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 _____	09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY MEMORY CARE	3810 HERITAGE 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to complete the administration of a medication for 1 of 1 residents (Resident #2), reviewed for self-administration of medication. Findings included: Review of facility policies entitled "Twin Lakes Community Nursing Policies and Procedures", and "Self Administration Of Medications" read in part: "Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. The resident is always observed after administration to ensure that the dose was completely ingested." "Residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility. Bedside medication storage is permitted for residents who are able to self -administer medications, upon the written order of the prescriber, and when it is deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team. Residents who request approval to self-administer shall be assessed by the	F 554	"Based on observations, record reviews, staff and resident interviews, the facility failed to complete the administration of a medication for 1 of 1 residents (Resident #2), reviewed for self-administration of medication." Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. We will conduct an assessment of all residents to determine individual ability for self administration of medication. If the resident's physician determines a resident is appropriate for self medication it will be noted on the resident care plan and the staff will follow the procedures outlined in the Twin Lakes Community Nursing Policies and Procedures and Self Administration of Medication. If a resident is not able to self administer medication, the nurse on duty will follow the Twin Lakes Nursing Policies and Procedures Pharmacy: Medication Administration (General Guidelines)policy. As stated in the policy "the resident is always observed after administration to ensure that the dose was completely	10/4/18

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

Electronically Signed | 09/17/2018

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F 554	Continued From page 1 interdisciplinary team to determine if the resident is competent." Resident #2 was admitted to the facility on 10/5/17 with diagnoses that included Dementia, Gastroesophageal Reflux, Orthostatic Hypertension, Mood Disorder, Osteoarthritis and Hyperlipidemia. Review of the resident's most recent quarterly MDS dated 6/20/18 revealed the facility assessed the resident as being moderately impaired. Resident #2 required supervision for most activities of daily living with one person assist. Review of Resident #2's active care plan, dated 10/5/17, revealed there was no care plan in place for resident to self - administer her own medications. Review of Resident #2's Medication Administration Record (MAR) and her Physician Orders for the months of August and September 2018 revealed no orders to self -administer her own medications. At 12:53 pm Resident #2 was observed in the dining room feeding herself lunch. On 9/4/18 at 1:03 pm Nurse #1 was observed to place a small medicine cup with 3 pills in front of Resident #2 in the dining room as she ate lunch Nurse #1 then returned to the nurse's station in the next room. The door was closed and he was observed through a glass window in the door with his back to the dining room, facing a computer screen. Resident #2 was observed to take her pills, one at a time between bites of food and observed removing bits of substance from her mouth between bites of food. At 1:13pm	F 554	ingested." Regarding the observation with Resident #2 and Nurse #1, Nurse #1 was immediately re-educated on the proper procedures for medication administration. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: An in-service for all nursing staff on the proper medication administration procedures will be completed by 9-28-18 by Amy Franklin, Director of Nursing. 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: An audit will be conducted by our pharmacy consultant once per month for three months starting in October 2018 through December 2018 to ensure nursing staff is following the proper procedures. Documentation of the audits will be collected by the facility DON and reviewed at the Quality Assurance meeting in January 2019. The corrective action will be completed by 10/04/2018 and the audit process will	

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F 554	Continued From page 2 Resident #2 was observed to continue to pick bits of substance out of her mouth between bites of food. The medication cup was then placed upside down onto the table by Resident #2. At 1:26 pm Resident #2 placed the upside down pill cup into her ice cream cup on the table and the housekeeper was observed to throw the ice cream cup away with the med cup still placed in it upside down. At 1:29 pm Nurse #1 was asked what medications he had set down in front of Resident #2. He stated "I gave her Calcium, Lexapro and a multivitamin." An Interview was conducted with Resident #2 on 9/4/18 at 3:22 pm. When asked about medications Resident #2 stated "I guess they give me my medications. I don't give them to myself." During an interview with Nurse #1 on 9/6/18 at 12:30 pm he stated about Resident #2's medication administration, "I always watch her but I don't always stand beside her. I keep an eye on her." Interview with the Director of Nursing (DON) on 9/5/18 at 4:52 pm was conducted. She stated "No resident in the unit was assessed as being able to self-medicate." She further stated her expectation would be that medications are administered by the nurse and the nurse would visually ensure that the resident takes the medication.	F 554	continue through January 2019.	
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing	F 640		10/4/18

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F 640	Continued From page 3	F 640		

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, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an

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F 640	Continued From page 4 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 transmit Quarterly MDS (Minimum Data Set) assessments within the required time frame for 3 of 5 residents (Resident #2, #5, and # 9) selected to be reviewed for submission of Resident Assessments within the required time frame. Findings included: 1. Resident #2 was admitted to the facility on 10/5/17 with diagnoses that included Dementia, Orthostatic Hypotension, Hyperkalemia, Mood disorder and Osteoarthritis. A review of Resident #2's most recent completed MDS was dated as 6/20/18. The assessment was coded as a Quarterly assessment. During an interview on 9/6/18 at 11:50am with the DON (Director of Nursing) she indicated the Quarterly assessment was completed on 6/20/18 but was not transmitted. She stated that a file was made for submission of the assessment on 7/4/18 but was unable to state why it was not transmitted. She further stated that she would transmit the assessment.	F 640	Based on record reviews and staff interviews, the facility failed to transmit Quarterly MDS (Minimum Data Set) assessments within the required time frame for 3 of 5 residents (Resident #2, #5, and # 9) selected to be reviewed for submission of Resident Assessments within the required time frame. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Regarding resident #2, #5, and #9 MDS assessments, a quarterly assessment was completed on 6/20/18 for Resident #2, a quarterly assessment was completed on 6/27/18 for Resident #5, and a quarterly assessment was completed on 6/13/18 for Resident #9. The file for the batch of assessments was created but did not submit. Resubmission for those three assessments occurred on 9/6/18 at 11:43am. The validation report was received and reviewed by the DON and Administrator.	

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F 640	Continued From page 5 2. Resident #5 was admitted to the facility 4/13/16 with diagnoses that included Alzheimer's disease, Hypertension, Atrial Fibrillation, Osteoarthrosis, Osteoporosis, Cervicalgia, Hypothyroidism and Dementia. A review of Resident #5's most recent completed MDS was dated 6/27/18. The assessment was coded as a Quarterly assessment. During an interview on 9/6/18 at 11:50am with DON she indicated the Quarterly assessment was completed on 6/27/18 but was not transmitted. She stated that a file was made for submission of the assessment on 7/4/18 but was unable to state why it was not transmitted. She further stated that she would transmit the assessment. 3. Resident #9 was admitted to the facility on 2/9/16 with diagnoses that included Alzheimer's disease, Anxiety disorder, Hypothyroidism, Sleep disorder, Osteoarthritis and Mood disorder. A review of Resident #9's most recent completed MDS was dated 6/13/18. The assessment was coded as a Quarterly assessment. During an interview on 9/6/18 at 11:50am with the DON she indicated the Quarterly assessment was completed on 6/13/18 but was not transmitted. She stated that a file was made for submission of the assessment on 7/4/18 but was unable to state why it was not transmitted. She further stated that she would transmit the assessment	F 640	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The MDS Tracking and Transmission Worksheet that was implemented and successfully used last year for six months will now be used for the entire year. 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. The form will be maintained by Amy Franklin, DON and reviewed by the interdisciplinary team on a weekly basis at the resident status meeting starting on 9/11/18 and continuing through 9/10/19. 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 one year starting on 9/11/18 and continuing through 9/10/19 to ensure compliance and a summary report will be included and reviewed at the quarterly Quality Assurance meetings held in October 2018, January 2019, April	

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F 640	Continued From page 6 During an interview with the DON on 9/6/18 at 12:30pm, she stated that she was the one responsible for completing and transmitting the MDS assessments. She indicated that she had created a file to transmit a batch of assessments on 7/4/18 but could not state why they weren't submitted. During an interview with the Administrator, who was also present during the interview with the Director of Nursing, on 9/6/18 at 12:30pm she stated that she expected all required MDS assessments to be completed and transmitted within the required time frame.	F 640	2019, July 2019, and October 2019. Corrective Action Date of Completion: 10/04/2018 and the Audit process will continue through October 2019.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put in to place in December 2017. This was for one recited deficiency which was originally cited in November 2017 during a recertification survey and was subsequently recited in September 2018 on an annual recertification survey. The deficiency was related to transmitting minimum data sets within the required time frame. The continued failure of the facility during two federal surveys of record shows	F 867	Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put in to place in December 2017. This was for one recited deficiency which was originally cited in November 2017 during a recertification survey and was subsequently recited in September 2018 on an annual recertification survey. The deficiency was related to transmitting minimum data sets within the required	10/4/18

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F 867	Continued From page 7 a pattern of the facility's inability to sustain an effective Quality Assurance Program. The finding included: This tag is cross referenced to: F640 MDS accuracy: Based on record reviews and staff interviews, the facility failed to transmit Quarterly MDS (Minimum Data Set) assessments within the required time frame for 3 of 5 residents (Resident #2, #5, and # 9) selected to be reviewed for submission of Resident Assessments within the required time frame. During the recertification survey of 11/30/2017 the facility was cited for failing to complete a Discharge Tracking MDS (Minimum Data Set) assessment and failing to transmit a Quarterly MDS assessment within the required time frame for 2 of 3 residents (Resident # 15 and #2) selected to be residents reviewed for Resident Assessments. An interview was conducted with the Administrator on 9/6/18 at 12:24PM. During this interview the Administrator stated the facility has continued to review MDS transmitting due to deficiencies cited during last year's survey.	F 867	time frame. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Regarding resident #2, #5, and #9 MDS assessments, a quarterly assessment was completed on 6/20/18 for Resident #2, a quarterly assessment was completed on 6/27/18 for Resident #5, and a quarterly assessment was completed on 6/13/18 for Resident #9. The file for the batch of assessments was created but did not submit. Resubmission for those three assessments occurred on 9/6/18 at 11:43am. The validation report was received and reviewed by the DON and Administrator. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The MDS Tracking and Transmission Worksheet that was implemented and successfully used last year for six months will now be used for the entire year. The form will be maintained by Amy Franklin, DON and reviewed by the interdisciplinary team on a weekly basis starting on	

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F 867	Continued From page 8	F 867	9/11/18 and continuing through 9/10/19 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 along with a copy of the transmission report will be brought 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 one year starting on 9/11/18 and continuing through 9/10/19 to ensure compliance and a summary report will be included and reviewed at the quarterly Quality Assurance meetings held in October 2018, January 2019, April 2019, July 2019, and October 2019. Corrective Action Date of Completion: 10/04/2018 and the Audit process will continue through October 2019.	