STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345310	A. BUILDING ______ B. WING ______	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CROSSING	100 HEDRICK DRIVE THOMASVILLE, NC 27360

(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 Tag F 280 was deleted by the team after the NH submitted additional information for IDR review. F 372 was deleted by the IDR panel.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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 material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		7/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/01/2016

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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Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for residents in the areas of medications (Resident #107), diagnoses (Residents #107 and #85), pressure relief devices and care (Resident #30), and Activities of Daily Living (Residents #8 and #71) for 5 of 19 residents reviewed.

The findings included:

1a) Resident #107 was admitted to the facility on 9/4/14 from another nursing facility. His cumulative diagnoses included depression, anxiety, and severe mood disorder with psychotic features.

A review of the resident's medical record revealed quetiapine (an antipsychotic medication) was ordered for Resident #107 on 2/28/16 to be given as 25 milligrams (mg) twice daily.

A review of Resident #107's quarterly MDS (Minimum Data Set) assessment dated 4/15/16 revealed the resident was assessed to have severely impaired cognitive skills for daily decision making. He required extensive assistance from staff for most of his Activities of Daily Living (ADLs). Section N of the MDS assessment did not indicate the resident received an antipsychotic medication.

A review of the April 2016 Medication Administration Record (MAR) revealed Resident #107 received 25 mg quetiapine twice daily until 4/26/16, when a change in dose was ordered.

The facility's MDS nurse was not available for interview. An interview was conducted on

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Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Piedmont Crossing of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey date, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance.

Prefix Tag: F278
It is the intent of this facility to accurately code the assessment to accurately reflect the resident'□s status

Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice.

Resident #107 had a modification assessment completed and submitted by Minimum Data Set Coordinator on 6/27/2016 to properly code section N to

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F 278	Continued From page 2	F 278		

6/16/16 at 9:00 AM with the facility's Administrator. The Administrator reviewed Resident #107' MDS assessment and medication history. The Administrator acknowledged Resident #107's MDS dated 4/15/16 should have been coded to indicate he received an antipsychotic medication.

1b) Resident #107 was admitted to the facility on 9/4/14 from another nursing facility. His cumulative diagnoses included depression. A review of the resident ' s medical record revealed sertraline (an antidepressant medication) was ordered for Resident #107 on 3/14/15 to be given as 25 milligrams (mg) once daily.

A review of Resident #107's annual MDS (Minimum Data Set) assessment dated 7/24/15 revealed the resident was assessed to have severely impaired cognitive skills for daily decision making. He required extensive assistance from staff for most of his Activities of Daily Living (ADLs). The resident's MDS assessment (Section I) did not indicate the resident had an active diagnosis of depression. Section N of the MDS assessment indicated he received an antidepressant medication on 7 of 7 days during the look back period.

A review of the Resident's Care Area Assessment (CAA) Summary dated 7/27/15 included the following, in part: "... (Name of resident) is diagnosed with Depression and is prescribed (sertraline) daily ..."

The facility's MDS nurse was not available for interview. An interview was conducted on 6/16/16 at 9:00 AM with the facility's Administrator. Upon inquiry, the Administrator

include an antipsychotic medication. The assessment modified was a quarterly dated 4/15/2016

Resident #107 had a modification assessment completed and submitted by MDS Coordinator on 6/28/2016 to properly code section I to indicate an active diagnosis of depression. The assessment modified was an annual assessment dated 7/24/2015

Resident #85 had a modification assessment completed and submitted by MDS Coordinator on 6/28/2016 to properly code Section I to indicate an active diagnosis of depression. The assessment modified was an admission MDS dated 7/13/2015

Resident #8 had a modification assessment completed and submitted on 6/16/2016 by MDS Coordinator to correctly code the Activities of Daily Living for eating, dressing, locomotion, personal hygiene and bathing. The assessment modified was a quarterly MDS dated 4/21/2016

Resident #71 had a modification assessment completed and submitted by MDS Coordinator on 6/27/2016 to correctly code ADLs for eating. The assessment modified was a quarterly assessment dated 4/8/2016

Resident #30 had a modification assessment completed and submitted by

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F 278	Continued From page 3 confirmed depression was incorrectly omitted from Resident #107's list of active diagnoses on the annual MDS assessment dated 7/24/15. She stated the diagnosis of depression should have been checked as an active diagnosis for the resident. 2) Resident #85 was admitted to the facility on 7/6/15 from the hospital. Her cumulative diagnoses included depression and mood disorder. The resident's admission medication orders included 20 milligrams (mg) citalopram (an antidepressant) to be given as one tablet by mouth daily. A review of Resident #85's admission MDS (Minimum Data Set) assessment dated 7/13/15 revealed the resident was assessed to have severely impaired cognitive skills for daily decision making. She required extensive assistance from staff for most of her Activities of Daily Living (ADLs). The resident's MDS assessment (Section I) did not indicate the resident had an active diagnosis of depression. Section N of the MDS assessment indicated her medications included an antidepressant medication on 7 of 7 days during the look back period. A review of the Resident's Care Area Assessment (CAA) Summary dated 7/17/15 included the following narrative, in part: "...Current (diagnoses) are: ...Depression. Resident is on psychotropic meds for dementia with behavioral disturbance and depression." A review of Resident #8 's quarterly MDS assessment dated 9/1/15 also revealed Section I did not indicate the resident had an active	F 278	MDS Coordinator on 6/15/2016 to correctly code interventions for Pressure Ulcer care. The assessment modified was a quarterly assessment dated 5/23/2016 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: On 6/27/2016 an audit was started by our MDS Coordinators to include the last completed and accepted MDS for all resident□s currently admitted. The audit includes: ADL coding, coding of proper wound care interventions, use of antipsychotic medications, use of antidepressant medications and Section I for proper inclusion of active diagnoses. Any discrepancies will be corrected via MDS modifications and re-submitted by the MDS Coordinators. Any discrepancies will be reported to the Nursing Home Administrator for trending. Audit with corrections to be completed by 07/10/2016 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. All completed MDS Assessments will be submitted to a program, CareWatch, by the MDS Coordinators prior to submission to CMS. This program is designed to flag MDS errors. The program will flag a	

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diagnosis of depression. Section N of the MDS assessment indicated her medications included an antidepressant medication on 7 of 7 days during the look back period.

The facility's MDS nurse was not available for interview. An interview was conducted on 6/16/16 at 9:00 AM with the facility's Administrator. Upon inquiry, the Administrator confirmed depression was incorrectly omitted from Resident #85 s list of active diagnoses on the admission MDS assessment dated 7/13/15 and quarterly MDS dated 9/1/15. She stated the diagnosis of depression should have been checked as an active diagnosis for Resident #85.

3. Resident #8 was admitted to the facility on 2/13/15 and last readmitted on 2/3/16. Cumulative diagnoses included quadriplegia (paralysis that causes partial or total loss of movement of all extremities).

A Quarterly Minimum Data Set (MDS) dated 4/21/16 indicated resident #8 was cognitively intact. He required total dependence for bed mobility, transfers and toilet use. During the seven day look back period, the MDS was coded as "8" (activity did not occur) for locomotion on and off the unit, dressing, eating, personal hygiene and bathing.

A review of the ADL (activities of daily living) verification worksheet (a worksheet that was used to determine accuracy of coding ADL information on the MDS) revealed Resident #8 was independent with locomotion on and off the unit and eating. Extensive assistance was needed for dressing and personal hygiene. He was totally

F 278

report indicating ADL changes from the last accepted assessment, coding of wounds without interventions, use of medications without an active diagnosis or an active diagnosis without medication use.

The NHA will monitor the CareWatch reporting daily X4 weeks, 3Xweekly for 3 months, 1X weekly for 2 months and every month for 6 months for any flags. The MDS Coordinators will notify the NHA daily of any corrections made to the MDS Assessments X4weeks, 3X weekly for 3 months, 1X weekly for 2 months and monthly for 6 months.

After all corrections have been made, the MDS Assessments will be placed into a submission file. At this point, the Director of Nursing will ensure that each Assessment has gone through the above steps prior to final submission.

Any new MDS Assessments that CareWatch cannot compare to a previous assessment will be audited by the NHA prior to final submission.

Both MDS Coordinators have been certified and obtained their Resident Assessment Coordinator-Certified (RAC-CT) within the last six months. Any additional training regarding the Resident Assessment Instrument process will be provided as is necessary

4) Facility'□s plan to monitor its performance so solutions are sustained

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dependent on staff for bathing.

The facility' s MDS nurse was not available for interview. An interview was conducted on 6/16/16 at 10:16AM with the facility's Administrator. The Administrator reviewed Resident #8's MDS dated 4/21/16 and stated the MDS was coded improperly and she did not know how that would have occurred. The Administrator said a modification would be done immediately to reflect accurate coding for locomotion on and off the unit, dressing, eating, personal hygiene and bathing.

4. Resident #71 was admitted to the facility on 2/26/14. Cumulative diagnoses included Alzheimer's disease, depression and diabetes.

A Quarterly Minimum Data Set (MDS) dated 4/8/16 indicated Resident #71 was moderately impaired in cognition. She was independent with eating.

A review of the ADL (activities of daily living) verification worksheet for 4/2/16 through 4/8/16 revealed Resident #71 required supervision with eating.

On 06/15/2016 at 2:32PM, an interview was conducted with MDS Nurse #1. She reviewed Resident #71's MDS and the ADL verification worksheet and stated Resident #71 should have been coded as supervision with eating. She stated she had witnessed Resident #71 feeding herself but should have coded the MDS based on the information on the ADL verification worksheet.

F 278

and integrated into the facility'�s quality assurance system.

These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. Trends in MDS errors will be noted with updates made to the POC as needed. The DON along with the MDS Coordinators will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.

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F 278	Continued From page 6 5. Resident # 30 was admitted to the facility 1/25/16 with diagnoses including diabetes, femur fracture and hypertension. Review of the Quarterly Minimum Data Set (MDS) dated 5/23/16 revealed Resident #30 was cognitively intact and was at risk for pressure ulcers. It also indicated she had a Stage 3 pressure ulcer but did not have a pressure reducing device for her bed or chair and was not receiving pressure ulcer care. Review of the Medical Record from 5/15/16 through 5/23/16 revealed that Resident #30 was receiving pressure ulcer care at the time of the MDS Assessment. Observation of Resident #30 on 6/15/16 at 11:15 AM in her room revealed that she had a pressure reducing mattress on her bed and a pressure reducing cushion on her wheelchair. Interview with the Administrator on 6/16/16 at 10:04 AM revealed that neither of the two MDS Coordinators could be available for interview. She stated that she had reviewed Resident #30 ' s MDS with the MDS Coordinators and that the 5/23/16 MDS was coded incorrectly for Pressure reducing devices and pressure ulcer care. The Administrator added that she did not know why it had been missed on the MDS because Resident #30 did have pressure reducing devices on her bed and in her wheelchair at the time of the MDS, as did all residents, and had been receiving pressure ulcer care at that time as well. The Administrator also said that the MDS needed to be correct and that a correction had already been submitted.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		7/1/16

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A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to develop a care plan to address the use of psychotropic medications for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #107).

The findings included:

Resident #107 was admitted to the facility on 9/4/14 from another nursing facility. His cumulative diagnoses included depression, anxiety, and severe mood disorder with psychotic features.

A review of the resident ' s medical record

F 279

Prefix Tag: F279
It is the intent of this facility to use the results of the assessment to develop, review and revise the resident�s comprehensive plan of care

1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice.

On 6/16/2016, resident #107�s care plan was reviewed. The care plan was updated to include the use of Psychotropic Medication and antidepressant medication with proper

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F 279	Continued From page 8 revealed sertraline (an antidepressant medication) was initiated for Resident #107 on 3/14/15. A review of the resident ' s annual MDS (Minimum Data Set) assessment dated 7/24/15 revealed he was assessed as having severely impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for most of his Activities of Daily Living (ADLs). Section N of the MDS assessment indicated Resident #107 received an antidepressant medication on 7 of 7 days during the look back period. A review of the resident ' s Care Area Assessment (CAA) dated 7/27/15 in Section V of the MDS revealed Psychotropic Medication Use was a triggered care area and would be addressed in his care plan. The CAA Summary for Psychotropic Medication Use included the following narrative, in part: " ....dementia (without) behaviors, depression, anxiety... (Resident #107) is (diagnosed) with depression and is prescribed (sertraline) daily. He is at risk for adverse side effects from this medication. I will proceed to (care plan) to identify those side effects so that staff may monitor for and report on for rapid intervention and interaction with Resident to help minimize the risk of behaviors ... " A review of Resident #107 ' s care plan initiated 9/4/14 and revised on 4/6/16 revealed the topic of Psychotropic Medication Use was not addressed. Further review of the resident ' s medical record indicated trazodone (an antidepressant medication) was initiated on 1/28/16 for Resident #107. The resident was also started on quetiapine, an antipsychotic medication, on	F 279	interventions by the MDS Coordinator responsible for the resident. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: On 6/20/2016, a comprehensive listing of residents receiving antipsychotics and antidepressants was obtained from pharmacy by the NHA. An audit was started by the NHA, DON and ADON of all resident□s care plans to ensure that the use of these drugs was properly care planned. All care plans will be audited and updated by 07/01/2016. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. A weekly report will be printed by the DON from our computer system of all medication changes to include antipsychotic/antidepressant drugs. These changes will be discussed weekly at the At Risk Meeting. All antidepressant/antipsychotic medications will be care planned weekly with appropriate interventions. The DON will provide the list of medications along with a listing of the updated Care Plans to the NHA on a weekly basis. The NHA will audit all listed Care Plans X4 weeks for accuracy, 2 times monthly for 3 months and monthly	

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F 279	Continued From page 9 2/24/16. The use of either the antidepressant medication or the antipsychotic medication was not addressed in his care plan. An interview was conducted with MDS Nurse #1 on 6/15/16 at 4:22 PM. Upon inquiry, MDS Nurse #1 reported she would expect a resident receiving an antidepressant and/or antipsychotic to be care planned for the use of a psychotropic medication. Upon request, the MDS nurse reviewed Resident #107 ' s care plan and acknowledged it did not appear to include the care area of psychotropic medication use. An interview was conducted on 6/16/16 at 9:00 AM with the facility ' s Administrator. Upon review of Resident #107 ' s care plan and medication history, the Administrator reported she would have expected the resident ' s care plan to have included a focus area on the use of psychotropic medications.	F 279	for 8 months 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility s quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON/MDS Coordinators will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315		6/29/16

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F 315	Continued From page 10 Based on observation, record review and staff interview, the facility failed to secure the indwelling catheter tubing to prevent excessive tension or accidental displacement for 4 of 4 sampled residents with an indwelling or suprapubic urinary catheter (Resident #13, #39, #65 and #8). The findings included: A facility policy titled "Catheter care, urinary" dated and last revised 3/1/15 stated, in part, "#15. Check to see that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh)." 1. Resident #13 was admitted to the facility on 8/23/14 and last admitted 2/4/15. Cumulative diagnoses included urinary retention, neurogenic bladder (dysfunction of the urinary bladder) and the use of a urinary device. A Quarterly MDS dated 4/21/16 indicated Resident #13 was cognitively intact. The MDS indicated Resident #13 had an indwelling urinary catheter. A care plan dated 2/10/15 and last reviewed on 4/22/16 stated Resident #13 had an indwelling urinary catheter secondary to neurogenic bladder requiring nursing maintenance. Interventions included, in part, to use care when repositioning and transferring resident related to injury, obstruction, pain or accident removal of cath. On 6/14/16 at 10:16AM, an interview was conducted with Resident #13. When asked if the indwelling catheter tubing was secured to her thigh, she stated "No" and pulled back the covers. The urinary catheter tubing was not secured to her thigh. Also, the urinary catheter	F 315	Prefix Tag: F315 It is the intent of this facility to secure the indwelling catheter tubing to prevent excessive tension or accidental displacement. Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. On 6/15/2016 the Director of Nursing verified that all residents with an indwelling catheter had securement devices applied or refusal of the device was documented Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: Education was provided by the Assistant Director of Nursing/Staff Development Coordinator to all Certified Nursing Assistants, Medication Aides and Nursing Staff regarding the use of securement devices beginning 6/16/2016. All staff to include weekend staff, as needed staff, part-time staff and full-time staff were educated. This will be added to the clinical portion of new hire orientation. Any resident requiring an indwelling catheter will have orders placed in our computer system for the securement device by the charge nurse. All new orders will be audited daily by our Shift Coordinators to ensure that the	

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	345310	A. BUILDING ______ B. WING ______	06/16/2016

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F 315 Continued From page 11

tubing was not secured with a clamp to the bed linens.
On 6/15/16 at 10:15AM, urinary catheter care was observed. NA#1 performed catheter care and did not secure the urinary catheter tubing to Resident #13' s body.
On 6/15/16 at 10:18AM, NA#1 stated she did not put securement devices or secure the catheter to Resident #13's body when Resident #13 was in bed. She stated there were securement devices available on the facility and she had seen them being used on residents at times.

On 6/15/16 at 10:30AM, an interview was conducted with the Administrator who stated securement devices were available at the facility and she expected staff to secure the urinary tubing with a securement device to the resident's thigh.

2. Resident #39 admitted to the facility 1/7/12 and last readmitted on 6/10/15. Cumulative diagnoses included: indwelling urinary catheter.

An Annual Minimum Data Set (MDS) dated 6/12/16 indicated Resident #39 was cognitively intact. The MDS indicated Resident #39 had an indwelling urinary catheter.

A care plan dated 6/7/15 and last reviewed 6/13/16 stated Resident #39 had a suprapubic catheter related to neurogenic bladder. Interventions included, in part, to anchor the suprapubic catheter to prevent excessive tension.

An observation was conducted on 6/15/16 at 10:30 AM. The suprapubic catheter urinary tubing was not secured to Resident #39's body.

F 315

nurse is visually inspecting the placement of the securement device every shift.

The securement device will be added to our Kardex (C.N.A. care plan) by the charge nurse so that the C.N.A. can check for the device daily each shift.

Use of a securement device or refusal of the device will be added to the resident□'s care plan by the MDS Coordinators.

3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur.

ADON/SDC will visually inspect securement devices Monday thru Friday daily for 4 weeks. Shift Coordinators will visually inspect securement devices every weekend for 4 weekends. Devices will be inspected 3X weekly for 3 months by the ADON/SDC and then monthly thereafter for a total of 12 months.

Findings will be reported to the DON by the ADON/SDC as needed for correction

4) Facility□s plan to monitor its performance so solutions are sustained and integrated into the facility□s quality assurance system.

These measures will be monitored by the Director of Nursing with oversight by the Administrator through the QAPI process. The Director of Nursing will report on the measures implemented to the QAPI

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F 315	Continued From page 12 On 6/15/16 at 10:30AM, an interview was conducted with the Administrator who stated securement devices were available at the facility and she expected staff to secure the urinary tubing with a securement device to the resident's thigh. 3. Resident #65 was admitted to facility 11/3/15. Cumulative diagnoses included neurogenic bladder and the use of a urinary catheter device. A Quarterly MDS dated 4/30/16 indicated Resident #65 was moderately impaired in cognition. The MDS indicated Resident #65 had an indwelling urinary catheter. A care plan dated 11/19/15 and last reviewed on 5/2/16 stated Resident #65 was at risk for infection related to the use of an indwelling urinary catheter. Interventions included, in part, anchor catheter to prevent excessive tension (added on 6/15/16). An observation on 6/15/16 at 9:15AM revealed Resident #65's urinary catheter tubing was not secured to her body. On 6/15/16 at 10:18AM, NA#1 stated she did not put securement devices or secure the catheter to Resident #65's body when Resident #65 was in bed. She stated there were securement devices available on the facility and she had seen them being used on residents at times. On 6/15/16 at 10:30AM, an interview was conducted with the Administrator who stated securement devices were available at the facility and she expected staff to secure the urinary	F 315	Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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tubing with a securement device to the resident ' s thigh.

4. Resident #8 was admitted to the facility 2/13/15 and last readmitted on 2/3/16. Cumulative diagnoses included neurogenic bladder and indwelling urinary catheter.

A Quarterly MDS dated 4/21/16 indicated Resident #8 was cognitively intact. The MDS indicated Resident #8 had an indwelling urinary catheter.

A care plan dated 2/26/16 stated Resident #8 had a diagnosis of neurogenic bladder and urethral stricture. He had a suprapubic catheter requiring nursing maintenance. Interventions included, in part, to use care when repositioning and transferring resident related to injury, obstruction, pain or accident removal of catheter.

An observation on 6/15/15 at 10:35AM revealed Resident #8 did not have the urinary catheter tubing secured to his body. Resident #8 stated, at that time, that he did not want a securement device applied to the urinary catheter tubing.

On 6/15/16 at 10:45AM, an interview was conducted with the Administrator who stated Resident #8 had not told them he did not want a securement for his tubing and, in fact, had allowed staff to apply a securement device to his thigh in the past. She stated he did not have a care plan that stated he did not want the securement device. The Administrator stated she expected staff to secure the urinary tubing with a securement device to the resident's thigh.

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F 520	483.75(o)(1) QAA	F 520		7/10/16

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F 520 SS=D	Continued From page 14 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. 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 record review and staff interviews, the facility ' s Quality Assessment and Performance Improvement committee (QAPI) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 7/9/15 in order to achieve and sustain compliance. The facility had a repeat deficiency on Minimum Data Set (MDS) assessment on the recertification survey 7/9/15	F 520	Prefix Tag: F520 It is the intent of this facility to ensure that areas for improvement and specific deficient practices are addressed by the QAPI Committee and that action plans are developed, implemented, monitored and revised as needed 1) Corrective action to be accomplished	

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F 520	Continued From page 15 and the recertification survey 6/16/16. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain and effective Quality Assurance Program. The findings included: This tag is cross referred to F278: assessment accuracy. Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for residents in the areas of medications (Resident #107), diagnoses (Residents #107 and #85), pressure relief devices (Resident #30), and Activities of Daily Living (Residents #8 and #71) for 5 of 19 residents reviewed. An interview was conducted with the Administrator on 06/16/2016 at 10:23AM. She stated the deficiency last year for accuracy of the MDS was regarding miscoding of Hospice. The Administrator stated the facility did a plan of correction and her focus was for accuracy of Hospice on the MDS.	F 520	for those residents to have been affected by the alleged deficient practice. All alleged deficient areas listed in the 2567 for our recertification survey beginning June 13, 2016 and ending June 16, 2016 have been addressed with the QAPI members involved to generate the POC. Any immediate actions needed for our residents have been listed in the POC above for F-tags 278, 279, 280, 315, 372 and 520. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: Audits involving all of our residents currently admitted that may be affected by the alleged deficient practices are being completed (deadline 07/01/2016 or 07/10/2016) by the appropriate staff members listed above. Corrective actions will be carried out for any resident affected by the alleged deficient practice by the proper staff member as listed above. Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. All findings of the audits will be reviewed with the Nursing Home Administrator, Director of Nursing and appropriate QAPI members weekly X4 weeks, 2X a month X3 months and then with scheduled QAPI meetings to equal 6 months.	

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F 520	Continued From page 16	F 520	4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the DON with oversight by the Administrator through the QAPI process. The DON will report on the measures implemented to the QAPI Committee which will evaluate for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	