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	345567	A. BUILDING _____ B. WING _____	C 01/20/2021

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AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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E 000	Initial Comments An unannounced on-site COVID-19 Focused Infection Control Survey was conducted on 01/04//2021 through 01/20/2021 with exit from the facility on 01/04/2021. Additional information was obtained through 01/20/2021. Therefore, the exit date was changed to 01/20/2021. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID: J3LH11.	E 000		
F 000	INITIAL COMMENTS A COVID 19 Focused Infection Control and complaint investigation survey was conducted on 01/04/2021 through 01/20/2021. The survey team entered the facility on 01/04/20 to conduct a COVID 19 Focused Infection Control and complaint investigation survey and exited on 01/04/2021. Additional information was obtained through 01/14/2021. The survey team conducted an extended survey on 01/20/2021. Therefore, the exit date was changed to 01/20/2021. Three allegations were investigated and not substantiated. Past non-compliance was identified at: CFR 483.12 at tag F 600 at a scope and severity of J. The tag F 600 constitued substandard quality of care. Non-compliance began on 12/22/2020. The facility came back in compliance effective 12/31/2020 . An extended survey was conducted on 01/20/2021.	F 000		

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

Electronically Signed | 02/17/2021

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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 record review, and interviews with staff, family, physician and nurse practitioner (NP), the facility failed to protect 1 of 3 sampled residents, Resident #1 from a significant injury of unknown origin. Resident #1 was evaluated in the Emergency Room (ER) after complaints of a fall in the facility. In the ER, Resident #1 was identified with acute fractures sustained of the distal end of her right femoral metaphyseal (thigh) and an impaction fracture of the proximal end of her left tibia (knee). Resident #1 required intravenous (IV) opioid analgesics for pain management. The findings included: Resident #1 was admitted to the facility 2/17/2017. Diagnoses included prior cerebral infarction with residual dense right hemiparesis, osteopenia and chronic pain, among others.	F 600	Past noncompliance: no plan of correction required.	2/2/21

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A quarterly Minimum Data Set (MDS) assessment, dated 09/15/2020 assessed Resident #1 with moderate cognitive impairment.

A Functional Abilities assessment dated 12/14/2020, assessed Resident #1 was dependent on staff for chair or bed to chair transfers.

An annual MDS assessment dated 12/16/2020, did not assess her cognitive status, but indicated she had clear speech, understood/understands, required extensive assistance of 2 staff for mobility, transfers only occurred once/twice and required extensive assistance of 2 staff when transfers did occur. Additionally, she was unsteady for surface to surface transfers, only able to stabilize with staff assistance.

A care plan, revised on 12/22/2020, documented Resident #1 required extensive staff assistance for bed mobility and transfers of 1 to 2 staff.

A care guide, revised December 2020, documented that 2 staff used a total body lift to transfer Resident #1.

A progress note, documented as a late entry note, by Nurse #1 on 12/30/2020 for 12/22/2020 recorded Nurse #1 entered the room of Resident #1 and conducted a head to toe assessment. Nurse #1 recorded "I pulled covers down and observed nothing unusual. Resident BLE (bilateral lower extremity) extended straight out and B (bilateral) knees arthritic. Palpated from B hips to toes and Resident had no complaints. No bruising or discoloration observed. Brief opened and no unusual findings observed. RUE (right

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upper extremity) no unusual findings observed. RUE flaccid from old CVA (stroke) and old surgical scar observed. Did not complete assessment to posterior due to Resident lunch being served. Resident did complain of pain to RUE with movement. Resident would grab her R (right) wrist with her L (left) hand and move extremity and moan. One to one provided for comfort and Resident calm and appears comfortable."

A second progress note for Resident #1 documented by Nurse #1, dated 12/22/2020 at 4:45 PM recorded that Nurse #1 entered the room of Resident #1 and "the Resident stated she wished I was in there when she was just talking to (Family member #3)." Resident stated (Family member #3) was calling the hospital. I asked Resident if she needed to go to the hospital and Resident stated, I don't think I need to go. I grabbed the cordless phone spoke with (Family member #3). In room with Resident regarding Resident claim of falling out of the mechanical lift today. Family member #3, expressed his wishes for having Resident sent to the ER for a 3rd party assessment. Informed him I would initiate but Resident had stated she didn't think she needed to go. Resident then said she would go. At 4:53 PM - medic initiated (Emergency Medical Services). At 5:20 PM - Resident left via stretcher per 2 medic."

An interview occurred on 01/04/2021 at 2:22 PM with personal care assistant (PCA) #1 and physical therapy assistant as an interpreter. During the interview, PCA #1 stated she worked as a PCA at the facility for the prior 4 months, typically on the 7 AM - 3 PM shift. PCA #1 stated that in the past she assisted Resident #1 with

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incontinence care and with transfers. PCA #1 described Resident #1 as alert/oriented with periods of confusion/forgetfulness, difficult to reposition because she required total staff assistance with transfers and that Resident #1 preferred to stay in bed. PCA #1 also stated that when she assisted with nursing care for Resident #1, there were always 2 staff, the Resident was transferred with a total body lift and the lift pad was left under the Resident to assist staff with her transfers. PCA #1 stated that on 12/22/2020 she and PCA #2 assisted Resident #1 with a transfer from her bed to her recliner to get ready for therapy. PCA #1 stated that a total body lift was used for the transfer and the transfer was uneventful. She stated that there were no concerns during the transfer. Then less than 30 minutes later, Nurse #1 advised PCA #1 that Resident #1 wanted to go back to bed. PCA #1 stated that when she entered the Resident's room, Resident #1 was seated on her recliner, leaning forward and to the left, her knees were bent and her feet were on the floor. PCA #1 stated that Resident #1 had only been out of bed less than 30 minutes, she complained of pain to her shoulder, she was uncomfortable in her recliner and wanted to be put back to bed. PCA #1 stated that she and PCA #2 used the lift pad that was underneath Resident #1 to lift her up and slid her back in her recliner. Then PCA #1 stated she and PCA #2 got the total body lift and used it to transfer Resident #1 back to bed. PCA #1 also stated that Nurse #1 was on the hall and was informed that Resident #1 was having shoulder pain and was back in bed. PCA #1 further stated that Resident #1 did not fall or hit anything during either transfer that morning and that a total body lift was used with both transfers. PCA #1 stated that shoulder pain was a common

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complaint for Resident #1, that was not new, and when Resident #1 got back to bed she said her legs hurt, and this was reported to Nurse #1.

A phone interview occurred on 01/07/2021 at 08:30 AM with PCA #2. During the interview, PCA #2 stated she worked at the facility on the 7 AM - 3 PM shift. PCA #2 stated she worked with Resident #1 occasionally. PCA #2 described Resident #1 as alert/oriented, at times forgetful/confused, bed bound, required a total body lift and 2 staff for transfers, bed mobility and nursing care. PCA #2 stated on 12/22/2020 she assisted PCA #1 with nursing care and transfers for Resident #1. PCA #2 stated when she first entered the Resident's room that morning, Resident #1 was in bed and requested to get up to her recliner for therapy. PCA #2 and PCA #1 worked on either side of the Resident to position the lift pad underneath her and used a total body lift to transfer Resident #1 to her recliner. While in the total body lift, PCA #2 stated Resident #1 was positioned on her side, she was not completely seated upright in the lift because it was difficult to position her upright due to her size. PCA #2 described that her feet were exposed outside of the lift pad during the transfer and stated Resident #1 was placed in her recliner. PCA #2 then stated PCA #1 and #2 left Resident #1 in her room in her recliner and went to care for another resident. After about 5 minutes, Nurse #1 advised PCA #2 and #1 that Resident #1 wanted to be repositioned in her recliner. PCA #2 stated that within about 10 minutes, she and PCA #1 went back to the Resident's room and found her in her recliner leaning on her right side, her feet were on the floor and her knees were bent. Resident #1 complained of pain but was not specific as to the location of her pain. PCA #2 stated the Resident

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appeared to be in distress. PCA #2 stated she advised Resident #1 that she would let Nurse #1 know that she was in pain. PCA #2 then stated she and PCA #1 used the lift pad that was underneath Resident #1 to lift her up and positioned her by sliding her back in her recliner. Resident #1 continued to complain of pain and then asked to be placed back in bed. PCA #2 stated, we then got the total body lift and used it to transfer Resident #1 back to bed. PCA #2 described both transfers as uneventful with no incidents of Resident #1 falling or hitting anything and denied that Resident #1 was lifted by her arms. PCA #2 stated that since she did not work with Resident #1 that often, PCA #2 was not sure if Resident #1 commonly complained of pain. PCA #2 stated she could not remember the specific time that the transfers occurred, but stated they occurred after breakfast but before lunch.

A telephone interview on 01/06/2021 at 1:57 PM with occupational therapist (OT) revealed the OT entered the room of Resident #1 before lunch on 12/22/2020 and observed Resident #1 in her bed. Resident #1 stated to OT that she had been dropped by staff that morning and fell to her knees because staff did not use a total body lift to move her. Resident #1 further stated to OT that when she was transferred that morning by staff from her recliner to her bed, she was picked up by her arms, was dropped to her knees and then picked up again by her arms and put in her bed. Resident #1 stated to OT that she could not tell if her knees were hurting at that time. OT stated she then left the room to obtain a grievance form, immediately returned to Resident #1's room to record her statement which remained consistent with her original complaint. After recording a

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written grievance for Resident #1, OT then advised Nurse #1.

A telephone interview with Nurse #1 occurred on 01/05/2021 at 12:11 PM. During the interview, Nurse #1 stated that on 12/22/2020 she was in the room of Resident #1 about 15 minutes before OT went into the Resident's room. Nurse #1 stated, the Resident was at baseline, described as alert/oriented with periods of confusion/forgetfulness, pleasant, verbal, and smiling with no complaints. Nurse #1 medicated the Resident with scheduled Tramadol for chronic pain. Resident #1 did not communicate a concern to Nurse #1 regarding a fall or being dropped to her knees. Nurse #1 stated she was on the hall completing her medication pass before she medicated Resident #1 that morning and remained on the hall after she medicated Resident #1 to continue her medication pass and that no one else went into the Resident's room before OT entered. Nurse #1 stated that she saw PCA #1 and #2 obtain the total body lift and take it into the room of Resident #1 earlier that morning because Resident #1 required total staff assistance with transfers due to limited mobility in her upper body. Nurse #1 also stated that if staff had dropped Resident #1 during a transfer, because she was on the hall administering medications, Nurse #1 stated that she believed she would have heard the "commotion." After being advised of Resident #1's complaint communicated by OT, Nurse #1 stated she went back into Resident #1's room, completed a head to toe assessment with no acute changes noted but during the assessment, Resident complained she had been dropped to her knees by staff, complained of pain to her shoulder and general pain to her legs. Nurse #1 medicated Resident #1

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with Tylenol. Nurse #1 further stated that complaints of pain were common for Resident #1 due to her diagnosis of chronic pain and that her complaints of pain varied between shoulder, legs and generalized pain. Nurse #1 also stated that once she was advised by OT of Resident #1's complaint of being dropped by staff, she spoke to PCA #1 and #2 who assisted Resident #1 that morning and both denied that Resident #1 was dropped. They both expressed to Nurse #1 that Resident #1 was always transferred with a total body lift.

A phone interview occurred on 01/14/2021 at 1:11 PM with family member (FM) #1. FM #1 stated that on 12/22/2020 around 2:00 PM, she had a window visit with Resident #1. At the time of the window visit, FM #1 described Resident #1 was upset and crying and stated Resident #1 kept repeating, "I'm hurting, they dropped me." FM #1 continued during the interview and stated that she asked Resident #1, when did this happen? Resident #1 responded, "At 11 o'clock when they transferred me to my bed". FM #1 stated she asked Resident #1 to describe what was hurting and stated Resident #1 responded "my knees". FM #1 then stated that she asked Resident #1 what were staff doing about her pain and that Resident #1 said "someone came and looked at me but did not find anything wrong, they gave me pain medicine, but I'm hurting now." FM #1 stated that she told Resident #1 that she would get her some help. FM #1 then said she immediately contacted FM #2 to advise.

A phone interview occurred on 01/04/2021 at 11:24 AM with FM #2. During the interview, FM #2 stated that she received a phone call on 12/22/2020 around 2:30 PM from FM #1. During

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the phone call, FM #2 stated she was told by FM #1 that when FM #1 went to see Resident #1 on 12/22/2020 around 2:00 PM at the facility for a window visit, Resident #1 complained she had been dropped by facility staff and that her knees hurt. FM #2 stated that she immediately contacted FM #3. FM #2 stated Resident #1 expired in the hospital with Hospice Services because of the fractures she sustained from her fall.

A phone interview occurred on 01/14/2021 at 09:19 AM with FM #3. During the interview, FM #3 stated that he received a phone call from FM #2 on 12/22/2020 around 2:30 PM advising that Resident #1 had a fall. FM #3 then stated that when he got the phone call from FM #2, he immediately called Resident #1 who advised him that around 11:00 AM that morning 2 staff came into her room to transfer her out of bed to her recliner. Resident #1 stated she asked the staff where the total body lift was because staff always used it to transfer her. The staff said, "We will be the muscle". FM #3 went on to say that Resident #1 informed him that she was lifted up under her arms and transferred to her recliner, but at some point during the transfer, she was dropped to her knees. The staff picked her up off the floor using her arms and put her in her recliner, but she was in pain and was not comfortable in the recliner, so she asked to be put back in her bed. The staff went and got the total body lift and used it to transfer Resident #1 back to bed. FM #3 stated he asked Resident #1 when did this happen and she said "around 11 o'clock that morning". FM #3 said since it was almost 3 PM at that point, I asked her what had staff done about it. Resident #1 replied that staff gave her pain medicine, but that she was in a lot of pain now. FM #3 stated he

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immediately got off the phone with Resident #1 and called the Administrator, he left a message and the Administrator called him back. FM #3 stated when he spoke to the Administrator, he told the Administrator what Resident #1 told him and the Administrator said that the facility was conducting an investigation, but that so far they had not found that the staff did anything wrong. FM #3 said he then asked the Administrator to have Resident #1 transferred by ambulance to the ER for evaluation by a physician. FM #3 then stated he called Resident #1 back, and Nurse #1 was in her room, so he spoke to Nurse #1 and told her to send Resident #1 to the ER for evaluation. FM #3 stated Resident #1 was sent to the ER. FM #3 also stated that Resident #1 was diagnoses with fractures, orthopedics was consulted about the fractures but surgical repair was not recommended. FM #3 then stated that Resident #1 later expired in the hospital.

Review of a hospital history and physical (H&P) dated 12/27/2020, recorded that Resident #1 was transferred to the hospital on 12/22/2020 and reported that today instead of staff using a mechanical lift they attempted to manually lift her out of bed and dropped her to her knees. Then facility nursing staff attempted to pick her up under the arms to lift her up and were unable to do so. At that time facility nursing staff used a mechanical lift to get her back in bed. Patient reports that when she fell she only hit her knees; did not hit her head or lose consciousness. Patient reports that several hours after her fall that she began having extreme pain. The hospital H&P noted Resident #1 was alert and oriented times 2 with intermittent confusion.

Review of a hospital discharge summary dated

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12/27/2020 reported Resident #1 was diagnosed with an acute right femoral fracture (thigh) and an impaction fracture of the left tibia (knee). While in the hospital, she required IV opioid analgesics for pain management. An orthopedics consult was completed with recommendation for non-surgical repair. Hospice services was consulted. Multiple attempts by the surveyor to interview radiology were unsuccessful.

Review of the death certificate for Resident #1 revealed she expired on 12/29/2020 in the hospital from aspiration pneumonia, acute renal failure, stroke and fractures.

An Initial Allegation Report regarding an injury of unknown origin, which occurred on 12/22/20, was submitted by the facility to Health Care Personnel Investigations (HCPI) on 12/29/2020 after being contacted by the family of Resident #1 on 12/29/2020 to notify the facility that Resident #1 had been diagnosed with fractures in the ER. A 5 Day Investigation Report was submitted by the facility to HCPI on 01/04/2020 which unsubstantiated the allegation for an injury of unknown origin sustained by Resident #1.

The Administrator was interviewed on 01/04/2021 at 01:32 PM and stated that on 12/22/2020 he received a grievance from Resident #1 regarding timely assistance to get up for therapy. The grievance indicated that on 12/22/2020 at 10:30 AM, Resident #1 was not up for therapy which started at 11:00 AM. The Administrator stated that Resident #1 was usually "a pretty decent historian, but lately she was more confused". The Administrator further stated that when he arrived to the facility on 12/22/2020 around 1:00 PM, he spoke to Resident #1 and she complained of pain

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to her shoulder, stated that staff did not get her up timely for therapy and that when staff transferred her that morning, they did not use a total body lift and dropped her. The Administrator described Resident #1 with a history of left sided weakness due to a prior stroke which left her without mobility or strength on her left side and stated she weighed about 180 pounds. The Administrator stated after he spoke to Resident #1, he then went to talk to Nurse #1 to advise of the Resident's complaints of pain, her grievance that staff transferred her without a lift, dropped her and to find out from Nurse #1 what happened. The Administrator stated that Nurse #1 responded that she had already addressed the Resident's complaints of pain, completed a head to toe skin assessment with no abnormal findings and that Resident #1 must be confused about the transfer because Nurse #1 had already confirmed with PCA #1 and #2 that Resident #1 was transferred with a total body lift and did not fall. The Administrator then stated he spoke to PCA #1 and #2 on 12/22/2020 and both staff denied that Resident #1 fell during a transfer and both staff stated that Resident #1 was transferred each time that morning with a total body lift. The Administrator also stated that he addressed Resident #1's grievance about her timely assistance for therapy and spoke to FM #3 of Resident #1 to advise him that Resident #1 did not fall, but was transferred with a total body lift, both in and out of bed. The Administrator stated FM #3 requested to have Resident #1 evaluated in the ER so the NP was contacted on 12/22/2020 and gave an order to send Resident #1 to the ER for evaluation. The Administrator then stated Resident #1 was transferred to the ER on 12/22/2020 for further evaluation at the request of FM #3. The Administrator stated that on

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	345567	A. BUILDING _____ B. WING _____	C 01/20/2021

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12/29/2020, FM #3 contacted him by phone to advise that Resident #1 was diagnosed with acute fractures in the hospital and to find out how the fractures occurred. The Administrator then stated he re-opened the investigation regarding Resident #1, obtained a copy of the Resident's hospital report and conducted an investigation regarding an injury of unknown origin. The Administrator stated staff were re-interviewed still without identification of a specific incident that caused the fractures. The Administrator further stated he was currently awaiting the Physician's review of her fractures in lieu of Resident #1 diagnosis of osteopenia.

The NP was interviewed via phone on 01/07/2021 at 12:08 PM. The NP stated during the interview that she assessed Resident #1 early in December 2020 due to complaints of right hip pain and obtained an X-ray that was negative for a fracture. The NP stated her pain was treated with Tramadol. The NP described Resident #1 as having a history of osteoarthritis and chronic pain. The NP stated that Resident #1 had frequent complaints of pain which varied. The NP further stated that in December 2020, Resident #1 complained of arthritic pain to her posterior neck, bilateral shoulders, and upper back, which was treated with Lidoderm cream. The NP stated pain was a common complaint from Resident #1 due to her osteoarthritis. The NP went on to say that when she assessed Resident #1 in early December 2020 it was for a cough and complaints of upper back, neck and shoulder pain. The NP stated that an X-ray was not ordered because Resident #1 denied trauma and stated that she would prefer to "have something for the pain" due to her history of arthritis. The NP stated when she assessed Resident #1 in

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December 2020, there was no swelling, redness, warmth or anything to indicate trauma. The NP stated that due to her cough we ordered a chest X-ray which was positive for pneumonia which was treated with antibiotic therapy. Resident #1 stated that she thought her hip pain was because her mattress was deflated so staff changed out her mattress. The NP also stated that she thought that the Resident's diagnosis of osteoporosis could contribute to the Resident sustaining non-pathological fractures, and that an impact fracture could be attributed to her comorbidities. The NP further stated that in the case of Resident #1 it was possible for her to sustain a fracture from being repositioned by staff and not from a traumatic event.

A phone interview occurred on 01/06/2020 at 3:00 PM with the Physician. The Physician stated that he was notified by the Administrator that Resident #1 reported a fall in the facility, she was transferred to the ER and diagnosed with fractures. The Physician stated the facility conducted an investigation, but that no staff admitted to dropping her or stated that any traumatic injury occurred. The Physician stated that in his evaluation he felt that the fractures she sustained could be consistent with staff lifting her and putting her back on her bottom. The Physician stated Resident #1 had an underlying diagnosis of osteopenia which meant that her bones were porous and would not break but would crush due to the force of injury being parallel to the longitudinal axis to the bone. As a result, the Physician stated that in the case of Resident #1, a fracture could occur during staff repositioning because Resident #1 did not have the upper body strength to assist staff during her transfers, so all of her weight would be on the

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staff. The Physician also stated that although an impaction fracture usually speaks to a forceful event, in the case of Resident #1, the mechanics of her injury could have resulted from being repositioned by staff.

The facility provided a plan of correction with a correction date of 12/31/2020. The facility's plan of correction included the following information:

1. On 12/22/2020, the facility assessed and interviewed Resident #1, interviewed Nurse #1 and PCA #1 and #2 and conducted an investigation as a result of a report from Resident #1 that she had been dropped by staff and that she was in pain. Resident #1 was assessed by Nurse #1 with no acute findings. Resident #1 was medicated by Nurse #1 for complaints of pain. Resident #1 was transferred to the ER at the request of family due to complaints of pain. Resident #1 was diagnosed with fractures and treated for pain management in the ER. The facility conducted and submitted an initial investigation on 12/29/2020 to the HCPI and submitted 5-day investigation to HCPI on 01/04/2021 for an injury of unknown origin.

2. The facility took the incident of unknown origin to QAPI (Quality Assurance and Performance Improvement) to develop a plan of correction with audit tools, monitoring tools and in-services.

The facility identified the following:

1. We did not investigate abuse timely. An Initial investigation report was not submitted until 12/29/2020 when the facility was notified by family that Resident #1 sustained fractures. Facility provided re-education to all staff regarding the

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facility policy on Abuse, Neglect and Exploitation, and on reporting abuse and conducting a thorough investigation after a reported event/concern to identify, report and investigate all allegations of abuse. This re-education began on 12/30/2020 and was completed on 12/31/2020. The facility began auditing any concerns related to abuse. The facility conducted a daily review of any allegations of abuse for any concerns with prevention, reporting or investigation. No further concerns were noted. Concerns will be discussed in QAPI meetings for further follow up.

2. We did not follow the care plan for transfers. Resident #1 alleged she was transferred by her arms and not with a total body lift. We conducted a 100% audit on all care plans regarding transfers to ensure the care plan documents correctly. All staff were re-educated on completing transfers per the care plan. If a resident is found in an awkward position, we have trained staff to consult the nurse for an assessment and direction on how to reposition. Re-education to all staff for transfers began on 12/30/2020 and was completed on 12/31/2020. All staff provided verbal and return demonstrations. The facility began audits and conducts audits on 10 transfer per week. Any concerns are taken to QAPI for further follow up.

All residents have the potential to be affected by the deficient practice. The facility has monitored transfers weekly, reviewed progress notes for any documentation of changes in condition to ensure these changes are addressed timely and that the MD/NP, Administrator and DON are notified. The facility has met with nurses to review audits, review progress notes, complete rounding sheets

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and to ensure head to toe assessments are completed and documented in the medical record when a change in condition occurs. The facility completed a 100% chart audit for all residents regarding a change in condition. No additional concerns found.

QAPI - The facility's QAPI team met after this incident occurred to discuss root cause, in-servicing, audit tools and monitoring. The facility identified the root cause to be Resident #1 slid down in her recliner, staff lifted her using her arms to get her upright then used the lift pad to slide her back in the recliner. Next meeting will be 01/21/2021 for review of audit tools, monitoring and discussion of any changes in monitoring needed.

The facility alleges correction date on 12/31/2020.

On 01/12/2021, the facility's corrective action plan with correction date of 12/31/2020 was validated by the following: review of staff in-services (nursing, managers, nurse aides, PCAs and therapy staff), audit tools and monitoring tools regarding identifying, reporting and investigating abuse and neglect, transfers conducted per the care plan, documenting changes in condition, and completing/documenting head to toe assessments in the medical record when a change in condition occurs. Interviews with staff revealed they were re-educated per the documentation of in-services provided. Interviews with management staff revealed they completed audits and monitoring per the audit tools and monitoring documentation provided. Observations of transfers for sampled residents were conducted while the survey team was onsite on 01/04/2021 with no concerns noted.

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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 a Minimum Data Set (MDS) assessment for cognitive patterns. This occurred for 1 of 3 sampled residents reviewed for MDS accuracy (Resident #1). The findings included: Resident #1 was admitted to the facility on 2/17/2017. Diagnoses included major depression disorder, anxiety disorder, unspecified dementia without behavioral disturbance and prior cerebral infarction with residual dense right hemiparesis, among others. Review of the electronic medical record (EMR) for Resident #1 revealed a quarterly Minimum Data Set (MDS) assessment, dated 09/15/2020 which assessed Resident #1 with a summary score of 12 out of 15 (moderate impairment) for a Brief Interview of Mental Status (BIMS) in Section C - Cognitive Patterns. Further review of the EMR for Resident #1 revealed an annual MDS assessment dated 12/16/2020, with an assessment score of 99 (resident unable to complete interview) for a BIMS in Section C - Cognitive Patterns but did not assess her cognition by conducting a staff assessment. The MDS Coordinator was interviewed by phone	F 641	F880 The MDS for Resident #1 was corrected on 12/31/2020. To prevent this from recurring on 2/12/21, all residents were reassessed for Section C – Cognitive Impairments to ensure the previous assessment accurately reflect the resident status. The facility Administrator educated the Social Worker and Social Worker assistant on 2/12/20 on accurately completing assessments to properly reflect the resident’s status. Education will be provided to all new Social Workers and social worker assistants during orientation. To monitor and maintain ongoing compliance, beginning 2/12/2021, the facility Administrator or their designee will audit 5 completed MDS Assessments per week for two weeks, then 5 MDS Assessments per week for two weeks and randomly thereafter to validate compliance properly completing assessments to reflect the resident’s status. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 2/12/21	2/12/21

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F 641	Continued From page 19 on 1/12/2021 at 2:06 PM. The MDS Coordinator stated that the Social Worker (SW) was responsible for completion of Section C - Cognitive Patterns of the MDS. The MDS Coordinator further stated that by the time she recognized that Section C had not been accurately completed, the Assessment Reference Date (ARD) had passed and it was too late to correct the MDS. The SW was interviewed by phone on 1/13/2021 at 9:49 AM and stated that she did not accurately complete Section C - Cognitive Patterns on the annual MDS of 12/16/2020 for Resident #1, but by the time she realized her error, it was past the ARD and too late to correct the MDS. An interview was conducted on 01/12/2021 at 10:00 AM with the Administrator and the Regional Director of Operations. The interview revealed that the facility recognized that Section C - Cognitive Patterns, was not accurately completed on the annual MDS of 12/16/2020 for Resident #1 and that MDS staff were instructed to correct the error by submitting a modified MDS.	F 641	Title of person responsible for implementing acceptable plan of correction: Joshua Wood, LNHA	