STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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 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 review and staff interviews the facility failed to accurately code the minimum data set (MDS) for 1 of 3 residents reviewed for falls (Resident #1.) Findings Included: Resident #1 was admitted to the facility on 11/13/17 and diagnoses included osteoarthritis, muscle weakness and Alzheimer ' s disease. Review of an incident report, provided by the Director of Nursing (DON), for Resident #1 dated 11/14/17 revealed resident was noted to be on his knees next to his bed. Resident was yelling for someone to get him up. No injuries were noted. Mechanical lift was used to get resident back into bed. Resident denied pain. A comprehensive MDS dated 11/20/17 for Resident #1 identified he had no history of falls and had not experienced any falls since admission to the facility. An interview on 3/21/18 at 3:56 pm with the MDS nurse revealed she had completed the comprehensive MDS assessment dated 11/20/17 for Resident #1. She stated she typically used the facility incident reports to code the fall section of the MDS. The MDS nurse added she must have missed the fall documentation for Resident #1 and should have coded Section J of the 11/20/17	F 641	F641 1. The plan of correcting the specific deficiency: Resident #1 MDS Assessment dated for 11/20/17 was modified and transmitted as well as accepted on 3/21/18 to reflect the fall that occurred during the MDS Assessment look back period. 2. What lead to the deficiency: The process that led to the deficiency was an omission/oversight of a fall in section J of the MDS Assessment resulting in a data entry error. 3. The procedure for implementing the acceptable plan of correction: MDS Nurse immediately modified and submitted the MDS in question, Regional Nurse Consultants re-educated the Interdisciplinary Team members responsible for coding section J on the MDS Assessments. This information will be included in the employee orientation program for newly hired IDT team members that complete section J. An audit was performed by Interdisciplinary Team members on current resident population on section J on the last MDS assessment completed to assure substantial compliance. Audit completed by 4/2/18. 4. Monitoring Procedures to ensure plan of correction is effective and remains	4/3/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/02/2018

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F 641	Continued From page 1 MDS to reflect the resident had 1 fall with no injury. An interview on 3/21/18 at 5:59 pm with the Administrator revealed it was her expectation that MDS assessments were coded accurately and according to the medical record.	F 641	corrected: The IDT will monitor 10 new MDS Assessments weekly times 4 weeks and then monthly times 3 months to ensure ongoing compliance in the accuracy of coding falls on the MDS. 5. Title of Person responsible for implementing the acceptable plan of correction: Director of Nursing in conjunction with MDS Nurses. Oversight provided by Regional Nurse Consultants. 6. Corrective dates: 4/3/18	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. 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 staff interviews and record review, the facility ' s Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the	F 865	F865 1. Plan for correcting the specific deficiency: An audit was performed by Interdisciplinary Team members on	4/3/18

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F 865	Continued From page 2 committee put into place following the 8/24/17 annual recertification survey. This was for recited deficiency in the area of assessment accuracy (F278). This deficiency was cited again during a complaint investigation survey conducted on 3/21/18. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAA Program. Findings Included: This tag is cross referenced to: 1. F641 - Assessment Accuracy: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 3 residents reviewed for falls (Resident #1.) This deficiency (F278) was originally cited 8/24/17 during an annual recertification survey for failing to code the MDS to reflect the resident ' s condition for 2 of 6 residents reviewed for behavioral and emotional status (Resident #241) and medications (Resident #222.) An interview was conducted on 3/21/18 at 5:59 pm with the Administrator and Regional MDS Consultant. The Regional MDS Consultant stated she conducted audits on MDS accuracy and if trends were identified she would include this information in the facility quality assurance process. The Administrator stated the facility MDS nurses received ongoing education from the Regional MDS nurse and additional outside sources.	F 865	current resident population on section J on the last MDS assessment completed to assure substantial compliance. Audit completed by 4/2/18. This audit will be discussed as a team at planned QAPI meeting 4/3/18 in which the VP of Operations will be in attendance. The IDT will monitor 10 new MDS Assessments weekly times 4 weeks and then monthly times 3 months to ensure ongoing compliance in the accuracy of coding falls on the MDS. This will be reviewed/discussed by QAPI team members monthly. 2. Process that lead to the deficiency: Facility's QAPI team members did not continue to monitor/audit accuracy of MDS assessments which resulted in a data entry error. 3. Monitoring Procedure: Regional Nurse Consultants will review/audit monthly QAPI results regarding accuracy of assessments for 4 months to assure facility maintains substantial compliance. A representative of the Regional Team will attend the QAPI meeting monthly times 4 months to assure ongoing compliance. 4. Title of person responsible for implementing the acceptable Plan of Correction- Facility MDS team in conjunction with DON and oversight from Regional Nurse Consultants. Facility Assistant Administrator will notify Regional team of the monthly QAPI as well as assure effective QAPI meetings. 5. Corrective dates: 4/3/18	