance and Process Improvement Plan as directed by facility'□s home/corporate office. This education will include ways to identify concern(s) utilizing root cause analysis, implement action, and monitoring of said actions. Monitoring Director of Nursing, Assistant Director of Nursing, and/or Regional Clinical	

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F 865	Continued From page 15	F 865	Resource Specialist will utilize a Quality Assurance monitoring tool to review all quarterly and annual assessments weekly x 4 weeks to ensure all residents with a significant change have corresponding MDS assessments coded as such. For ongoing compliance, Director of Nursing, Assistant Director of Nursing, and/or Regional Clinical Resource Specialist will utilize the Quality Assurance monitoring tool to review 5 assessments monthly x 3 months to ensure proper assessments are coded and immediately notify Administrator and MDS Coordinator of any errors. Continued compliance will be monitored through the facility'□s Quality Assurance and Process Improvement Plan and Quality Assurance Program for 4 months. Additionally, Director of Nursing, Assistant Director of Nursing, and/or Regional Clinical Resource Specialist will utilize a Quality Assurance monitoring tool to review 5 assessments per week x 4weeks to ensure accuracy in coding. For ongoing compliance, Director of Nursing, Assistant Director of Nursing, and/or Regional Clinical Resource Specialist will utilize the Quality Assurance monitoring tool to review 2 assessments monthly x 3 months to ensure accuracy of assessments and immediately notify Administrator and MDS Coordinator of any errors. Continued compliance will be monitored through the facility□s Quality Assurance and Process Improvement Plan and Quality Assurance Program for 4 months. Additional education and monitoring will be initiated for any individual concerns.	

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F 865	Continued From page 16	F 865	The facility□s Quality Assurance Committee, as part of the facility□s Quality Assurance and Process Improvement Plan, will re-evaluate the monthly monitoring results after 4 months. Additional education and monitoring will be initiated for any identified concerns.	