STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(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 of 6/16/16. Event ID# YH1K11.	F 000	1. PASARR II Level II Assessment corrected for resident #5 to reflect PASARR Level II coded on Minimum Data Set and submitted by RN Case Mix Coordinator to CMS on 7/8/16. All current Level II PASARR residents will be audited by RN Case Mix Coordinator by 7/13/16 to verify PASARR is coded accurately on Minimum Data Set assessment. Review of any new Level II PASARRs will be discussed and validated for accurate coding on assessment in weekly standup meeting from Social Services Director for new admissions, RN Director of Health Services/RN Assistant Director of Health Services for current resident and RN Case Mix Coordinator for the accurate coding of assessments starting 7/8/16 to ensure accurate coding of Minimum Data Set Assessment. RN Case Mix Coordinator/Social Service Director inserviced by RN Clinical Reimbursement Consultant on 6/21/16 for accurate coding in relation to PASARR section A 1500 of the Minimum Data Set Assessment. Findings of compliance of accurate coding of PASARR Level II assessments will be conducted by RN Case Mix Coordinator 5xweekly for 4 weeks; then weekly for 4 weeks; then monthly for 3 months. Tracking and trending of the effectiveness of the education and system changes will be reported to the QAPI meeting by the RN Case Mix Coordinator for recommendations and suggestions for change until substantial compliance is achieved. 2. Behavior Assessment for resident #5 corrected by RN Case Mix Coordinator to reflect behaviors coded on Minimum Data Set for resident and submitted by RN Case Mix Coordinator to CMS on 7/8/16. All current behavior residents audited by RN Case Mix Coordinator/RN Director of Health Services by 7/13/16 to verify behavior is coded accurately on the assessments. Any discrepancies in coding will be corrected by RN Case Mix Coordinator and submitted to CMS by 7/13/16.	
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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra Grisso | TITLE: Administrator | (X6) DATE: 7/8/16

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 278	Continued From page 1 Based on observation, record review and interviews with staff, the facility failed to accurately code Preadmission Screening and Resident Review(PASRR) (section A1500) , failed to accurately code behavioral symptoms(section E)on the Minimum Data Set(MDS) for 1 of 1 sampled resident (Resident #5). The facility failed to acccurately code resident #97 for wandering behaviors on a comprehensive assessmen. Findings included: 1. A. Resident # 5 was admitted to the facility on 9/10/2015 with diagnoses which included Hypertension, Hyperlipidemia, Seizure disorder, Anxiety and Schizophrenia. The annual MDS (Minimum Data Set) dated 2/9/2016 indicated the resident ' s cognition as moderately impaired. The MDS did not indicate the resident received PASRR (Preadmission screening and Resident Review) level II services. On 6/15/2016 at 10:00 AM, the MDS nurse was interviewed. She acknowledged that the resident did have a diagnosis of mental illness and it should have been coded on the MDS under section A1500 because the resident was receiving PASRR services. On 6/15/2016 at 10:30 AM, the Social worker was interviewed. She reported that it was her responsibility to notify the MDS coordinator about the residents at the facility receiving PASRR services. She added that she will make sure next time she notifies the MDS coordinator about the residents at the facility receiving PASRR services. On 6/15/2016 at 2:00 PM, the Director of Nursing (DON) was interviewed. She acknowledged the annual MDS dated 2/9/2016 should have coded the resident as receiving (PASRR) services. She	F 278	Review of any new behaviors will be discussed and validated for accurate coding on assessment in weekly standup meeting by Social Service Director/RN Director of Health Services/RN Assistant Director of Health Services/RN Case Mix Coordinator starting 7/8/16 to ensure accurate coding of Minimum Data Set Assessment. RN Case Mix Coordinator/Social Service Director inserviced by RN Clinical Reimbursement Coordinator on 6/21/16 for accurate coding in relation to behaviors section E of the Minimum Data Set Assessment. Findings of compliance of accurate coding of behavior assessments will be conducted by RN Case Mix Coordinator 5xweekly for 4 weeks; then weekly for 4 weeks; then monthly for 3 months. Tracking and trending of the effectiveness of the education and system changes will be reported to the QAPI meeting by the RN Case Mix Coordinator for recommendations and suggestions for changes until substantial compliance is achieved. 3. Wandering assessment for resident #97 corrected by RN Case Mix Coordinator to reflect removal of wandering coding from assessment and submitted by RN Case Mix Coordinator to CMS on 7/8/16. All current wandering residents audited by Social Service Director by 7/13/16 to verify wandering is coded accurately on the assessments. Review of any new wandering residents, by placement of sigma shield device, will be discussed and validated for accurate coding on the assessment in weekly standup meeting by Social Service Director/RN Director of Health Services/RN Assistant Director of Health Services/RN Case Mix Coordinator starting 7/8/16 to ensure accurate coding of Minimum Data Set Assessment. RN Case Mix Coordinator/Social Service Director inserviced by RN Clinical Reimbursement Consultant	

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F 278	Continued From page 2 added her expectation was for MDS nurse to accurately code the MDS information. B. Resident # 5 was admitted to the facility on 9/10/2015 with diagnoses which included Hypertension, Hyperlipidemia, Seizure disorder, Anxiety and Schizophrenia. The quarterly MDS (Minimum Data Set) dated 5/9/2016 indicated the resident ' s cognition as moderately impaired. The MDS did not indicate the resident as having behavioral problems under section E. On 6/15/2016 at 10:00 AM, the MDS nurse was interviewed. She acknowledged that the resident did have a diagnosis of mental illness and exhibited behavioral problems daily. The MDS nurse further stated it should have been coded on the MDS under section E that the resident had behavioral problems but it was missed by the Social worker. On 6/15/2016 at 10:30 AM, the Social worker was interviewed. She reported that it was her responsibility to complete Section E and the quarterly MDS was not coded accurately. She added the resident exhibited behavioral problems daily and she had documented her behaviors in her social services notes. On 6/15/2016 at 2:00 PM, the Director of Nursing (DON) was interviewed. She acknowledged the quarterly MDS dated 5/9/2016 should have coded the resident as exhibiting behavioral symptoms. She added her expectation was for MDS nurse to accurately code the MDS information.	F 278	on 6/21/16 for accurate coding in relation to wandering section E of the Minimum Data Set Assessment. Finding of compliance of accurate coding of wandering assessment will be conducted by RN Case Mix Coordinator 5xweekly for 4 weeks; then weekly for 4 weeks; then monthly for 3 months. Tracking and trending of the effectiveness of the education and system changes will be reported to QAPI meeting by RN Case Mix Coordinator for recommendations and suggestions for changes until substantial compliance is achieved.	7/13/16

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F 278	Continued From page 3 2. Resident #97 was admitted 5/10/15 with cumulative diagnoses of Parkinson's and dementia. He was initially care planned on 8/3/15 for wandering behaviors with his care planned was last reviewed and updated 4/26/16. Interventions included a wander guard (departure alert device) to be in placed on Resident #97, notification of staff or wandering behaviors and redirection as needed. A review of the facility incident logs from January 2016 to present included no wandering intakes by Resident #97. A review of the facility grievance logs from January to present included no intakes regarding Resident #97 wandering into any resident rooms. The quarterly MDS dated 2/3/16 indicated no wander behaviors and a review of Resident #97's Social Services Assessment Form completed by the facility Social Worker (SW) dated 2/3/16 indicated there was no behavioral issues noted. A review of the facility nursing notes and social services notes from 4/1/16 to present included no documentation related Resident #97 wandering into unsafe places or into other resident rooms. The annual MDS dated 4/26/16 indicated Resident #97 exhibited wandering behaviors 4 to 6 days of the 7 day look back period and his wandering placed him at risk for getting to a dangerous place and intruding on the privacy of others. The Social Services Assessment Form completed on 4/26/16 by the SW noted no behavioral issues. In an interview on 6/14/16 at 4:00 PM, the Director of Nursing (DON) stated Resident #97 had a wander guard in place for safety due to his wanting to be with his wife and his ability to self-propel about the facility but he had made no attempt to depart the facility to her knowledge.	F 278		

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F 278	Continued From page 4	F 278		

She also stated she was not aware of Resident #97 ever wandering into other resident ' s rooms uninvited. The DON stated it was her understanding the SW completed the cognition and behavioral sections of the MDS.
In an observation on 6/15/16 at 10:40 AM, Resident #97 was participating in activities. There was a wander guard device noted to his right lower leg. After the activity, Resident #97 was engaged and found to be pleasant. He showed no signs of distress and exhibited no wandering or intrusive behaviors.
In an interview on 6/15/16 at 12:10 PM, the SW confirmed she was responsible for completing the Social Service Assessment Form and the behavioral section of the MDS on each resident to include Resident #97. The SW stated she reviewed the medical record prior to completing Resident #97 ' s annual MDS dated 4/26/16. The SW agreed there was no documentation Resident #97 had exhibited wandering behaviors at any time during the annual MDS assessment period. The SW stated the annual MDS dated 4/26/16 was not coded accurately.

In an interview on 6/15/16 at 12:40 PM, the Nursing Assistant (NA) assigned to Resident #97 stated she had worked at the facility for sixteen years. She stated she was very knowledge about Resident #97. The NA stated she had never known Resident #97 to actually attempt to exit the facility but he had voiced a desire to leave in the past but not in a very long time. The NA also stated Resident #97 never wandered into other resident ' s rooms.

In an interview on 6/15/16 at 12:50 PM, the Administrator stated she was made aware during the course of the recertification survey there was

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F 278	Continued From page 5 a Social Services MDS coding problem and it was her expectation that the MDS accurately reflect Resident #97 behavioral issues.	F 278		