STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: THE REHAB AND HC CTR AT VILLAGE GR

STREET ADDRESS, CITY, STATE, ZIP CODE: 1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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<th>ID</th>
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<tr>
<td>F 164</td>
<td>SS=D</td>
<td>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</td>
<td>F 164</td>
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<td>4/10/17</td>
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The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident’s right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident’s records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, Responsible Party (RP) interview and staff interviews, The facility failed to honor confidentiality and privacy by transferring medical records to another facility for 1 of 1 sampled resident. (Resident # 3)

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<tr>
<th>DATE</th>
<th>LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’s SIGNATURE</th>
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<td>03/28/2017</td>
<td>Electronically Signed</td>
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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.
Findings included:

Resident #3 was admitted to the facility on 9/29/2015 with diagnosis of Hemiplegia, Cerebrovascular, Muscle weakness, Dysphagia, Hypertension. The Minimum Data Set (MDS) dated 1/13/2017 indicated the resident was severely cognitively impaired.

During the interview with the director of Social Services on 3/13/2017 at 10:55 AM. She reported the RP did not speak with her personally regarding the transfer of the medical records to another facility. She further reported the RP spoke to Nurse #1 about looking into transferring the resident to another facility.

During the interview with Nurse #1 on 3/13/2017 at 11:30 AM, she reported she did not document anywhere in the records regarding the RP giving consent to transfer the medical records to another facility.

During the interview with the RP on 3/13/2017 at 11:45 AM, he reported he did not give any consent to the facility's staff to transfer medical records to another facility.

During the interview with Administrator on 3/13/2017 at 3:00 PM, he reported he expected the staff to have documented the conversation with the RP regarding consent to transfer the medical records to another facility.

corrective action could be taken since the resident information had already been disseminated. We did apologize to resident #3 and the RP for the error.

2) Actions taken for all residents due to the potential for being affected:

A. On 3/28/2017 the appropriate facility staff were in-serviced by the Social Worker regarding:

(1) The importance of documenting that a resident or RP has requested for resident information to be sent outside the facility prior to the dissemination of the information.

3) Actions taken to prevent further recurrence:

A. Social Worker, or designee, will audit all requests for information to be sent out of the facility 2X week for 4 weeks for proper documentation of such request.

B. Following Step 3A, Social Worker, designee, will conduct random monthly audits X 2 months, followed by quarterly X 2 quarters, and as needed for compliance with documentation of all requests for resident information.

4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee:

A. Social Worker, designee, will bring results of audits to morning administrative team meeting for review, weekly X 4 weeks.

B. Results of all audits will be brought to the facility QAA meeting by the Social Worker, designee, and reviewed by the QAA committee monthly X 2 months, quarterly X 2 quarters, and as needed.

C. Any non-compliance with established
## Statement of Deficiencies and Plan of Correction

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<td>F 164</td>
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<td>F 164</td>
<td>plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised.</td>
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<tr>
<td>F 250</td>
<td>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</td>
<td>F 250</td>
<td>D. Discussion, interventions, and/or revisions to established plan will be included in the meeting minutes.</td>
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<td>E. Any adjustment to the established plan, through revision and/or interventions for non-compliance will require re-in servicing of the applicable staff by the Social Worker, or appropriate designee.</td>
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<td>F. Any revision to the established plan will require the monitoring to begin again at Step 4A and continue as outlined.</td>
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### 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, Responsible Party (RP) interview and staff interviews, The facility failed to acquire consent before transferring medical records to another facility for 1 of 1 sampled resident.(Resident # 3)

Findings included:

Resident # 3 was admitted to the facility on 9/29/2015 with diagnosis of Hemiplegia, Cerebrovascular, Muscle weakness, Dysphagia,
Hypertension. The Minimum Data Set (MDS) dated 1/13/2017 indicated the resident was severely cognitively impaired.

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<td>F 278</td>
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<td>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</td>
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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
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This REQUIREMENT is not met as evidenced by:

- Based on record review and staff interviews, the facility failed to accurately assess the functional limitation in range of motion for the quarterly minimum Data Set (MDS) assessment and the Annual Comprehensive Assessment for one (1) of five (5) sampled residents. (Resident #1)

The findings are:

- Resident #1 was admitted to the facility with diagnosis of Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, and Dementia. A review of the resident's medical record revealed staff had assessed the resident's as no upper extremity impairment in the Quarter MDS assessment dated 1/26/17 and the Comprehensive Annual MDS Assessment dated 05/03/2016.

- During an interview on 3/13/17 at 3:12 PM, the MDS coordinator acknowledged the assessment must have been missed or was overlooked, because Resident (#1) has upper extremity impairment.

- During an interview on 3/13/17 at 3:25 PM, the Administrator and the Director of Nursing (DON) indicated their expectations of MDS Staff was to complete the MDS accurately.

- F 278: 483.20(g) (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

  1) Actions taken for Residents #1:

  - With regards to resident #1, the MDS was immediately corrected to accurately reflect that the resident has upper extremity impairment.

  2) Actions taken for all residents due to the potential for being affected:

     - On/before 4/10/2017, the MDS Coordinator, appropriate designee, will visually assess all residents for upper or lower extremity impairment. The MDS Coordinator, appropriate designee, will then compare all assessments to the MDS to ensure accurate coding.

  3) Actions taken to prevent further recurrence:

     - MDS Coordinator, or designee, will audit all Initial MDS Assessment Sheets 2X week for 4 weeks for proper extremity impairment coding.

     - Following Step 3A, MDS Coordinator, designee, will conduct random monthly audits X 2 months, followed by quarterly X 2 quarters, and as needed for compliance with extremity impairment coding in the MDS. Any non-compliance will be
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addressed by the MDS Coordinator, designee, as soon as practical.

4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee:
   A. MDS Coordinator, designee, will bring results of audits to morning administrative team meeting for review, weekly X 4 weeks.
   B. Results of all audits will be brought to the facility QAA meeting by the MDS Coordinator, designee, and reviewed by the QAA committee monthly X 2 months, quarterly X 2 quarters, and as needed.
   C. Any non-compliance with established plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised.
   D. Discussion, interventions, and/or revisions to established plan will be included in the meeting minutes.
   E. Any adjustment to the established plan, through revision and/or interventions for non-compliance will require re-in servicing of the applicable staff by the ADON, or appropriate designee.
   F. Any revision to the established plan will require the monitoring to begin again at Step 4A and continue as outlined.