STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345521	A. BUILDING _____ B. WING _____	C 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNUG HARBOR ON NELSON BAY	272 HIGHWAY 70 SEALEVEL, NC 28577

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey. Event ID #9FHA11.	F 000	**STATEMENT OF COMPLIANCE:** The following represents the plan of correction for the alleged deficiencies cited during the survey conducted on May 30, 2017 to June 1, 2017 at Snug Harbor on Nelson Bay. Please accept this plan of correction as Snug Harbor's Credible Allegation of Compliance with the completion date of June 29, 2017. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of Snug Harbor. This plan of correction is completed in good faith and as Snug Harbor's commitment to quality outcomes for the residents. In addition, this	6/29/17
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on review of resident medical records and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) within 3 months of the last MDS for 1 of 4 sampled residents (Resident #6). Findings included: Resident # 6 had diagnoses including Gastro-esophageal Reflux Disease, Anorexia, Cough, Hypothyroidism, Urine Retention, Sepsis, Osteoarthritis, Dry Eye Syndrome, and Atrial Fibrillation. Record review on 6/01/17 revealed the most recent Minimum Data Set (MDS) on the active record was dated 12/20/2016. There was no evidence that the Quarterly assessment, due 03/20/2017, had been completed. During an interview on 6/01/17 at 2:29 PM, the Medicaid MDS Coordinator indicated she was aware that the March assessment was due but had no explanation as to why it had not been done. On 6/1/2017 at 4:10 pm the Director of Nursing and the Administrator indicated it was the	F 276		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Penny Sprouse — Administrator — 6/29/17

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 276	Continued From page 1 expectation that the assessments be completed at least every three months.	F 276	plan of correction is completed as it required by law. **F 276** A Quarterly assessment was completed on 06/10/2017 for Resident #6. Residents residing in the facility without completed Quarterly assessments have the potential to be affected in a similar manner. A 100% Audit will be completed by the MDS Nurse Consultant and ARD Date's will be set on those residents who were found to have late Quarterly assessments by 06/29/2017.	

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F 276	Continued From page 1 expectation that the assessments be completed at least every three months.	F 276	MDS Consultant will have ongoing training with the MDS Coordinator. MDS Coordinator has been scheduled to attend Mary Maas' MDS training on September 14, 2017 and the Myers and Stauffer Seminar on August 9, 2017. The MDS Coordinator will utilize the scheduling tools provided by the MDS Consultant; 100 Day Medicare Assessment Schedule and the MDS SCHEDULE AND RUG RATES, to ensure Quarterly assessments are scheduled timely. The Administrator will meet with the MDS Coordinator weekly x 4 weeks and monthly x 2 months to audit MDS	

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F 276	Continued From page 1 expectation that the assessments be completed at least every three months.	F 276	scheduling tools to ensure Quarterly assessments are scheduled timely. The Administrator will bring the results of the audit to the monthly QAPI committee meeting for further review and recommendations.	