STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345545	A. BUILDING _____ B. WING _____	11/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY MEMORY CARE	3701 WADE COBLE DRIVE BURLINGTON, NC 27215

(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 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer,	F 640		12/19/17

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

Electronically Signed | 12/19/2017

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 640	Continued From page 1 reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a Discharge Tracking MDS (Minimum Data Set) assessment and failed to transmit a Quarterly MDS assessment within the required time frame for 2 of 3 residents (Resident # 15 and #2) selected to be reviewed for Resident Assessments. Findings included: 1. Resident # 15 was admitted to the facility on 8/22/14 with diagnoses of Other Mental Disorders, Essential Hypertension, Gastro Esophageal Reflux Disease, and Mood Disorder. A review of Resident # 15's last MDS dated 7/26/17 was coded as a quarterly assessment. A review of Resident # 15's nursing note dated 9/14/17 revealed the resident died in the facility under Hospice care. During an interview on 11/30/17 at 10:38 am with the DON (Director of Nursing), the DON reported she also has the duties of MDS coordinator. The DON reported a discharge MDS assessment was not done on Resident # 15 due to an oversight.	F 640	Plan of Correction for F640 "the facility failed to complete a Discharge Tracking MDS (Minimum Data Set) assessment and failed to transmit a Quarterly MDS assessment within the required time frame for 2 of 3 residents (Resident # 15 and #2) selected to be reviewed for Resident Assessments." Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Regarding Resident #15, a discharge assessment was completed and transmitted on 11/30/17. Additionally, an audit of all residents discharged in the previous six months will be conducted to ensure a compliance. Regarding Resident #2, the quarterly assessment was retransmitted and accepted on 11/28/17. Address what measures will be put into	

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F 640	Continued From page 2 The DON reported it is her expectation that discharge MDS's should be completed on all residents discharged. 2. Resident #2 was admitted to the facility on 4/13/16 with diagnoses that included Osteoporosis, Hypothyroidism and Hypertension. A review of resident's most recent MDS had an ARD (Assessment Reference Date) of 10/18/17 and was coded as a quarterly assessment. The MDS was signed as completed by the MDS Coordinator on 11/01/17. A review of the facility's MDS submission report revealed the MDS dated 10/18/17 was transmitted and accepted on 11/28/17. The submission report message for this assessment read: "Record submitted Late: The submission date is more than 14 days after Z00500B on this new (A0050 equals 1) assessment." During an interview with the DON on 11/30/17 at 11:00am, the DON stated she was the one responsible for completing and transmitting the MDS assessments. She indicated when she transmitted a batch of assessments on 11/28/17, she realized the assessment dated 10/18/17 had not been accepted and she re-submitted and transmitted the assessment dated 10/18/17 on 11/28/17.	F 640	place or systemic changes made to ensure that the deficient practice will not occur: An MDS Tracking and Transmission Worksheet has been created and will be reviewed by the interdisciplinary team weekly at the resident status meeting. The worksheet will list completed assessments along with their transmission date. If the transmission was not accepted initially, we will list the date it was resubmitted and accepted. This form will be completed by the MDS Nurse and she will bring it along with a copy of the transmission report to the meetings for verification by the Administrator or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility: The interdisciplinary team will review the MDS Tracking and Transmission Worksheet weekly for six months to ensure compliance and a summary report will be included and reviewed at our quarterly Quality Assurance meetings. This corrective action will be completed by December 22, 2017.	

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F 641	Continued From page 3	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) to include the active diagnoses on 1 of 5 residents (Resident #11) reviewed for unnecessary medication use and 1 of 1 residents (Resident #13) reviewed for behavioral/emotional status. Findings included: 1. Resident #11 was admitted to the facility on 9/6/11 with diagnoses of Alzheimer's disease, unspecified, Dementia without behavioral disturbances, Vitamin D deficiency, and essential Hypertension. A review of Resident #11's most recent MDS dated 9/6/17 was coded as a quarterly assessment. The assessment was coded as the resident had received antidepressants 7 out of 7 days of the assessment period. There was no diagnosis of depression marked on the MDS. A review of Resident #11's MDS dated 3/22/17 was coded as a quarterly assessment. The assessment was coded as the resident had received antidepressants 7 out of 7 days of the assessment period. There was no diagnosis of depression marked on the MDS. A review of Resident #11's physician orders revealed an order was written on 7/29/14 that	F 641	Plan of Correction for F641 "the facility failed to accurately code the MDS (Minimum Data Set) assessment to include the active diagnoses on 1 of 5 residents (Resident #11) reviewed for unnecessary medication use and 1 of 1 residents (Resident #13) reviewed for behavioral/emotional status." Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: A Diagnoses Review Sheet has been created and will be reviewed by the MDS Nurse at time of assessment. The worksheet will prompt the MDS Nurse to check the MD Progress Notes, Physician Orders, Previous MDS, History & Physical, FL2, and other consults to ensure all current diagnoses are accounted for on the assessment. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Once the MDS Nurse has completed the	12/19/17

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F 641	Continued From page 4 read Citalopram HBR (Hydrobromide) 40mg daily for depression/anxiety. During an interview on 11/29/17 at 1:30pm with the DON (Director of Nursing), the DON reported that she also performs the duties of the MDS coordinator. She indicated that depression should have been coded on Resident #11's MDS dated 3/22/17 and 9/6/17. During the interview with the DON, she stated that it is her expectation that if a resident was receiving antidepressant medications, the diagnosis of Depression should be marked on the MDS. 2. Resident #13 was admitted to the facility on 8/15/17 with diagnoses of Unspecified Dementia, Weakness, Renovascular Hypertension, and Hypothyroidism. A review of Resident #13's most recent comprehensive MDS dated 8/21/17 was coded as an admission assessment. The assessment was coded as the resident had received antidepressants 5 out of 7 days of the assessment period. There was no diagnosis of depression marked on the MDS. A review of Resident #13's physician orders revealed an order was written on 8/17/17 that read Cymbalta 30mg 1 capsule by mouth daily. A review of Resident #13's physician admission note dated 8/17/17 revealed a diagnosis of depression. A review of Resident #13's MAR (medication record) for August 2017 revealed the resident received Cymbalta daily starting on August 17,	F 641	Diagnoses Review Sheet, it will be reviewed by the backup MDS Nurse. The backup MDS Nurse will be asked to also review the MD Progress Notes, Physician Orders, Previous MDS, History & Physical, FL2, and other consults to ensure all current diagnoses are accounted for on the assessment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility: A summary report will be included and reviewed at our quarterly Quality Assurance meetings. This corrective action will be completed by December 22, 2017.	

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F 641	Continued From page 5 2017. During an interview on 11/30/17 at 10:25 am with the DON, the DON reported she performs the duties of the MDS coordinator. The DON indicated depression should have been coded on Resident #13's MDS dated 8/21/17. During the interview, the DON stated it was her expectation that if a resident is receiving antidepressants the diagnosis of Depression should be marked on the MDS.	F 641		