DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345560	A. BUILDING ______ B. WING ______	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME-KINSTON	**2150 HULL ROAD KINSTON, NC 28504**

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F 000	INITIAL COMMENTS A complaint survey was conducted from 11/7/18 through 11/9/18. Past non complaince was identified at CFR 483.12 at tag F600 at a scope and severity of J. This constituted substandard quality of care. Non-noncompliance began on 10/3/18. An extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations of a security surveillance video recording, record review, interviews with facility staff and resident ' s physician, the facility failed to protect a severely cognitively impaired resident from neglect when he was found with a belt loosely clasped around his neck and after he was found this way, a staff member left him in his room unattended to get assistance for 1 of 3 residents reviewed (Resident #1) for neglect. The resident was evaluated at the facility and	F 600	Past noncompliance: no plan of correction required.	12/10/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/10/2018

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.

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found to have no physical injuries and was sent to the hospital for further evaluation. The hospital reported no injuries.
The findings included:

Resident #1 was admitted to the facility on 2/09/17. He had diagnoses which included dementia without behaviors, severe osteoarthritis of both shoulders and complete rupture of both rotator cuffs in 2009 for which he was not a surgical candidate for repair. Additional diagnoses included post-traumatic stress disorder (PTSD), muscle weakness, major depressive disorder, difficulty walking and repeated falls.

His most recent Minimum Data Set (MDS) dated 8/10/18, coded as a quarterly review revealed Resident #1 was severely cognitively impaired. He required limited assistance with one person physical assistance for bed mobility, transferring and walking. He required extensive assistance of one person for dressing and personal hygiene. He required 2 person physical assistance for toileting. The MDS indicated no range of motion impairment of his upper or lower extremities. The MDS also revealed Resident #1 was in a private room.

A review of the care plan revised on 8/20/18 revealed Resident #1 had symptoms of delirium related to PTSD and dementia, had impaired decision making/memory deficits related to dementia, had self-care deficits of activities of daily living (ADLs) related to poor cognitive and physical status, right shoulder necrosis, osteoarthritis and gout and he required extensive assistance with ADLs.

A review of the hospital records revealed his

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range of motion to bilateral upper extremities was limited due to pain. Resident #1 sustained a distal right clavicle fracture and right rib fracture from a fall on 9/22/18.

On 11/7/18 at 11:00 AM Nursing Assistant (NA) #4 stated she worked with Resident #1 frequently. She said she checked on Resident #1 often but he could tell staff of his needs including the need to go to the bathroom. She stated she would offer to assist the resident with toileting but he was occasionally incontinent so she would change him when necessary. She stated Resident #1 could feed himself but had difficulty with the task so they assisted him with lifting his beverage glass and they had to assist him with picking up the correct utensil to use otherwise he would feed himself using his hands. She added he frequently attempted to get up from his wheelchair alone and he does not remember he needs assistance with walking.

During an interview on 11/8/18 at 12:00 PM Nursing Assistant (NA) #3 stated Resident #1 could move his extremities and feed himself at times but had to have staff assistance to finish the meal. She stated he frequently attempted to get up and walk and he had to wear a sling on his right arm due to a broken bone but he could move his arms and legs. She said she was not sure how much range of motion he had in his upper extremities.

During an observation of Resident #1 on 11/8/18 at 9:00 AM he was sitting in the dining area and the Occupational Therapist (OT) was assisting him with eating. The OT was observed to assist the resident by placing his fingers around the coffee mug but he was not able to place his

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fingers through the handle just around the outside of the coffee mug. The OT was feeding the resident but she assisted him with drinking.

On 11/8/18 at 11:47 AM Resident #1 was observed sitting in a high-back wheelchair in the day room. He had his right arm in a sling. He was verbal but unintelligible.

On 11/8/18 at 1:30 PM during an observation of incontinent care Resident #1 was observed to use the grab bars in the bathroom to pull himself up but he needed frequent rest breaks while care was being provided. He was assisted by 2 staff members and needed constant verbal cueing and directions to be able to perform the task of using the bathroom. The resident was in a private room.

On 11/9/18 at 11:03 AM Activity Assistant (AA) #1 stated on 10/3/18 she and another activity staff member were going through Resident #1 ' s unit. When they passed the room of Resident #1, she heard someone say "Hey Ya ' ll" so both staff entered the resident ' s room to see who was speaking to them. AA #1 said it was NA #1 who spoke and she observed NA #1 sitting in a chair which was pulled up close to the side of the resident ' s bed. AA#1 said she approached the resident and asked him how he was doing. She stated he did reply but his words were mumbled so she was not able to completely understand him. AA#1 said she noticed it was not normal for a NA to be sitting in a chair in the resident ' s room. AA#1 reported there was a curled up belt sitting on the foot of the bed. AA#1 said she had assisted Resident #1 during activity programs where she had to help him with using a paint brush or opening a package of nab crackers.

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F 600	Continued From page 4 She said the resident would "fumble" with task during arts and crafts activities. On 11/9/18 at 11:26 AM AA#2 stated on 10/3/18 she and another AA (AA#1) were walking through Resident #1 ' s unit because she was getting her personal belongings before she left for the day. She heard someone say "Hey Ya ' ll" so they stopped and entered the room of Resident #1. AA#2 said she asked NA #1 why she was in there because NA #1 was sitting in a chair next to the resident ' s bed. AA#2 stated the reply from NA#1 was because he had been falling a lot. AA#2 stated it was not normal for a NA to be sitting in a resident ' s room. AA #2 stated she did not notice a belt in the room and she would not have stopped if NA #1 had not spoken to them. During an interview on 11/9/18 at 9:05 AM Housekeeper #1 stated on 10/3/18 at about 3:45 PM she was assisting the laundry staff by delivering laundry on the hall where Resident #1 resided. She said she entered Resident #1 ' s room and she saw NA #1 sitting with the resident. She stated NA #1 told her she was sitting with him because "He was trying to hang himself." Housekeeper #1 asked if it was with the belt which was laying on the bed beside the resident and NA #1 said "yes." Housekeeper #1 then said she continued delivering the laundry and was on the way out of the unit when she saw NA #1 on that end of the hall way. She said to NA #1 "I thought you were sitting with (Resident #1)." Housekeeper #1 said NA #1 said "he cussed me out and kicked me out of the room." Housekeeper #1 added she had heard Resident #1 say words but he was not usually understood. She said she had never heard him give a command or speak in a complete sentence.	F 600		

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On 11/8/18 at 4:30 PM an observation of the facility ' s 10/3/18 security surveillance video was conducted with the facility ' s administrator present. There was no audio on the recording. The following was observed:

3:27:26 NA #1 was outside Resident #1 room and appeared to be talking to someone towards the camera which was also in the same direction as the nursing station.

3:28:17 Nurse #1 followed by nurse #2 go into Resident #1 room

3:31:25 Nurse #2 went out of resident #1 room and into room next door

3:32:35 Nurse #2 out of next door room and Nurse #1 comes out of Resident #1 room.

3:32:40 Nurse #1 and Nurse #2 are visible outside of Resident #1 room appear to be talking then Nurse #2 leaves towards the nursing station and Nurse #1 goes back into Resident #1 ' s room

3:33:02 Nurse #1 exited Resident #1 ' s room and walks towards nursing station. NA #1 remained in Resident #1 ' s room.

3:34:52 Two staff (Activity Assistants #1 and #2) go into Resident #1 ' s room

3:35:22 Activity Assistants #1 and #2 exit Resident #1 ' s room

3:44:40 Housekeeper #1 pushed laundry cart close to Resident #1 room. She took clothes into next door room then obtained more clothes and took to Resident #1 room. She was out of his room in 45 seconds went back to the laundry cart and got more clothes which she began to carry towards the nursing station. She then turned and went back to the laundry cart and she remained visible on the camera but appeared to be talking to someone. She then leaves the area again towards the nursing

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station and then returned back to the cart. She pushed the cart down the hall away from the nursing station.

3:52:05 NA #1 exited Resident #1 room and walked toward the nursing station. She rubbed the top of her head from front to back as she was walking

4:12:11 NA #1 returned back to Resident #1 room. (Time span of 20 minutes elapsed since NA #1 exited Resident #1 ' s room and returned. No other staff member or resident was observed to enter the resident ' s room on the video footage during this time span.)

4:12:47 NA #1 exited Resident #1 room walked towards nursing station. She was walking at the same pace as previously observed on the video.

4:14:02 NA #1 was followed by both Nurse #1 and Nurse #2 back to Resident #1 room.

4:17: Nurse #1 and Nurse #2 were observed to exit the room and one of the nurses had numerous belts in her hand.

A review of the Resident Incident Report dated 10/03/18 at 4:15 PM prepared by Nurse #3 revealed "Resident was observed by three staff members with belt looped around his neck as if he were attempting to commit suicide." The immediate action taken was documented as "resident sent to ER (emergency room) for evaluation. MD/RP (medical doctor/responsible party) notified."

A review of the emergency room physician record revealed "Staff requesting mental health" evaluation. The report revealed Resident #1 had no suicidal ideation, no homicidal ideation no acute psychotic features. The resident was sent back to the facility.

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During a telephone interview at 9:30 am on 11/9/18 Nurse #1 stated she had worked on the 3:00 PM to 11:00 PM shift on Resident#1 ' s unit previously and knew the residents well. She reported on 10/3/18 NA #2 came to her and said NA #1 needed her in Resident #1 ' s room. Nurse #1 stated she went to the room and Resident #1 was laying on his back across the bed with his feet planted on the floor. She said she and another nurse (Nurse #2) assisted NA #1 to reposition Resident #1 so his head was at the head of the bed and his feet were at the foot of the bed. Nurse #1 said approximately 30 minutes later NA #1 came and got her and Nurse #2. She said they all went back to the room and Resident #1 was laying in the bed with a belt around his neck. She added his arms were folded across his chest. She said she asked the resident how he was doing and what he was doing but he only smiled. She indicated Resident #1 did not communicate. Nurse #1 stated she had NA #1 to remove the belt and she assessed his neck for any signs of injury or bruising. She said she did not see any bruising, redness or indications of injury. Nurse #1 stated she asked NA #1 to stay with the resident until she could get a supervisor or the administrator to seek further guidance to see what she needed to do next. Nurse #1 said she couldn ' t ask Resident #1 for details because he could not say. Nurse #1 said the belt was looped around his neck with the belt through the buckle and the buckle was not near his hand. She added his hands were folded across his chest and the length of the belt was hanging to his right side. Nurse #1 said she was not able to converse with Resident #1 but he could answer questions yes or no when asked things like are you hungry or hot. She was only able to understand him

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when he would ask, where is (Resident #1 ' s wife ' s name)? Nurse #1 stated she did not know how Resident #1 got the belt around his neck but she had never seen him lift his arms up. She added he may have been able to get the belt around his neck but he could not have threaded the belt through the buckle. Nurse #1 also stated she could not ask the resident for details of what happened because he was not capable of saying what happened.

Nurse #2 was interviewed on 11/9/18 at 11:43 AM. Nurse #2 stated she was the nurse working the 7:00 AM to 3:00 PM shift on 10/3/18 on Resident #1 ' s unit. Nurse #2 stated she was giving report to Nurse #1 when NA #2 told her NA #1 needed to see a nurse. Nurse #2 reported she and Nurse #1 went to Resident #1 ' s room. She said when they entered the room NA #1 said he kept trying to get out of the bed. Nurse #2 observed Resident #1 laying across the bed with his feet on the floor but the resident was asleep. NA #1 asked for assistance to get the resident straightened in the bed. Nurse #2 stated she and Nurse #1 assisted NA #1 to reposition Resident #1 on the bed then both nurses left the room. She stated Resident #1 was fully dressed including having shoes on. Nurse #2 stated NA #1 came back to the nursing station and asked for them (the nurses) to come and look at what Resident #1 had done. Nurse #2 said she entered the room to see Resident #1 had his arms lying on his chest and she observed a leather belt around his neck like a necklace with the belt through the buckle without being secured through a belt hole. She said there was about 2 1/2 feet of the belt draped over his right side. Nurse #2 said Nurse #1 asked NA #1 "Did he do that?" and Nurse #1 removed the belt. Nurse #2

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assessed and noted the resident did not appear to be in any pain, no sadness or tearfulness. Nurse #2 stated she and Nurse #1 left the room and Nurse #1 went to find a supervisor. Nurse #2 reported she did not think Resident #1 had the physical or mental capacity to place the belt around his neck. She stated Resident #1 could follow commands and could feed himself but he had trouble lifting his arms. She said he always needed help reaching things because he was not able to extend his arms but could move them at the elbows. She said he was not able to speak in complete sentences but at times his speech was clear. She added that he may start out speaking clearly but the more he spoke his speech became "gibberish" due to his mental state.

A telephone interview was also conducted with Resident #1 ' s physician on 11/9/18 at 10:28 AM. The physician reported he remembered an incident with the resident in October. The doctor stated he did not feel the resident had the mental capacity to process what he was doing. He said Resident #1 did not have the physical or mental capacity to attempt suicide or to put a belt around his neck. He said the resident could not move his arm high enough to bring something around his neck or head.

During an interview with the Administrator on 11/8/18 at 4:00 PM he reported he started a 24 hour report then on 10/4/18 Nurse #2 approached Nurse #3 with a concern that Resident #1 could not have placed the belt around his neck so both nurses told him. He then viewed the facility ' s security surveillance video. He stated the video revealed NA#1 left the resident alone in his room with the belt around his neck so she was suspended for neglect pending the outcome of

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F 600	Continued From page 10 the investigation. During an interview with the Administrator on 11/8/18 at 5:15 PM immediately following viewing of the video surveillance, the administrator explained his investigation verbally. He indicated after completing his investigation, he was unable to determine exactly how the belt ended up around the resident ' s neck. He stated that during his interview with NA #1, she was inconsistent with her answers and at times would remain silent. When asked specifically what he thought may have happened, he stated he did not think the resident could have placed it (the belt) himself nor could he 100% prove who put the belt around the resident ' s neck. He then added that the nursing assistant had been terminated based on her leaving the room in a situation when a resident should not have been left alone. Additionally, he stated that each room has an emergency switch in the room that sounds an alarm to be used by staff instead of the call bell in case of emergency and he saw no reason for the nursing assistant to have left the room. On 11/9/18 at 12:49 PM and at 12:50 PM three attempts to contact NA #1 were unsuccessful. The Administrator provided the following Plan of Correction on 11/9/18 at 5:40 PM. The plan of correction was verified through interviews with staff and residents and record review with a compliance date of 10/31/18. CORRECTIVE ACTION FOR RESIDENT FOUND TO HAVE BEEN AFFECTED BY DEFICIENT PRACTICE On 10-3-18 upon entering room of the resident, Nurse #1 and Nurse #2 observed resident lying	F 600		

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F 600	Continued From page 11 on the bed with a belt looped around his neck with eyes open looking toward the ceiling with hands folded across his chest. Nurse #1 called out resident ' s name and immediately removed the belt from around his neck. Nurse #1 then assessed the resident for any bruises and scratches to neck area, none noted. Resident #1 voiced no complaints of pain or discomfort. All belts were then removed from resident ' s room and room was observed for any potential hazards at that time. Nurse #1 instructed CNA #1 to stay with the resident while she located supervisor, Director of Health Services, and Administrator for direction. Per further orders from MD, resident #1 was transferred to hospital to be evaluated for possible suicide attempt based on information provided at that time by CNA #1. Per hospital, resident was returned to facility that night on 10/3/2018 with no sign and symptoms of a possible suicide attempted. CNA #1 shift ended at 11pm and was not in the building when resident returned. 10/4/2018, the Administrator became suspicious of abuse and neglect allegation after the camera was reviewed and the alleged employee was interviewed. This suspicion was based on her statement and testimony, she stated she left the resident to get the nurse and did not stop the resident. Administrator and Performance Improvement Coordinator again returned to the resident ' s room to assess the resident for any sign and symptoms of abuse; no sign and symptoms of abuse was noted on 10/4/2018. Alleged employee was called in to be interviewed 10/4/2018 that led to a suspension pending investigation on 10-04-2018 and upon completion of investigation was terminated based on facility '	F 600		

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s abuse policy on 10-10-2018. Nurse Aide registry and Police were notified on 10/10/2018

Initial (24Hr) Report was sent 10/4/2018 and Investigation (5-day) Report was sent 10/10/2018.

OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN

· All staff involved in the event were interviewed regarding incident and investigation was immediately implemented on 10-04-2018. Facility reviewed video recording for the previous day to determine who went in the resident ' s room. Alleged employee did not work on 10/4/2018, however, was called in and suspended pending investigation on 10-04-2018 for leaving the resident in the room and not reporting to the nurse. Upon completion of investigation CNA #1 was terminated on 10-10-2018. CNA #1 did not work with any other resident in the facility after the incident on 10/3/2018.

· 10/4/2018 through 10/31/2018 all staff were reeducated on abuse and neglect by the Clinical Competence Coordinator and Nurse Management. Staff was also educated on knowing how to properly report suicide to never leave the resident in a compromising position to immediately return the resident ' s environment to safe state and pull the emergency call light to call for assistance.

· 10/4/2018, even though it was isolated incident on the Memory Support (Dementia) Unit. Nurses on each unit assessed 100% of all facility ' s residents for any sign and symptoms of abuse

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	345560	A. BUILDING ______ B. WING ______	C 11/09/2018

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and neglect. No sign and symptoms were noted or reported to the Administrator.

· Additionally, 100% audit of all residents was conducted to ensure no belts were found around any resident ' s neck. This was done by the Nurses on each unit on 10/4/2018 and rechecked by the DHS on 10/5/2018.

· On 10/5/2018, The Social Worker Director and Social Service Assistant utilized the current census (10/5/2018) of 96 residents to develop a list of residents with dual diagnoses of dementia and depression and those with just a diagnosis of depression for those residents with increased potential of self-harm. The list was used to determine any residents at risk.

· On 10-8-18 Social Worker/Social Service Assistant completed questionnaire PHQ-9 Item I (One of the elements of the MDS Assessment questionnaire which determined which residents are at risk for depression) for total facility head count of 96 residents to identify any residents that had exhibited any suicidal behaviors in the past two weeks. If the resident had a dual diagnosis of dementia and depression, both resident and staff were interviewed for the questionnaire. The IDT reviewed data collected, and based on responses no residents were assessed to be at risk.

· All belts were removed for those residents with potential risk of self-harm, until it was determined, that resident was cleared based on assessment. Medical Director, Residents, and their RP were notified if belts were taken and when they were returned, they understood and were in agreement with facility ' s plan for safety. This assessment was completed on 10/5/2018.

PROCESS FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION FOR SPECIFIC DEFICIENCY

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F 600	Continued From page 14 · On 10-4-18 Education was provided to all nursing staff regarding the Abuse & Neglect policies and procedures. All staff were enrolled in the Abuse & Neglect self-paced computer course as a supplemental resource to reinforce the primary training. Education was provided by the Clinical Competency Coordinator (CCC) and the Nurse Management. Education was completed on 10-31-18. · All staff were in-serviced starting 10/04/2018 regarding the suicide policy and completed 10/31/2018, due to the initial report by Competency Coordinator (CCC) and the Nurse Management. · 10/4 /18 through 10/31/18 all partners were reeducated on abuse and neglect by the CCC and/or Nurse Management. This in-service was the primary tool for re-educating the staff. In addition, all staff were enrolled in the Abuse & Neglect self-paced computer course as a supplemental resource to reinforce the primary training. · The CCC will review the abuse policy in orientation and annually with all employees and new hires. This included knowing how to properly report abuse and to never leave the resident in a compromising position to immediately return the resident ' s environment to safe state and pull the emergency call light to call for assistance. · To ensure 100% of employee completion of both courses by 10/31/2018, the Administrator and CCC compared the signature log from the primary in-service, the completion report that was ran from the online educational system, and the current HR payroll roster. · Each employee is required during the online course to review the presentation and videos and then take an exam at the end of the course. Employee must score at least 80% to	F 600		

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receive credit.
· IDT including the Social Worker used the MDS Assessments questionnaire (PHQ9) to develop a list of residents with dual diagnoses of dementia and depression to determine those that could be at risk of similar incident on 10/5/18.
· Belts were removed from residents with a diagnosis of depression due to an increased potential risk of self-harm until each resident was assessed for safety. Residents and their RP were notified if belted were taken and when they were returned, they understood and in agreement with facility plan for safety. This assessment was completed on 10/5/2018

MONITORING PROCEDURE TO ASSURE THAT THE PLAN OF CORRECTION IS EFFECTIVE
· Even though this was an isolated incident, facility monitors resident care and safety by continuing the daily rounds conducted by the CNAs, Nurses, and facility ' s leadership team to include signs and symptoms of abuse and to report to the Administrator and/or the Director of Health Services if resident expresses or there are signs of abuse and neglect.
· Administrator/DHS will log daily any findings and follow policy and procedures accordingly.
· Nursing staff completes weekly body audit to include reporting any sign of abuse or injuries of unknown origin to Administrator/DHS. Administrator/DHS will log daily any findings and follow policy and procedures accordingly.
· To ensure facility monitors competency of the staff regarding what to look for and what to do, On 10-10-18 ongoing weekly random questioning of staff to ensure understanding of abuse and neglect policy and procedures as well as suicide prevention and intervention policy by

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F 600	Continued From page 16 the DHS or designee for the next three month. · The results of the questionnaires and the investigation of the event were reported and discussed by the Administrative staff at the monthly QAPI meeting 10/19/2018. · QAPI Committee reviews all data from the questionnaires to determine any potential risk of self-harm with resident with diagnoses of depression and continued education that was initiated 10/4/2018 for all partners and new hires on how to report Abuse & Neglect and will be on-going. The QAPI Committee determined that this was an isolated incident and agreed with terminating the partner for leaving the room. · QAPI Committee will review the results of the staff questionnaire, staff rounds and feedback from resident and family members, monthly to maintain compliance regarding abuse and neglect policy times three months. TITLE OF PERSON RESPONSIBLE FOR IMPLEMENTING ACCEPTABLE PLAN OF CORRECTION The Administrator is responsible for implementing the acceptable plan of correction. Date of alleged compliance: 10/31/2018 The Plan of Correction was verified on 11/9/18 as evidenced by: Review of the abuse and neglect policy education provided to the staff and the attendance roster was verified. Random staff were questioned about the in-service education they received and were able to answer all questions appropriately. The stated the education included keeping residents safe, not leaving any resident who could be unsafe and	F 600		

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F 600	Continued From page 17 using the emergency call system located in each resident room. Observed the documentation of the audit. A review of the monitoring documentation was conducted and revealed the monitoring was in process. Interviews with staff revealed they continued to be questioned about abuse and neglect. A review of the Quality Assurance minutes revealed the monitoring was discussed during the meeting on 10/19//18. The meeting was attended by the full committee including the medical director.	F 600		
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 record review and staff interviews the facility failed to accurately code the range of motion limitations for 1 of 7 residents (Resident #1) Minimum Data Set (MDS) assessments reviewed for accuracy. The findings included: Resident #1 was admitted to the facility on 2/09/17. He had diagnoses which included muscle weakness, severe osteoarthritis of both shoulders and complete rupture of both rotator cuffs in 2009 for which he was not a surgical candidate for repair. Additional diagnoses included post-traumatic stress disorder (PTSD), major depressive disorder, difficulty walking and	F 641	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Address how corrective action will be accomplished for those residents found to have been affected by the deficient	12/28/18

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repeated falls.

His most recent Minimum Data Set (MDS) dated 8/10/18, coded as a quarterly review revealed Resident #1 was severely cognitively impaired. He required limited assistance with one person physical assistance for bed mobility, transferring and walking. He required extensive assistance of one person for dressing and personal hygiene. He required 2 person physical assistance for toileting. The MDS indicated no range of motion impairment of his upper or lower extremities.

A review of the care plan revised on 8/20/18 revealed Resident #1 had self-care deficits of activities of daily living (ADLs) related to poor cognitive and physical status, right shoulder necrosis, osteoarthritis and gout and he required extensive assistance with ADLs.

During a telephone interview at 9:30 am on 11/9/18 Nurse #1 stated she had worked on the 3:00 PM to 11:00 PM shift on Resident#1 ' s unit previously and knew the residents well. Nurse #1 said she had never seen him lift his arms up.

Nurse #2 was interviewed on 11/9/18 at 11:43 AM. Nurse #2 stated Resident #1 could follow commands and could feed himself but he had trouble lifting his arms. She said he always needed help reaching things because he was not able to extend his arms but could move them at the elbows.

F 641

practice;

•MDS assessment for resident #1 has been reopened and modified to correct the resident's limitations and retransmitted on 12/7/18 by the Case Mix Director.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

•On 12/7/2018, Administrator assigned all MDS coordinators reeducation with appropriate testing on accurate coding of section G0400. They were assigned course MDS US: 07 Section G-2018 in Pruitt University, this was completed by 12/7/2018.
•100% audit of all active residents, who have the potential of being affected by the deficient practice related to coding MDS section G0400 will be reviewed by the MDS Nurses with collaboration with Nurse Management for verification of accuracy of MDS section G0400. All identified coding discrepancies will be corrected and retransmitted by 12/10/2018.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

•On 12/7/2018, Administrator assigned all MDS coordinators reeducation with appropriate testing on accurate coding of section G0400. They were assigned course MDS US: 07 Section G-2018 in Pruitt University, this was completed by

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F 641	Continued From page 19	F 641	12/7/2018. •All MDS assessments completed will be reviewed and verified for section G0400 coding accuracy by ensuring MDS coding is accurate and reflective of the resident's current limitation status. This verification and review will be accomplished by printing MDS section G0400 and both the MDS nurses and DHS/Unit Manager/Designee will assess resident and verify accurate coding for MDS section G0400, weekly times 4 weeks, then monthly times 3 months starting 12/7/2018. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and •Case-Mix Director and Performance Improvement Coordinator will randomly review five records for MDS coding section G0400 for accuracy and will report audit findings monthly to the QAPI team for review times 3 months. Include dates when corrective action will be completed. Corrective Action date: December 28, 2018	