F 278
SS=D
483.20(g) - (j) ASSESSMENT
ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview the facility inaccurately assessed Resident #16 bladder incontinence. This was evident in 1 of 5 resident assessments reviewed for incontinence.

Findings included:

Preparation and submission of this plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exits or that...
Resident #16 was admitted to the facility on 1/12/15 with cumulative diagnoses which included hypertension and dementia.

Record review of the Minimum, Data Set (MDS) admission assessment dated 1/19/15 revealed Resident #16 was coded being occasionally incontinent of urine (referring to less than 7 episodes of incontinence).

Continued record review revealed the quarterly MDS assessment dated 4/8/15 revealed Resident #16 experienced a decline of urinary incontinence and was coded as being frequently incontinent (referring to 7 or more episodes of urinary incontinence, but at least one episode of continent voiding).

Interview and record review of the nursing assistant (NA) documentation and nurses’ notes of Resident #16 bladder incontinent with the current MDS coordinator was conducted on 6/24/15 at 5:39 PM. The current MDS coordinator indicated Resident #16 was coded inaccurately. Review of the NA documentation and nurses’ notes indicated Resident #16 had experienced 9 episodes of urinary incontinence during the period of assessment for 1/19/15. The current MDS coordinator indicated the resident status had not changed and was always frequently incontinent of urine. The previous MDS coordinator who conducted the assessment was no longer employed at the facility. A telephone interview on 6/25/15 at approximately 11 AM with the previous MDS coordinator revealed she could not recall the inaccurate assessment.

F 278 one was cited correctly. This plan of correction is submitted to meet requirements by the state and federal law.

F278: It is the policy of this facility to ensure that all patients are accurately assessed for medical, social, mental, emotional, and physical needs. The facility must conduct, initially and periodically, a comprehensive, accurate, standardized reproducible assessment of each patient's functional capacity.

This was achieved for the resident #16 by reviewing the resident's bladder incontinence status using the continence documentation completed by the nurse aids from January 13-19, 2015 through June 2015. This was completed during the annual survey by the current MDS nurse on June 25, 2015. The MDS dated 1/19/15 was modified to reflect resident frequent urinary incontinence status. Resident #16 successfully completed the rehab stay at the facility and was discharged back to an assisted living facility.

For other residents with the same potential to be affected by this alleged deficient practice, by achieving the following.

A 100% audit of urinary status coding was completed by the MDS nurse and DON to
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ensure each resident's current MDS is accurately coded to reflect the resident's urinary continence status.

The audit was completed utilizing the resident list generated on the resident census and condition report from data generated from each resident's current MDS in the electronic health record, identifying residents with occasional or frequent incontinence.

To enhance currently compliant operations and under the supervision of the DON the current MDS nurse was reeducated for Chapter 3, section H coding of urinary status 07/07/17. The MDS nurse was reeducated to monitor the nurse aides documentation for the continence during a look back period, but also refer to nurses narrative notes and verbal interviews with residents and staff during the look back period.

Licensed nurses and aides were in serviced for the accuracy of documentation required to code and MDS to reflect the functional needs of each resident. Also the DON reviewed the regulatory interpretive for compliance with F 278 with all Licensed nurses and nurse aides. Completed date for training is 7/10/15.

Effective 7/10/15 a quality assurance program was completed under the supervision of the DON to monitor coding of MDS for accuracy. The DON or designated Licensed RN will audit 5 MDS's weekly x 4 weeks for accuracy of coding, then the DON for designated
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 278</td>
<td>Continued From page 3</td>
<td>F 278</td>
<td>Licensed RN will audit 3 MDS's weekly x 4 weeks. Any concerns identified will be immediately addressed and corrected on the spot. The MDS nurse is responsible for compliance, monitored by the DON. All concerns identified are documented and presented at the quarterly QA meeting for further review or corrective action.</td>
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<td>F 371</td>
<td>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</td>
<td>F 371</td>
<td>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and date frozen food items when opened. The findings included: During the initial tour of the kitchen on 6/23/15 at 8:40 AM an observation of food items in the walk-in freezer revealed bags of beef steak patties, cauliflower, sweet potato patties, pancakes, and 4 way vegetable mix which had been opened but did not have labels of open dates on them. During an interview with the Dietary Manager on 6/23/15 at 8:47 AM she stated she was not aware the items in the freezer were not dated. She was observed to use a marker to begin dating the</td>
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<td>Preparation and submission or this plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exits or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law.</td>
<td>7/10/15</td>
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<td>F 371</td>
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<td>F 371: It is the practice of this facility to store, prepare, serve, and distribute food under</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

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<td>outer boxes which contained the opened bags. She stated she knew when the food items were opened based when they were on the menu.</td>
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