No deficiencies were cited as a result of the compliant investigation. Event ID # PC4311

### Accuracy/Coordination/Certified

- **(g)** Accuracy of Assessments. The assessment must accurately reflect the resident's status.
- **(h)** Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
- **(i)** Certification
  - (1) A registered nurse must sign and certify that the assessment is completed.
  - (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
- **(j)** Penalty for Falsification
  - (1) Under Medicare and Medicaid, an individual who willfully and knowingly-
    - (i) 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
  - (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.
  - (2) Clinical disagreement does not constitute a...
F 278 Continued From page 1

This REQUIREMENT is not met as evidenced by:

Based on record reviews and staff interviews, the facility failed to accurately code information on an admission Minimum Data Set regarding assistance with eating for 1 of 1 sampled resident with a tube feeding (Resident #61).

The findings included:

Resident #61 was admitted on 12/01/16 with diagnoses including dysphagia (difficulty swallowing), severe debility, and severe protein calorie malnutrition.

Review of a progress note written by the Registered Dietitian on 12/06/16 revealed Resident #61 had a PEG (percutaneous endoscopic gastrostomy) tube for feeding due to dysphagia according to the hospital report. The RD noted Resident #61's diet was NPO (nothing by mouth) and he was a total tube feed.

Review of the admission Minimum Data Set (MDS) dated 12/08/16 revealed Resident #61 had severely impaired cognition, unclear speech, and was sometimes understood. The admission MDS noted Resident #61 had a feeding tube and received 51% or more of his total calories through the tube feeding. The admission MDS indicated Resident #61 required extensive assist of one person with eating.

An interview with Nurse #1 on 02/17/17 at 12:50 PM revealed Resident #61 was NPO and did not have orders for comfort foods. Nurse #1 stated Resident #61 did not participate in his tube feeding in any way.

All residents having a PEG (percutaneous endoscopic gastrostomy) tube for eating have the potential to be affected by the alleged deficient practice. Audit revealed no other residents affected.

MDS Coordinator to be re-educated on accurate coding of residents having a PEG tube for eating by the Director of Nursing (DON) by March 3, 2017. The DON or Assistant DON will audit MDS for accurate coding for residents having a PEG tube for eating weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 4 months.

The DON/Assistant DON will report results of audit to the Quality Assessment and Performance Improvement Committee monthly for six months with revisions as determined by the QA Committee.

March 9, 2017
An interview was conducted with the MDS Nurse on 02/17/17 at 2:52 PM which included a review of Resident #61's admission MDS. The MDS Nurse confirmed she had completed Resident #61's admission MDS assessment dated 12/08/16 including Section G for Activities of Daily Living Assistance. The coding for eating self-performance and support was reviewed and the MDS Nurse stated Resident #61 should have been coded for total dependence on one person with eating and not extensive assist of one person with eating due to the continuous tube feeding. The MDS Nurse could not explain how the coding error had occurred.