| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345063 | A. BUILDING _____ B. WING _____ | 09/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AVANTE AT WILSON | 1804 FOREST HILLS ROAD WILSON, NC 27893 |

| (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 |
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| F 278 SS=E | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>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.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 6 of 7 residents (Residents #49, #72, #43, #115, #38 and #112) | F 278 | This Plan of Correction is the center's credible allegation of compliance.<br><br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of | 10/13/16 |

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

Electronically Signed | 10/05/2016

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| F 278 | Continued From page 1<br>identified as a Level II PASRR resident.<br><br>Findings included:<br><br>1. Resident #49 was admitted to the facility on 04/07/14 with diagnoses include Schizoaffective Disorder and Major Depressive Disorder.<br><br>Review of Resident #49's PASARR level II, dated on 06/30/14, revealed that the resident had a permanent number.<br><br>Review of the Annual MDS, dated on 02/10/16, indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.<br><br>During an interview with the MDS Coordinator on 09/15/16 at 10:50 AM she stated that it was an oversight.<br><br>During an interview with the Director of Nursing (DON) on 09/15/16 at 4:05 PM she stated that it her expectation that the Business Office Manager and Admission Coordinator work with the MDS Coordinator to make sure the PASRR level II residents are coded accurately.<br><br>2. Resident #72 was admitted to the facility on 03/14/16 with a diagnosis of major depressive disorder.<br><br>Review of Resident #72's North Carolina | F 278 | the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.<br><br>Deficiency is Corrected<br><br>A. Corrective action taken for the affected residents<br><br>Corrective action has been accomplished for the alleged deficient practice in regards to accurate coding of PASRR status for Residents (Residents # 49, #72, #43, #115, #38 and #112). On 9/15/16, MDS assessment for all 6 residents (Residents # 49, #72, #43, #115, #38 and #112) were modified, coded accurately to reflect a Level II Preadmission Screening and Resident Review (PASRR) determination. The MDS assessments were transmitted to the state successfully and accepted on 9/15/16.<br><br>B. Corrective action taken for those residents having the potential to be affected by the deficient practice<br><br>The MDS coordinator completed an audit on 9/15/16, for current facility residents, to validate that residents with a Level II PASRR were coded correctly on the MDS. Assessments identified as inaccurate were modified and transmitted to the state and accepted on 9/15/16 | |

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| F 278 | Continued From page 2<br>Medicaid FL 2 dated on 03/14/16 revealed that the resident PASSAR level II number was temporary.<br><br>Review of Resident #72's admission MDS, dated on 03/21/16, indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.<br><br>During an interview with the MDS Coordinator on 09/15/16 at 10:50 AM she stated that it was an oversight.<br><br>During an interview with the DON on 09/15/16 at 4:05 PM she stated that it her expectation that the Business Office Manager and Admission Coordinator to work with the MDS Coordinator to make sure the PASRR level II residents are coded accurately.<br><br>3. Resident #115 was admitted to the facility on 04/10/15 with diagnoses including Schizoaffective Disorder and Altered Mental Status.<br><br>Review of Resident #115's annual MDS, dated on 04/06/16, indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an | F 278 | C. Measures Implemented and /or Systemic changes made to ensure that deficient practices will not reoccur<br><br>The Business Office Manager (BOM) and/or designee will notify the MDS coordinator when a resident has a Level II PASRR, to assure accurate coding on the MDS. A form was developed as a communication tool between Business Office and MDS Nurses. The Director of Nursing (DON) will review MDS comprehensive assessments weekly for 4 weeks to validate that the MDS assessment is coded accurately to reflect the Level II PASRR.<br><br>D. How the facility plans to monitor its performance to assure ongoing compliance is sustained.<br><br>The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.<br><br>E. Date Corrective Action Completed<br><br>Corrective action was achieved on 10/13/16 | |

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| F 278 | Continued From page 3 | F 278 | | |

appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.
Review of the PASARR Level II number for Resident #115 revealed that it was approved from 08/11/16 through 10/10/16. The resident was nursing facility (NF) appropriate for 60 days.

During an interview with the MDS Coordinator, on 09/15/16 at 10:50 AM, she stated that it was an oversight that the resident was not coded as a Level II PASRR.

During an interview with the DON, on 09/15/16 at 4:05 PM, she stated that it was her expectation that the Business Office Manager and Admission Coordinator work with the MDS Coordinator to make sure the PASRR level II residents are coded accurately.

4. Resident #43 was admitted to the facility on 3/16/15 with a diagnosis history that included Major Depressive Disorder.

Review of the PASRR Level II number for Resident # 43 revealed that the resident had a permanent number, dated 3/15/2015.

Review of Resident #43's most recent annual MDS, dated 2/10/16, indicated the resident was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for servicing to help develop an individual's plan of care.

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 278 | Continued From page 4 | F 278 | | |

During an interview with the MDS Coordinator, on 09/15/16 at 10:50 AM, she stated that it was an oversight that the resident was not coded as a Level II PASRR.
During an interview with the DON, on 09/15/16 at 4:05 PM, she stated that it was her expectation that the Business Office Manager and Admission Coordinator work with the MDS Coordinator to make sure the PASRR Level II residents are coded accurately.

5. Resident #38 was admitted to the facility 8/15/2009 and had a diagnosis history that included Schizoaffective Disorder.

Review of the resident's PASRR Level II number revealed the resident had a permanent Level II PASRR since 8/15/10.

Review of Resident #38's most recent annual MDS, dated 12/18/2015, indicated the resident was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendation for servicing to help develop an individual's plan of care.

During an interview with the MDS Coordinator, on 09/15/16 at 10:50 AM, she stated that it was an oversight that the resident was not coded as a Level II PASRR.
During an interview with the DON, on 09/15/16 at 4:05 PM, she stated that it was her expectation that the Business Office Manager and Admission Coordinator work with the MDS Coordinator to

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| F 278 | Continued From page 5<br>make sure the PASRR Level II residents are coded accurately.<br><br>6. Resident #112 was admitted to the facility on 07/19/16 with a diagnosis history that included Major Depressive Disorder.<br><br>Review of the resident's North Carolina Medicaid FL2, dated 7/18/16, showed the resident had a Level II PASRR with a 60 day limitation.<br><br>Review of Resident #112's Admission/5 Day MDS, dated 07/26/16, indicated the resident was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendation for servicing to help develop an individual's plan of care.<br><br>During an interview with the MDS Coordinator, on 09/15/16 at 10:50 AM, she stated that it was an oversight that the resident was not coded as a Level II PASRR.<br>During an interview with the DON, on 09/15/16 at 4:05 PM, she stated that it was her expectation that the Business Office Manager and Admission Coordinator work with the MDS Coordinator to make sure the PASRR Level II residents are coded accurately. | F 278 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives | F 323 | | 10/13/16 |

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| F 323 | Continued From page 6<br>adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interviews with staff and residents, the facility failed to maintain hot water temperature at or below 116 degrees Fahrenheit to reduce the risk of burns in 3 of 15 residents' rooms and 1 of 1 common shower. Findings include:<br><br>An initial tour of the facility was conducted on 09/12/16 at 10:45 AM. At that time water temperatures felt hot to touch and the Maintenance Director (MD) was requested to check the water temperatures from the hot water faucets.<br>On 09/12/16 at 11:45 AM the MD was observed measuring the facility's water temperatures using a calibrated thermometer. The water temperatures were noted to be:<br>Room A27: water temperature 120 F<br>Room A26: water temperature 130 F<br>Shower room (1 of 1): water temperature 120 F<br>Room A04: water temperature 125 F<br><br>After the MD performed the water temperature check on 09/12/16 at 11:45 AM he found the water temperatures down the A-hall to be above 116 F. He stated he immediately adjusted the A-hall water mixing valve to lower the water temperatures. He stated he would continue to monitor the A-hall ' s water temperatures until the hot water temperatures were below 116 F. | F 323 | This Plan of Correction is the center's credible allegation of compliance.<br><br>Preparation and/or execution of this plan of correction does not constitute admission<br>or agreement by the provider of the truth of the facts alleged or conclusions set forth<br>in the statement of deficiencies. The plan of<br>correction is prepared and/or executed solely<br>because it is required by provisions of federal<br>and state law.<br><br>Deficiency is Corrected<br><br>A. Corrective action taken for the affected residents<br><br>On 9/14/16, deficiency identified and addressed. An outside contractor adjusted the facility's mixing valve that controls the hot / cold water supply in the facility. The water temperatures were noted to range from 104 F to 110 F in rooms A03-A27, and B06-B24 and shower room. | |

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| F 323 | Continued From page 7<br>An interview on 09/12/16 at 12:20 PM with Nursing Assistant (NA) #1 and NA #2, both stationed on the A-hall, revealed A-hall had 3 cognitively impaired residents who were able to use their sinks. Both NAs stated none of the 3 cognitively impaired residents had burns or had any complaints of water being too hot.<br><br>In an interview with the Director of Nursing (DON) on 09/12/16 at 12:35 PM, the DON stated no residents in the facility had received burns from hot water in the shower room or from their bathroom sinks. She stated she had informed all nurses and aides to immediately stop giving baths or showers until the water temperatures were verified to be below 116 F.<br><br>In an interview on 09/12/16 at 12:55 PM with NA #3, she stated she had no issues or complaints of the water being too hot that morning and would have let the MD know as soon as possible if she noticed the water was too hot.<br><br>An observation on 09/12/16 at 1:00 PM revealed the MD had shut off the hot water throughout the A-hall.<br><br>The DON stated she had informed all the nurses and aides to hold all showers, and informed all facility residents who were able to use their sinks to not use their sinks until the water temperatures were within a safe range below 116 F.<br><br>A temperature observation on 09/12/16 at 1:12 PM on the A-hall (rooms A04, A26, and shower room), revealed the A-hall hot water was turned off and that the hot water residuals in the pipes were below 116 F. | F 323 | B. Corrective action taken for those residents having the potential to be affected by the deficient practice<br><br>During 9/12/16 to 9/14/16, hot water temperatures log was maintained through out the facility by the facility Maintenance Director to ensure the water temperatures in resident rooms and the one shower room were between 100 – 115 degrees Fahrenheit. All tested areas were in compliance with our policy.<br><br>C. Measures Implemented and /or Systemic changes made to ensure that deficient practices will not reoccur<br><br>The facility Maintenance Director or Maintenance Assistant will test water temperatures in resident rooms and the shower room at least twice daily, 5 times a week for one month then once daily, 5 times a week thereafter. Any areas of concern will be addressed and corrections implemented as appropriate to ensure compliance with the standard is achieved and maintained.<br><br>D. How the facility plans to monitor its performance to assure ongoing compliance is sustained. | |

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| F 323 | Continued From page 8<br>In an interview with the MD on 09/12/16 at 1:14 PM, he stated he checked the water temperature in the residents' rooms, shower room, and mixing valve 5 times per week, and recorded the temperatures on an electronic log.<br><br>In an interview on 09/12/16 at 1:50 PM with the MD, he stated the facility had a boiler system with 3 water heaters for resident halls and showers, and a separate higher water temperature heater for the kitchen and laundry. The MD said he thought a faulty mixing valve might have been the reason for elevated water temperatures on the A-hall. The MD stated he called a plumber to look at the mixing valve.<br><br>The facility water temperature log dated 09/12/16 at 3:00 PM revealed all temperatures were between 102 F - 110 F.<br><br>On 09/12/16 at 3:01 PM the MD performed a check of the facility s water temperatures using a calibrated thermometer. The water temperatures were noted to range from 102 to 108 F in rooms A03 - A027 and shower room.<br><br>On 09/13/16 at 3:01 PM the MD performed a check of the facility's hot water using a calibrated thermometer. The water temperatures were noted to range from 102 F to 108 F in rooms A03 - A027 and shower room.<br><br>A facility visit was conducted by a plumber on 09/14/16 at 9:15 AM. The plumber checked the hot water temperature and found the mixing valve to be stuck. He freed the valve, adjusted the cold water, and re-checked the operation of the valve.<br><br>On 09/14/16 at 12:30 PM the MD performed a | F 323 | The Maintenance director and/or the Administrator will review the results of the audits to identify patterns/ trends and will be<br>reviewed at the monthly and quarterly QA (Quality Assurance) meetings to maintain compliance.<br><br>E. Date Corrective Action Completed<br><br>Corrective action was achieved on 10/13/16 | |

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| F 323 | Continued From page 9<br>check of the facility's hot water temperatures using a calibrated thermometer. The water temperatures were noted to range from 104 F to 110 F in rooms A03 - A27, and B06 - B24.<br><br>The shower room water temperature on 09/14/16 at 1:15 PM after showers was 98 F.<br><br>On 09/14/16 at 2:35 PM the Maintenance Director performed a check of the facility's hot water temperature using a calibrated thermometer. The water temperatures were noted to range from 104 F to 110 F in rooms A06 - A07, B04 - B10, and shower room.<br><br>The facility water temperature log dated 09/14/16 at 3:00 PM revealed all temperatures were between 102 F-110 F.<br><br>On 09/15/16 at 9:11 AM the MD performed a check of the facility's mixing valve temperatures. The water temperatures were noted to be:<br>Mixing valve A-hall: Hot water temperature 108 F<br>Mixing valve B-hall: Hot water temperature 108 F<br><br>In an interview on 09/15/16 at 9:45AM with the DON, she revealed that it was her expectation that all hot water accessible to residents be maintained at or below 116 F. She stated if the hot water was too hot, the facility would adjust the water temperature down until it was below 116F, and until then the facility would stop all resident showers, notify maintenance, and keep residents who were cognitively impaired away from their sinks until the temperatures were back within a safe range. | F 323 | | |
| F 463 SS=D | 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH | F 463 | | 10/13/16 |

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| F 463 | Continued From page 10<br><br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the call bell failed to activate when pressed in 1 of 12 resident rooms (A5A) in the facility.<br><br>The findings included:<br><br>On 09/14/16 beginning at 12:30 PM, call bells were tested in 12 resident rooms. In 1 of the 12 rooms (A5A) when the call bell was activated, the call light did not illuminate outside the resident door, and the call bell failed to sound at the nursing station. The maintenance Director (MD) stated the problem was the cord and touch pad to the call bell system needed to be replaced. The MD reported he checked random call bells weekly, but was not aware of a problem with the call bell system in room A5A. He commented he did not know the exact date when the call bell was last checked in room A5A.<br><br>On 09/15/16 at 8:35 AM., Nurse #1 stated she was not aware that a call light was not working inside room A5A. She stated the resident was capable of using his call light, but he had not voiced any complaints about it not working. She stated if the resident needed anything, he would usually just call out for an aide or nurse. She stated she never checked if his call light was working or not working, or questioned why he was calling out instead of using his call light. | F 463 | This Plan of Correction is the center's credible allegation of compliance.<br><br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.<br><br>Deficiency is Corrected<br><br>A. Corrective action taken for the affected residents<br><br>On 9/14/16, the non-functioning touch pad and cord to the call bell system for Room (A-5A) was replaced and call bell system was functional. | |

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|---|---|---|---|
| | 345063 | A. BUILDING _____ B. WING _____ | 09/15/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AVANTE AT WILSON | 1804 FOREST HILLS ROAD WILSON, NC 27893 |

| (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 |
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| F 463 | Continued From page 11<br><br>In an interview on 09/15/16 at 8:40 AM with resident in room A5A, he stated he used his call bell, and was not aware his call light was not working.<br><br>An observation on 09/15/16 at 9:40 AM revealed the non-functioning call light in room A5A was replaced with a functioning new call light.<br><br>During an interview with the facility Director of Nursing (DON) on 09/15/16 at 9:45 AM., the DON indicated that it was her expectation that all call lights would be working, and her expectation was not being met with regard to the resident in room A5A. She stated if a call light was not working, the staff would report the problem to in-house maintenance or after hours by phone 24 hours a day, and (if needed) provide the resident with a manual hand bell to be used until their call light was fixed. | F 463 | B. Corrective action taken for those residents having the potential to be affected by the deficient practice<br><br>On 9/14/16, an audit was done by Maintenance Director throughout the facility to ensure all components of the call bell system are functional.<br>Audit revealed all other rooms call bell system was functioning correctly.<br><br>C. Measures Implemented and /or Systemic changes made to ensure that deficient practices will not reoccur<br><br>The Facility Maintenance Director will check four residents rooms at least once daily five times a week for one month to ensure call bell system is functional, thereafter three times a week for next two months and after that once a week as part of the Preventive Maintenance (PM) program.<br><br>D. How the facility plans to monitor its performance to assure ongoing compliance is sustained. | |

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| F 463 | Continued From page 12 | F 463 | The Maintenance director and/or the Administrator will review the results of the audits to identify patterns/ trends and will be reviewed at the monthly and quarterly QA (Quality Assurance) meetings to maintain compliance.<br><br>E. Date Corrective Action Completed<br><br>Corrective action was achieved on 10/13/16 | |
| F 520 SS=E | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>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.<br><br>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.<br><br>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.<br><br>Good faith attempts by the committee to identify | F 520 | | 10/13/16 |

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| F 520 | Continued From page 13<br>and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review the facility's quality assurance (QA) committee failed to prevent the recurrence of deficient practice related to the accuracy of assessments which resulted in a repeat citation at F278. The re-citing of F278 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included:<br>This tag is cross-referenced to:<br>F278: Accuracy of Assessment: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 6 of 7 residents (Residents #49, #72, #43, #115, #38 and #112) identified as a Level II PASRR resident.<br>Review of the facility's survey history revealed F278 was cited during a 10/08/15 annual recertification survey, and was re-cited during the current 09/15/16 annual recertification survey.<br>In an interview on 09/15/16 at 5:15 PM the Administrator stated that during the last survey the facility was cited for an inaccurate bowel and bladder assessment. He indicated the problem had been corrected. However, he stated the F278 citation this year involved inaccurate coding on the Minimum Data Set (MDS). He indicated that although the facility received a citation in 2015 and 2016 at F278, he felt the deficient practice was not the same as they involved a bowel and bladder assessment in 2015 and inaccurate | F 520 | Deficiency is Corrected<br><br>A. Corrective action taken for the affected residents<br><br>Corrective action has been accomplished for the alleged deficient practice in regards to accurate coding of PASRR status for Residents (Residents # 49, #72, #43, #115, #38 and #112). On 9/15/16, MDS assessment for all 6 residents (Residents # 49, #72, #43, #115, #38 and #112) were modified, coded accurately to reflect a Level II Preadmission Screening and Resident Review (PASRR) determination. The MDS assessments were transmitted to the state successfully and accepted on 9/15/16.<br><br>B. Corrective action taken for those residents having the potential to be affected by the deficient practice<br><br>The MDS coordinator completed an audit on 9/15/16, for current facility residents, to validate that residents with a Level II PASRR were coded correctly on the MDS. Assessments identified as inaccurate were modified and transmitted to the state and accepted on 9/15/16 | |

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| F 520 | Continued From page 14<br>coding of the MDS in 2016. | F 520 | C. Measures Implemented and /or Systemic changes made to ensure that deficient practices will not reoccur<br><br>The Business Office Manager (BOM) and/or designee will notify the MDS coordinator when a resident has a Level II PASRR, to assure accurate coding on the MDS. A form was developed as a communication tool between Business Office and MDS Nurses. The Director of Nursing (DON) will review MDS comprehensive assessments weekly for 4 weeks to validate that the MDS assessment is coded accurately to reflect the Level II PASRR. The MDS coordinators will submit the MDS assessments to Point Right for review prior to submitting to state to identify areas for further review and recommendations. The Administrator and or DON will review Data Integrity Audit through Point Right weekly to assure MDS assessments have been submitted and reviewed with appropriate changes made to maintain accuracy of assessments.<br><br>D. How the facility plans to monitor its performance to assure ongoing compliance is sustained.<br><br>The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. | |

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| F 520 | Continued From page 15 | F 520 | E. Date Corrective Action Completed<br><br>Corrective action was achieved on 10/13/16 | |