STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 4/10/23 through 4/13/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VLTN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 4/10/23-4/13/23. Event ID# VLTN11. The following intakes were investigated: NC00200663, NC00190698, NC00193620, NC00193485, and NC00190625. 9 of the 9 complaint allegations did not result in deficiency.	F 000		
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 staff interviews and record reviews, the facility failed to accurately code significant weight loss, cognitive status, mood, and medications received on the Minimum Data Set (MDS) assessments for 3 of 23 residents (Residents #24, #1 and #48) reviewed for MDS accuracy. 1. Resident #24 was admitted to the facility on 5/6/2022 with diagnoses that included Diabetes Mellitus type II and acute kidney failure. A review of the quarterly Minimum Data Set	F 641	This plan of correction constitutes our written plan of compliance for deficiencies cited; however, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal laws. On 4/12/2023 a modification was submitted for resident #48 correcting the coding for antidepressants in section N of	5/2/23

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

Electronically Signed | 04/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

(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 641	Continued From page 1 (MDS) for Resident #24, dated 2/20/2023, was conducted. Next to the question, for significant weight loss, had the Resident lost 5% or more in the last month or 10% or more in the last 6 months, the answer was no. A review of the electronic medical record revealed Resident #24 weighed 270.0 pounds (lbs.) on 1/2/2023 and 252.8 lbs. on 2/4/2023. The Resident had lost 17.2 lbs. and 15.7% of his body weight. An interview was conducted with the MDS Nurse #1 on 4/12/2023 at 11:42 a.m. The MDS nurse reviewed the electronic medical record for Resident #24 and stated the Resident had lost 17.2 lbs. from 1/2/2023 and 2/4/2023. She added the weight loss was prior to the assessment date for the quarterly MDS dated 2/20/2023 and the response that the Resident had not experienced 5% weight loss was inaccurate. 2. Resident #1 was admitted to the facility on 3/10/21 with diagnoses that included, in part, dementia and anxiety disorder. The quarterly MDS assessment dated 2/14/23 revealed the Brief Interview for Mental Status (BIMS) and mood interview should be conducted with Resident #1; however, the interviews were coded with dashes which indicated the resident's cognitive status and mood state were not assessed. The Social Worker (SW) and MDS Nurse #1 were interviewed on 4/12/23 at 2:35 PM. The SW shared she was responsible for the completion of the cognition and mood sections of the MDS assessment and Resident #1 was able to be interviewed for the sections. The SW verified she	F 641	the MDS. On 4/13/2023 a modification was submitted for resident #24 correcting the coding for weight loss on the MDS assessment. Resident #1 still resides in the facility. She has had a new MDS assessment completed on 3/31/23. The mental status (BIMS) was coded accurately. The mood interview was also completed accurately. To identify other residents who have the potential to be affected, beginning 4/17/2023 MDS assessments were audited for the last 30 days for accurate coding of section N, C, D, and K. Any identified issues will be corrected and submitted for modifications. To prevent this from recurring, on 4/19/2023 the Regional MDS Consultant educated the MDS coordinators and social worker on accurately coding MDS assessments per the RAI manual. On 4/26/2023 the Regional MDS Consultant educated the Dietary Manager on accurately coding MDS assessments per the RAI manual. On 5/1/2023, the Regional MDS Consultant educated the social worker on accurately coding MDS assessments per the RAI manual. All new MDS coordinators, social workers, and dietary managers will receive this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

(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 641	Continued From page 2 completed the cognition and mood sections, but she had missed the assessment reference date deadline to interview Resident #1 and coded dashes (not assessed) for the resident interviews. The SW added she wasn't sure why she missed completing the interviews with Resident #1 and said there may have been "a lot going on" that day or she may have been overwhelmed with responsibilities and hadn't completed the resident interviews on time. MDS Nurse #1 clarified if the resident interviews were not conducted by the ARD, then staff coded the interviews as not assessed. During an interview with the Administrator on 4/13/23 at 3:30 PM, he stated MDS Nurse #1 should have reviewed the SW's coding and verified the assessment was accurate and complete. 3. Resident #48 was admitted to the facility on 10/30/21 with diagnoses that included, in part, dementia and generalized anxiety disorder. The physician orders were reviewed for January 2023 and February 2023 and revealed no orders for an anti-depressant medication. The quarterly MDS assessment dated 2/3/23 and completed by MDS Nurse #1 revealed Resident #48 received an anti-depressant medication seven of seven days during the look back period. On 4/12/23 at 2:41 PM, an interview was completed with MDS Nurse #1. She verified she completed Resident #48's MDS assessment. She said when she coded medications on the MDS, they were coded per drug classification and not how they were used. She explained she	F 641	same education prior to completing MDS assessments. To monitor and maintain ongoing compliance beginning 4/1/2023, the MDS consultant or designee will audit 5 MDS assessments per week X 12 weeks for accurate completion of section N, C, D, and K. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 5/2/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

(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 641	Continued From page 3 thought she might have mistakenly coded another medication (Memantine) as an anti-depressant and added the coding error was an oversight. During an interview with the Administrator on 4/13/23 at 3:27 PM, he said there might have been some confusion with how MDS Nurse #1 viewed medications on the facility's computer system which resulted in the coding error.	F 641		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring,	F 867		5/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

(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 867	Continued From page 4	F 867		

and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

(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 867	Continued From page 5	F 867		

high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

(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 867	Continued From page 6 action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 1/27/22. This was for 1 deficiency that was cited for Accuracy of Assessments (F641) cited on 1/27/22 and recited on the current recertification and complaint survey of 4/13/23. The duplicate citations during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag is cross referenced to: F641- Based on staff interviews and record reviews, the facility failed to accurately code significant weight loss, cognitive status, mood, and medications received on the Minimum Data Set (MDS) assessments for 3 of 23 residents (Residents #24, #1 and #48) reviewed for MDS accuracy. During the recertification and complaint survey of 1/27/22, the facility failed to accurately code the Pre-Admission Screening and Resident Review (PASRR) on the comprehensive MDS assessment for 1 of 3 residents reviewed for PASRR.	F 867	On 4/12/2023 a modification was submitted for resident #48 correcting the coding for antidepressants in section N of the MDS. On 4/13/2023 a modification was submitted for resident #24 correcting the coding for weight loss on the MDS assessment. Resident #1 still resides in the facility. She has had a new MDS assessment completed on 3/31/23. The mental status (BIMS) was coded accurately. The mood assessment was coded accurately. All residents have the ability to be affected by this deficient practice. The findings from the MDS accuracy assessment will be reviewed weekly by the QAPI committee to ensure compliance with the implemented measures. To prevent this from reoccurring, on 4/25/23 the Regional Director of Clinical Services educated the interdisciplinary team on the federal regulations of QAPI. All new IDT members will receive this same education prior to completion of orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

(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 867	Continued From page 7 An interview with the Administrator on 4/13/23 at 3:33 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through quality measures, trends with grievances, previous survey results and corporate established standards. The Administrator shared the facility had a high volume of admissions and discharges which required numerous MDS assessments and that may have contributed to the inaccurate coding on the MDS assessments.	F 867	Beginning 5/4/2023, a QAPI meeting form will be completed weekly to show compliance for the plan of correction for F641 for 12 weeks. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 5/2/2023	