## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345483

**Multiple Construction:**
- **A. Building:**
- **B. Wing:**

**Date Survey Completed:** 11/04/2015

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Regulation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 278</td>
<td>SS=D</td>
<td>483.20(g) - (j)</td>
<td>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</td>
<td></td>
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</tbody>
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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 interviews the facility failed to accurately assess and include the active diagnoses such as dementia and hypertension on the Minimum Data Set (MDS) for 1 of 14 residents (Resident #53) comprehensive assessments reviewed.

This Plan of Correction is submitted to address deficiencies cited under Tag #F278.

This is to state that we do not concur with this recommendation as stated for.

### Laboratory Director's or Provider/Supplier Representative's Signature

**Date:** 11/30/2015

Electronically Signed
### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 278</td>
<td>Continued From page 1</td>
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- **F 278**
  - **Findings included:**
    - Resident #53 was admitted to the facility on 9/17/15. Accumulative diagnoses included dementia and hypertension.
    - A record review of Resident #53 admission MDS dated 9/24/15 revealed dementia and hypertension were not coded in section I - Active diagnoses.
    - Physician orders for resident #53 for the corresponding time frame included an order for Aricept for dementia and Norvasc for hypertension.
    - On 11/3/15 at 1:42 PM, an interview with the MDS coordinator revealed dementia and hypertension should have been coded on the MDS. She stated that she would correct it on the next MDS.
    - On 11/3/15 at 2:13 PM, an interview with the director of nursing (DON) revealed her expectation was for dementia and hypertension to be coded accurately on resident #53’s MDS.
    - On 11/03/15 at 2:15 PM, an interview with the administrator revealed his expectation would be for the MDS to be coded accurately.
  - **deficient practice. Upon finding stated deficiencies.**

  - On November 3, 2015 the assessment date October 15, 2015 for Resident #53 was corrected with appropriate diagnosis codes added to Section I of the MDS.

  - On November 10, 2105 the MDS Coordinator and Director of Nurses audited and reviewed current resident MDSs to ensure accuracy of diagnosis coded in Section I of the MDS. All MDSs were found to be coded accurately.

  - The MDS Coordinator and Rehab Director will discuss and review resident diagnosis and the relevance of the diagnosis to resident care while in the facility on a weekly basis. Diagnosis to be coded will have a direct relationship to the resident’s current functional, cognitive, or mood or behavior status, medical treatments or nurse monitoring.

  - All MDS Assessments will be completed accurately, timely and according to the RAI Manual. The Director of Nurses will conduct random reviews on a weekly basis. All findings will be reported to the Q.A. Committee monthly for a period of three months.