

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

PRINTED: 07/12/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/22/2016
NAME OF PROVIDER OR SUPPLIER PENICK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
(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 278} SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to accurately assess behaviors on the Minimum Data Set (MDS) assessment for one of three residents (Resident #42) reviewed for assessment accuracy. The findings included:</p>	{F 278}	The medical record of resident #42 was reviewed. Based on the nursing aide documentation in the medical record at the time of the survey the MDS assessment for resident # 42 was inaccurate. Nurses and nursing aides	6/28/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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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{F 278}	<p>Continued From page 1</p> <p>Resident #42 was admitted to the facility on 12/15/15 with multiple diagnoses that included anxiety and Parkinson's disease.</p> <p>A comprehensive Minimum Data Set (MDS) assessment dated 6/1/16 indicated Resident #42 had moderately impaired cognition and had received an antianxiety medication one day during the seven day look back period. The Behavior Section of the 6/1/16 MDS indicated he had no behavioral issues during the look back period.</p> <p>Nursing Assistant (NA) behavioral documentation for the 6/1/16 MDS look back period revealed Resident #42 had verbal and physical behaviors on 5/26/16 and 5/28/16.</p> <p>A review of Resident #42's physician's order indicated an order for Lorazepam (antianxiety medication) 0.5 milligrams (mg) for agitation every six hours as needed (PRN) for agitation. Resident #42's Medication Administration Record (MAR) for the 6/1/16 MDS look back period revealed the PRN Lorazepam was administered to Resident #42 twice on 5/31/16 for anxiety.</p> <p>An interview was conducted on 6/22/16 at 10:20 AM with the Social Worker (SW). She stated she was responsible for completing the Behavior Section of the MDS. She indicated she utilized nurse notes, nurse interviews, NA notes, and NA interviews to complete the Behavior Section of the MDS. The 6/1/16 MDS for Resident #42 was reviewed with the SW. The NA behavioral documentation that indicated Resident #42 had verbal and physical behaviors on two days (5/26 and 5/28) during the look back period of the</p>	{F 278}	<p>involved in the care of resident # 42 during the look back period were met with to discuss resident # 42. It was determined that resident # 42 did not have any behaviors during the look back period. Resident # 42 received the anti-anxiety medication because he was experiencing anxiety and agitation. The order for the anti-anxiety medication states that it is for agitation. The Social Worker's assessment was that the agitation did not categorize as a behavior during the look back period. A nursing aide erroneously documented behaviors by clicking a box within our medical record system. On Saturday June 25th we interviewed the nursing aide who documented the behaviors. He indicated that resident # 42 sometimes gets anxious and agitated. The nursing aide indicated that he only meant to document resident # 42's anxiety and agitation. After learning the distinction between agitation / anxiety and a behavior our nursing aide corrected the documentation he had entered on resident # 42. After the nursing aide documentation was corrected the medical record and the MDS assessment were congruent.</p> <p>Our Director of Nursing, Social Worker and Minimum Data Set Coordinator audited the Nursing Aide documentation for all current residents on Monday June 27, 2016 to ensure that all documented behaviors are acknowledged and addressed in our care plans. We provided in-services on June 27th for all of our nurses and nursing aids to</p>		

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{F 278}	Continued From page 2 6/1/16 MDS was reviewed with the SW. The MAR that indicated Resident #42 had received PRN Lorazepam for anxiety two times on one day (5/31) during the look back period of the 6/1/16 MDS was reviewed with the SW. The SW stated she had looked at the NA behavioral documentation when she completed the 6/1/16 MDS for Resident #42. She indicated that to her knowledge Resident #42 had no behaviors and she thought the information in the NA behavioral documentation was inaccurate. She additionally indicated she had not known what behaviors precipitated the PRN Lorazepam that was administered to Resident #42 on 5/31/16. She stated that for those reasons she indicated on the 6/1/16 MDS that Resident #42 had no behavioral issues during the look back period. She revealed the Behavior Section of the 6/1/16 MDS for Resident #42 had not corresponded to the documentation in the medical record. An interview was conducted on 6/22/16 at 11:50 AM with the Director of Nursing. She indicated her expectation was for the MDS to be accurately.	{F 278}	clearly define how behaviors are defined and how behaviors should be documented. Nursing aides can now only document information on Activities of Daily Living. Nurses and physicians are the only healthcare professionals capable of documenting behaviors. If a nursing aide believes that a behavior needs to be documented the nursing aide will communicate that to the nurse or physician. Annual In-services on behaviors will be held and will include education on what qualifies as a behavior, what to do (by position) if a behavior is occurring, behavior documentation requirements and the follow up requirements involved with behavior management. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review how behaviors are being documented and managed. All new behaviors for that week will be reviewed and both nursing documentation and MDS documentation will be audited for accuracy. Date of Completion June 28, 2016		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		6/28/16	

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F 520	Continued From page 3 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 5/5/16 recertification survey. This was for the recited deficiency in the area of Assessment Accuracy (F278). This deficiency was cited again on the follow up recertification survey of 6/22/16. The continued failure of the facility during two federal surveys of record show	F 520	Penick Village has a Quality Assurance committee that meets at least quarterly and includes our Physician Medical Director, Director of Nursing and at least three other members of our staff. The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) have been meeting weekly as described in our plan of		

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F 520	<p>Continued From page 4</p> <p>a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included:</p> <p>This tag is cross referenced to:</p> <p>F278 Assessment Accuracy: Based on medical record review and staff interviews, the facility failed to accurately assess behaviors on the Minimum Data Set (MDS) assessment for one of three residents (Resident #42) reviewed for assessment accuracy.</p> <p>During the recertification survey on 5/5/16 the facility was cited F278 for failing to accurately assess Resident #42 in the area of behaviors on the MDS assessment. On the follow up recertification survey of 6/22/16 the facility failed to correct the inaccurate assessment of behaviors for Resident #42 on the MDS assessment.</p> <p>An interview was conducted with the Administrator on 6/22/16 at 2:00 PM. He indicated he was the head of the facility's QAA Committee. He stated the QAA Committee consisted of the Medical Director, Director of Nursing, Clinical Coordinator, MDS Coordinator, Social Worker, Therapy Coordinator and the Pharmacy Consultant. He indicated the committee met monthly.</p> <p>The Administrator stated he was aware assessment accuracy was a repeat deficiency from the recertification survey on 5/5/16. He indicated he was not aware of the continued failure to accurately assess Resident #42 in the area of behaviors on the MDS assessment. He stated the facility became aware of extensive</p>	F 520	<p>correction following our May 2016 recertification survey. Topics covered in that weekly meeting include but are not limited to: audits of comprehensive assessments and audits of quarterly assessments. Documented findings and completion dates are reported during the next facility QA meeting as described in our plan of correction following our May 2016 recertification survey.</p> <p>Cross Reference to F 278 -</p> <p>After the survey on June 22nd the medical record of resident #42 was reviewed. Based on the nursing aide documentation in the medical record at the time of the survey the MDS assessment for resident # 42 was inaccurate. Nurses and nursing aides involved in the care of resident # 42 during the look back period were met with to discuss resident # 42. It was determined that resident # 42 did not have any behaviors during the look back period. Resident # 42 received the anti-anxiety medication because he was experiencing anxiety and agitation. The order for the anti-anxiety medication states that it is for agitation. The Social Worker's assessment was that the agitation did not categorize as a behavior during the look back period. A nursing aide erroneously documented behaviors by clicking a box within our medical record system. On Saturday June 25th we interviewed the nursing aide who documented the behaviors. He indicated that resident # 42 sometimes gets anxious and agitated.</p>		

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F 520	Continued From page 5 concerns with MDS assessments during the recertification survey on 5/5/16. He indicated the facility had a new MDS Coordinator and they were working to resolve their issues with MDS assessments. When asked about monitoring for the accuracy of assessments the Administrator was not able to provide evidence they had corrected the deficiency.	F 520	<p>The nursing aide indicated that he only meant to document resident # 42's anxiety and agitation. After learning the distinction between agitation / anxiety and a behavior our nursing aide corrected the documentation he had entered on resident # 42. After the nursing aide documentation was corrected the medical record and the MDS assessment were congruent.</p> <p>Our Director of Nursing, Social Worker and Minimum Data Set Coordinator audited the Nursing Aide documentation for all current residents on Monday June 27, 2016 to ensure that all documented behaviors are acknowledged and addressed in our care plans.</p> <p>We provided in-services on June 27th for all of our nurses and nursing aids to clearly define how behaviors are defined and how behaviors should be documented.</p> <p>Nursing aides can now only document information on Activities of Daily Living. Nurses and physicians are the only healthcare professionals capable of documenting behaviors. If a nursing aide believes that a behavior needs to be documented the nursing aide will communicate that to the nurse or physician.</p> <p>Annual In-services on behaviors will be held and will include education on what qualifies as a behavior, what to do (by position) if a behavior is occurring,</p>		

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F 520	Continued From page 6	F 520	<p>behavior documentation requirements and the follow up requirements involved with behavior management.</p> <p>The Penick Village Nursing Home Administrator (NHA), Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) will meet weekly for the next 90 days to review how behaviors are being documented and managed. All new behaviors for that week will be reviewed and both nursing documentation and MDS documentation will be audited for accuracy.</p> <p>Date of Completion June 28, 2016</p>		