STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 10/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(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 There were no deficiencies cited as a result of the complaint investigation. Event ID PPKW11. An amended Statement of Deficiencies was provided to the facility on 10/27/16 to include an additional example for tag F-278. Event ID PPKW11.	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.	F 278		11/11/16

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

Electronically Signed | 11/03/2016

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record review the facility inaccurately assessed 3 of 10 residents on the minimum data set (MDS). The MDS was inaccurate for Resident #97 for pressure sores and vision, Resident #100 for nutrition, and Resident #9 for behaviors. Findings included: 1. Resident #97 was admitted 09/30/2013 with diagnosis that included neuropathy, morbid obesity, peripheral artery disease, degenerative joint disease lower leg and disorder of the bone and cartilage. a. Review of the wound care specialist notes dated 08/29/2016 documented a stage 4 pressure wound sacrum that measured 1.8 X 4.2 X 0.3 centimeters (cm) and surface area 7.56 cm with light serous drainage. Review of the annual MDS 09/02/2016 documented a stage 2 pressure ulcer. Interview 10/14/2016 12:00 PM the MDS nurse stated it should have been coded a stage 4 instead of a stage 2 pressure ulcer on the MDS. Interview 10/14/2016 12:06 PM the Director of Nursing stated her expectation was the MDS be coded correctly. b. Review of the most recent annual Minimum Data Set (MDS) assessment dated 09/02/16 revealed Resident #97 was cognitively intact, had	F 278	1. For Resident #97, the annual Minimum Data Set dated 9/2/2016 and the corresponding triggered Care Area Assessment dated 9/14/2016 was modified by the Minimum Data Set Coordinator to accurately reflect the resident's pressure sore and vision status. For resident #100, the quarterly Minimum Data Set dated for 7/14/2016 was modified by the Minimum Data Set Coordinator to accurately reflect the resident's nutritional status. For resident #9, the quarterly Minimum Data Set dated 09/16/2016 was modified by the Minimum Data Set Coordinator to accurately reflect the resident's behavioral status. All modifications were resubmitted on 10/14/2016. 2. For residents that currently reside in the facility, a quality monitoring of the most current Comprehensive MDS Assessments and corresponding triggered CAAs was completed by 11/11/2016 by the MDS Coordinator, Social Worker and Registered Dietitian to ensure accurate coding for pressure sores, vision, nutrition and behavioral status. The MDS Coordinator completed modifications as indicated. Follow up based on findings. 3. On 11/7/16, the Regional Case Mix Coordinator provided re-education to the Minimum Data Set Coordinator, Social Workers and Registered Dietician regarding accurate completion and coding	

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F 278	Continued From page 2 impaired vision and did not wear corrective lenses. A review of the safety care plan dated 09/02/16 indicated Resident #97 had vision problems and wore glasses as needed. The goal was for Resident #97 not to experience injury related to visual problems. The care plan also indicated Resident #97 decreased vision related to aging and was able to see large objects but not small print. The care area assessment (CAA) summary signed by the MDS coordinator on 09/14/16 indicated the visual function care area triggered and care planning decision was checked. The visual function CAA worksheet indicated Resident #97 had decreased visual acuity and the overall objective was to minimize risks. Care plan considerations included "at risk for visual acuity related to aging, disease process. He is able to see large object but not small print. Will continue to monitor and to make sure that his safety is maintained. " An interview was conducted on 10/13/2016 at 4:01 PM with the director of nursing. She stated her expectation was for MDS assessments to be completed accurately. An interview was conducted with Resident #97 on 10/13/2016 at 5:11 PM. Resident #97 stated he used bifocals for reading. An interview was conducted with the MDS coordinator on 10/14/2016 at 10:52 AM. The MDS coordinator stated corrective lenses should have been checked on the MDS.	F 278	of the MDS to accurately reflect pressure ulcers, vision, nutrition and behavioral status of the resident. Newly hired MDS Coordinators, Social Workers and Registered Dieticians will be educated during orientation period. The MDS Coordinator, Social Workers and Registered Dieticians will complete accurate Comprehensive MDS Assessments upon admission, quarterly, annually and with significant change in residents condition to accurately reflect residents pressure sore, vision, nutrition and behavioral status. 4. A quality monitoring of the residents' most recently completed Comprehensive MDS Assessments will be completed by DCS/ RN designee for (3) residents per week for (3) months, then monthly for 9 months to ensure that the MDS is accurately coded. The DCS/RN designee will report the results of the quality monitoring at the Quality Assurance Performance Improvement Committee Meeting monthly for (12) months. The QAPI committee will recommend and implement revisions to the plan as indicated to sustain substantial compliance.	

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F 278	Continued From page 3	F 278		

2. Resident #100 was admitted to the facility on 12/30/14 with diagnoses which included diabetes and dysphagia.

A review of the most recent quarterly Minimum Data Set (MDS) assessment dated 07/14/16 revealed Resident #100 was cognitively intact and required extensive assistance for eating. The "swallowing and nutrition status" section of the MDS revealed Resident #100 received 51% or more of his total calories through parenteral or tube feeding and his average fluid intake per day by intravenous or tube feeding during the assessment period was 501 milliliters per day or more. The "swallowing and nutrition status" section was electronically signed by the registered dietician.

Review of the activities of daily living care plan implemented on 01/04/16 and revised on 07/14/16 indicated interventions for staff to encourage Resident #100 to eat meal, and staff to open and set up items for eating. The nutrition care plan initiated on 01/04/16 and revised on 07/14/16 indicated interventions for registered dietician to evaluate and make diet change recommendations as needed and provide and serve diet.

"Nurse tech Information Kardex" indicated the diet was carbohydrate controlled/no added salt.

The physician order sheet for July 2016 revealed mechanical soft diet with thin liquids.

An interview was conducted with the registered dietician on 10/13/16 at 2:30 PM. The registered dietician looked at the electronic MDS dated 07/14/16 and stated that she marked the MDS

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F 278	Continued From page 4	F 278		

incorrectly. She added the resident did not have a feeding tube and never had one.

An observation on 10/13/16 2:50 pm revealed no tube feeding solution or equipment in Resident #100's room.

An interview was conducted on 10/13/2016 at 4:01 PM with the Director of Nursing. She stated her expectation was for MDS assessments to be completed accurately.

An interview was conducted on 10/13/2016 at 5:29 PM with Nurse #1. She stated Resident #100 ate by mouth.

3. Resident #9 was admitted to the facility 04/27/15 with diagnoses which included failure to thrive, hypertension, and schizophrenia.

A review of Resident #9's medical record revealed a physician's order dated 08/18/16 for an antibiotic recommended by the infectious disease department. The antibiotic was ordered 1 time a day for 2 weeks. Further medical record review revealed a nurses note that specified on 08/18/16, 8/21/16, 8/25/16 and 8/28/16 the medication was not administered due to the resident's refusal of the drug.

A review of a quarterly Minimum Data Set (MDS) dated 09/16/16 indicated Resident #9's cognition was intact. Section E0800 entitled Rejection of Care - Presence and Frequency asked in the assessment if the resident rejected taking medications or activities of daily living assistance. The MDS was coded this behavior was not exhibited.

An interview with Nurse #2 on 10/14/16 at 3:16 PM revealed Resident #9's history of medication and meal refusal dated back to February 2016. The nurse stated the resident's food or

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F 278	Continued From page 5 medication refusal occurred on average of 7 times per week. During an interview on 10/14/16 at 4:19 PM the MDS Coordinator confirmed Section E0800 of the quarterly MDS was incorrectly coded. The MDS Coordinator also confirmed Resident #9 had demonstrated multiple episodes of medication and meal refusals in the past few months. The MDS Coordinator explained the assistant social worker was responsible for coding this section of the MDS.	F 278		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by:	F 322		11/11/16

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F 322	Continued From page 6 Based on observations, staff and physician interviews, and record review, the facility failed to provide tube feeding as ordered for 1 of 2 sampled residents who required tube feeding (Resident #65). The findings included: Resident #65 was admitted to the facility on 08/10/10 with diagnoses which included anoxic brain injury. Review of Resident #65's quarterly Minimum Data Set (MDS) dated 08/10/16 revealed an assessment of short and long term memory loss. The MDS indicated Resident #65 received nutrition through a feeding tube. Review of Resident #65's care plan revealed interventions to provide nutrition and prevent dehydration included provision of tube feedings according to physician's orders. Review of nurse practitioner's orders dated 09/08/16 revealed Resident #65's sole source of nutrition was a brand specific 1.5 calories per cubic centimeter (cc.) caloric dense formula through a gastrostomy tube from 8:00 PM to 8:00 AM at 65 cubic centimeters (cc.) per hour for a total of 780 cc. Review of Resident #65's nutrition evaluation dated 09/08/16 revealed the Registered Dietician (RD) documented Resident #65 received 100% of nutrition via a tube. The RD documented Resident #65 estimated caloric needs for a planned weight loss were 1180 to 1475 kilocalories daily and 47 to 59 grams of protein daily to achieve an ideal body weight between	F 322	1. Resident #65 continues to receive continuous enteral nutrition via feeding tube (12) hours daily per physician's orders. On 10/14/2016 the Assistant Director of Clinical Services reeducated identified licensed nurses regarding continuous enteral nutrition via feeding tube per physician's orders. 2. On 10/17/2016, the DCS/licensed nurse designee completed quality monitoring and observations of current residents receiving continuous enteral nutrition via feeding tube to ensure accurate, timely administration as ordered by the physician. No additional discrepancies were identified. 3. By 11/11/2016, the DCS/Registered nurse designee provided reeducation to licensed nurses regarding administering continuous tube feeding as ordered for nutritional needs; to include starting and stopping feeding pump at the right time. Newly hired licensed nurses will be educated upon hire. The licensed nurse will administer continuous enteral nutrition via feeding tube per physician's orders; to include starting and stopping pump at the right time to meet resident's nutritional needs. 4. Quality monitoring and observations will be conducted by the Director of Clinical Services / licensed nurse designee for (3) residents each week for (3) months, then monthly for (9) months to ensure residents with continuous enteral nutrition via feeding tubes receive nutrition as ordered. The DCS/licensed nurse designee will report the results of the quality monitoring and observations at the	

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F 322	Continued From page 7 130 to 140 pounds. The RD specified Resident #65 should receive tube feedings every a 12 hours period for a total of 780 cc. of formula with a total of 1170 kilocalories. Review of Resident #65's September 2016 weight measurements revealed the following: 09/07/16: 150.2 pounds (lbs.); 09/12/16: 144.3 lbs.; 09/19/16: 143.9 lbs.; and on 09/26/16: 143.5 lbs. Review of Resident #65's September 2016 and October 2016 Medication Administration Records revealed documentation of tube feeding "on" at 8:00 PM and "off" at 8:00 AM. Review of Resident #65's October 2016 weight measurements revealed 141.7 lbs. on 10/04/16 and 145 lbs. on 10/06/16. Review of a RD progress note dated 10/12/16 revealed the RD documented a planned weight loss of 5.66% in one month with continuance of weekly weight monitoring. Observation on 10/13/16 at 7:05 AM revealed Resident #65's tube feeding shut off. Approximately 400 cc. remained in the 1000 cc. formula bottle. Hand writing on the formula bottle indicated the feeding began on 10/12/16 at 8:00 PM. Observation on 10/14/16 at 6:54 AM revealed Resident #65 did not have a tube feeding. Interview with Nurse #3 on 10/14/16 at 6:55 AM revealed she administered Resident # 65 a 6:00 AM medication and reconnected the tube feeding at that time. Nurse #3 explained the day shift nurse would shut off the tube feeding.	F 322	Quality Assurance Performance Improvement Committee Meeting monthly for (12) months. The QAPI committee will recommend and implement revisions to the plan as indicated to sustain substantial compliance.	

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F 322	Continued From page 8 Interview with Nurse #4 on 10/14/16 at 7:00 AM revealed she worked full time on the day shift caring for Resident #65. Nurse #4 explained she took off Resident #65's tube feeding upon report to duty since there was "one hour leeway" for administration of medication. Nurse #4 reported she considered the tube feeding a medication. Interview with the RD on 10/14/16 at 9:36 AM revealed Resident #65 should receive tube feeding for 12 hours. The RD explained she calculated Resident #65's nutritional needs and all 12 hours of the feeding was required. The RD explained she met with Resident #65's family members on 09/08/16 and the family members desired Resident #65 weight to return to between 130 and 140 pounds. Interview with Resident #65's physician on 10/14/16 at 12:06 PM revealed she expected Resident #65 to receive 12 hours of tube feeding as ordered. The physician explained she approved the planned weight loss for Resident #65 and relied on the RD's recommendations. Interview with the Director of Nursing (DON) on 10/14/16 at 12:33 PM revealed she expected Resident #65 to receive 12 hours of tube feeding as ordered. The DON reported staff should not stop the feeding one hour early.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		11/11/16

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F 323	Continued From page 9 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to lock wheel chair brakes and to use a gait belt during a transfer which resulted in a fall for 1 of 4 sampled residents reviewed for risk for falls (Resident #17). The findings included: Resident #17 was admitted to the facility on 02/05/10 with diagnoses which included cerebral vascular accident with hemiplegia. Review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated 08/04/16 revealed the resident was severely cognitively impaired. The MDS indicated Resident #17 required the extensive assistance of two persons with transfers and fell one time without injury since the prior assessment. Review of Resident #17's care plan dated 08/24/16 revealed there were interventions in place to prevent falls including staff assistance with transfers. Review of a SBAR (Situation, Background, Assessment and Recommendation) form dated 09/18/16 revealed Resident #17 fell without injury during a transfer from the toilet to the wheel chair. Review of the fall investigation report dated	F 323	1. For Resident #17, nursing staff continue to lock wheelchair brakes and use gait belt to assist with transfers to aid in the resident's safety per the plan of care. On 10/14/2016, Assistant Director of Nursing reeducated NA #3 regarding use of gait belt to assist with transfers to aid in resident's safety per Kardex. NA #2 is no longer employed by the facility. 2. By 11/11/2016, the DCS/licenses nurse designee completed quality monitoring and observations of residents at risk for falls to ensure appropriate safety interventions are in place per the resident's plan of care and kardex to aid in minimizing the risk of accidents. 3. By 11/11/2016, the Director of Clinical Services / licensed nurse designee provided reeducation to the Nursing Staff regarding resident safety and ensuring interventions are in place to aid in fall prevention; to include locking wheelchair brakes and use of a gait belt during transfers if indicated on the resident's plan of care and kardex. Newly hired nursing staff will be educated during orientation period. The licensed nurse will evaluate residents' fall risk upon admission, quarterly and with significant change in resident's condition and determine appropriate safety interventions to maintain safety. Licensed nurses will	

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F 323	Continued From page 10 09/18/16 revealed Resident #17 fell when Nurse Aide (NA) #2 attempted to transfer her into a wheelchair with unlocked brakes and without a gait belt. The report contained a statement by NA #2. NA #2 reported she forgot to lock the brakes of the wheelchair and use a gait belt. The investigation identified the unlocked brakes and omission of gait belt caused Resident #17's fall. Review of Resident #17's care plan revealed a revision on 09/19/16 with a hand written addition which specified nurse aide education to use a gait belt for transfers and to ensure locked wheel chair brakes prior to transfer. Observation on 10/14/16 at 7:19 AM revealed NA #3 transferred Resident #17 into a wheelchair with locked brakes. NA #3 assisted Resident #17 to stand and pivot on the right leg from the bed to the wheelchair. NA #3 did not use a gait belt during the transfer. In an interview on 10/14/16 at 7:21 AM, NA #3 stated Resident #17 required the assistance of one person for transfers. NA #3 reported a gait belt was not required for Resident #17's transfers. Interview with Nurse #2 on 10/14/16 at 11:00 AM revealed Resident #17 required the assistance of one person and use of a gait belt during transfers. Nurse #2 reported NA #2 reported Resident #17's fall at the evening of 09/18/16. Nurse #2 explained Resident #17 received a physical assessment and was not injured. Nurse #2 reported NA #2 did not lock the wheel chair brakes prior to the transfer and the chair rolled back. Nurse #2 revealed NA #2 did not use a gait belt which was required for Resident #17's transfer.	F 323	update, monitor and follow the resident's safety care plan and transcribe safety interventions on the kardex for nursing aides to follow to minimize the risk of resident accidents. 4. Quality monitoring and observations will be conducted by the Director of Clinical Services / licensed nurse designee for (5) residents each week for (3) months, then monthly for (9) months to ensure resident safety interventions are in place per the plan of care/kardex. The DCS / RN Designee will report the results of the quality monitoring and observations at the Quality Assurance Performance Improvement Committee Meeting monthly for (12) months. The QAPI committee will recommend and implement revisions to the plan as indicated to sustain substantial compliance.	

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F 323	Continued From page 11 NA #2 was not available for interview. Interview on 10/14/16 at 11:17 AM with the Director of Nursing (DON) revealed Resident #17 required the assistance of one person and use of a gait belt with all transfers. The DON explained unlocked wheel chair brakes and omission of a gait belt caused the fall on 09/18/16. The DON reported she reeducated NA #2 on the use of the gait belt and importance of locking the brakes. The DON reported she expected staff to use a gait belt for Resident #17's transfers to prevent falls.	F 323		
F 520 SS=D	483.75(o)(1) QAA 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.	F 520		11/11/16

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	345388	A. BUILDING _____ B. WING _____	C 10/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(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 520	Continued From page 12 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 reviews and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November of 2015. This was for one recited deficiency which was originally cited in August 2015 on a recertification and complaint survey and subsequently recited on the current recertification and complaint survey. The deficiency was in the area of accuracy of the assessment. Additionally, the facility's QAA Committee failed to maintain implemented procedures and monitor these interventions that the Committee put into place in November 2015. This was for one recited deficiency which was originally cited in October 2015 on a follow up survey and subsequently recited on the current recertification and complaint survey. The deficiency was in the area of QAA. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1a. F 278: Accuracy of the assessment: Based on staff interviews and clinical record review the facility inaccurately assessed 3 of 10 residents on the minimum data set (MDS). The MDS was	F 520	1. The Executive director conducted a Quality Assurance and Improvement Committee meeting on 10/17/2016 to discuss the recitation of tag 278. For Resident #97, the annual Minimum Data Set dated 9/2/2016 and the corresponding Care Area Assessment dated 9/14/2016 was modified by the Minimum Data Set Coordinator to accurately reflect the resident's pressure sore and vision status. For resident #100, the quarterly Minimum Data Set dated for 7/14/2016 was modified by the Minimum Data Set Coordinator to accurately reflect the resident's nutritional status. For resident #9, the quarterly Minimum Data Set dated 09/16/2016 was modified by the Minimum Data Set Coordinator to accurately reflect the resident's behavioral status. All modifications were resubmitted on 10/14/2016. 2. For residents that currently reside in the facility, a quality monitoring of the most current Comprehensive MDS Assessments and corresponding triggered CAAs, has been completed by 11/11/2016 by the MDS Coordinator, Social Worker and Registered Dietician to ensure accurate coding for pressure sores, vision, nutrition and behavioral status. The MDS Coordinator completed modifications by 11/11/16, as appropriate.	

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F 520	Continued From page 13 inaccurate for Resident #97 for pressure sores, Resident #100 for nutrition, and Resident #9 for behaviors. During the recertification and complaint survey of 08/27/15 the facility was cited for failure to accurately assess the dental section of the MDS assessment for a resident. On the current recertification and complaint survey the facility again failed to accurately assess the MDS assessment related to pressure sores, nutrition and behaviors for 3 residents. 1b. F 520: Quality Assessment and Assurance Program: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November of 2015. This was for one recited deficiency which was originally cited in August 2015 on a recertification and complaint survey and subsequently recited on the current recertification and complaint survey. The deficiency was in the area of accuracy of the assessment. Additionally, the facility's QAA Committee failed to maintain implemented procedures and monitor these interventions that the Committee put into place in November 2015. This was for one recited deficiency which was originally cited in October 2015 on a follow up survey and subsequently recited on the current recertification and complaint survey. The deficiency was in the area of QAA. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 520	3. The Regional Director of Clinical Services reeducated the Interdisciplinary team and members of the Quality Assurance and Process Improvement Committee on 11/2/2016 regarding the importance of maintaining implemented processes and continued quality monitoring to maintain substantial compliance. Additionally, education was provided regarding the responsibilities of reporting, revising and implementing ongoing action plans as appropriate. Newly hired Interdisciplinary team and QAPI Committee members will be educated upon hire. On 11/7/16, the Regional Case Mix Coordinator provided re-education to the Minimum Data Set Coordinator, Registered Dietician and Social Workers regarding accurate completion and coding of Comprehensive MDS Assessments to accurately reflect pressure ulcers, vision, nutrition and behavioral status of the resident. Newly hired MDS Coordinators, Registered Dieticians and Social Workers will be educated upon hire. The MDS Coordinator, Registered Dietician and Social Worker will complete accurate Comprehensive MDS Assessments upon admission, quarterly, annually and with significant change in residents condition to accurately reflect residents pressure sore, vision, nutrition and behavioral status. 4. A quality monitoring of the most recently completed Comprehensive MDS Assessments will be completed by the DCS/RN Designee for (3) residents per week for (3) months, then monthly for 9	

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F 520	Continued From page 14 During the follow up survey of 10/15/15 the facility was cited for failure to maintain implemented procedures and monitor these interventions that the committee put into place in November 2015. This was for one recited deficiency which was originally cited in October 2015 on a follow up survey and subsequently recited on the current recertification and complaint survey. The deficiency was in the area of QAA. In an interview on 10/14/2016 at 3:45 PM, the Administrator stated that the QAA Committee met monthly and discussed agenda items based on facility internal audits, corporate requirements and deficiencies identified during surveys. The Administrator further stated that the next QAA meeting would discuss why the facility continued with concerns related to inaccurate MDS assessments and implement monitoring to identify the root cause. The Administrator also stated that she attributed a repeat deficiency related to accuracy of MDS assessment to a change in staffing in this department. She stated that the facility used to have 2 MDS Coordinators, but now had only 1 MDS Coordinator along with corporate support. The Administrator further stated that the facility monitored the accuracy of the MDS assessment for 6 months after the October 2015 follow up survey and did not identify further concerns, so accuracy of the MDS was removed as a QAA agenda item.	F 520	months to ensure that the MDS is accurately coded. The DCS/RN designee will report the results of the quality monitoring at the Quality Assurance Performance Improvement Committee Meeting monthly for (12) months. The QAPI committee will recommend and implement revisions to the plan as indicated to sustain substantial compliance. Additionally, the Regional DCS and/or Regional MDS nurse will attend QAPI facility meetings at a minimum of quarterly to further validate compliance with F278.	