STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH REHABILITATION CENTER	616 WADE AVENUE RALEIGH, NC 27605

(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 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record review the facility failed to	F 278	The statements included are not an admission and do not constitute	3/3/17

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

Electronically Signed | 02/24/2017

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F 278	Continued From page 1 accurately code the presence of a prosthesis as a mobility device on the most recent comprehensive Minimum Data Set (MDS) for 1 of 13 sampled residents (Resident #219). Findings included: Resident #219 was admitted to the facility on 12/13/16. The resident's active diagnoses included right, above knee amputation. Resident #219's most recent comprehensive MDS assessment dated 12/20/16 was coded that the resident had no limb prosthesis. During an observation on 2/14/17 at 2:05 PM, Resident #219 had a limb prostheses in place. During an interview on 2/14/17 at 2:09 PM Nurse #1 stated Resident #219 had a right leg prosthesis when admitted to the facility. During an interview on 2/14/17 at 2:14 PM Resident #219 stated that he had a prostheses for his right leg since December 2015. He further stated he used the prosthesis the entire time he was in this facility for mobility and transfers. During an interview on 2/15/17 at 9:37 AM MDS Nurse #1 stated that the resident had a right leg limb prosthesis upon admission. She further stated she expected the limb prosthesis for Resident #219 to be captured in the admission assessment on 12/20/16. MDS Nurse #1 stated that the assessment was incorrect. During an interview on 2/15/17 at 10:25 AM the Director of Nursing stated it was her expectation that MDS assessments reflected a resident's use	F 278	agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F278 1. Corrective action for the affected resident: The Minimum Data Set (MDS) dated 12/20/16 for resident #219 was modified on 2/14/17 to include the use of a limb prosthesis. 2. Corrective action for those residents identified as having the potential to be affected: On 2/23/17, the MDS Nurse completed a 100% audit of remaining Minimum Data Set assessments on all current residents with a limb prosthesis to ensure correct coding of limb prosthesis. There were no other findings to correct. 3.Systemic Change: The MDS Nurses were re-educated by the Director of Nursing on 2/24/17 regarding correct coding and accuracy of the	

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F 278	Continued From page 2 of prosthesis correctly. She stated that the MDS dated 12/20/16 was incorrect.	F 278	Minimum Data Set to include the use of a limb prostheses. The Director of Nursing will audit all Minimum Data Set assessments for residents using a limb prostheses weekly for 12 weeks to monitor the Minimum Data Set for accuracy. 4. Monitoring of the change to sustain compliance ongoing: Monthly for the next 3 months, the Director of Nursing will report audit findings from the weekly Minimum Data Set audits to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will review the audits and make any needed recommendations to ensure compliance is sustained ongoing and determine the need for further auditing beyond 3 months.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans	F 279		3/3/17

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F 279	Continued From page 3	F 279		

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) 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 §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the resident’s representative (s)-

(A) The resident’s goals for admission and desired outcomes.

(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to

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F 279	Continued From page 4 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a Care Plan to address antianxiety medication for 1 of 1 resident (Resident #229) who was receiving antianxiety medication. The findings included: Resident #229 was originally admitted to the facility on 9/30/16 and was readmitted on 10/16/16 with diagnoses including Major Depressive Disorder and Anxiety Disorder. According to the most recent Quarterly Minimum Data Set (MDS) dated 1/19/17, Resident #229's cognition was intact. He required extensive assistance in the areas of bed mobility, dressing, toileting and personal hygiene. He was totally dependent in the area of bathing. Resident #229 required limited assistance in the area of transfers. He required supervision during meals as well as walking from one location to another both on and off the unit. Review of Section N of the MDS revealed Resident #229 received antianxiety medication for the last seven (7) days and since admission. Review of Resident #229's Care Area Assessment Summary (CAA) dated 10/23/16 revealed he was at risk for adverse drug	F 279	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F279 1. Corrective action for the affected resident: The care plan for resident #229 was updated to include the use of anti-anxiety medication on 2/23/17. 2. Corrective action for those residents identified as having the potential to be affected: On 2/24/17, a 100% audit of current	

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F 279	Continued From page 5 reactions due to being administered antianxiety medication, Xanax, daily for anxiety. Psychotropic Drug Use triggered on the Care Area Assessment Summary and the recommendation was to care plan for antianxiety medication. Review of Resident #229's updated Care Plan dated 12/29/16 revealed antianxiety medication was not care planned. Review of January and February 2017's Physician's orders revealed Resident #229 was receiving Clonazepam 0.5 mg. tablet for Klonopin at bedtime for anxiety/agitation since 11/28/16 and Alprazolam 0.5mgs. for Xanax twice daily for anxiety since 12/15/16. During an interview on 2/15/17 at 12:53 PM, the Minimum Data Set (MDS) Coordinator revealed she did not have an explanation for the antianxiety medication not being care planned, other than it was overlooked. During an interview on 02/15/2017 at 1:58 PM, the Unit Manager revealed Resident #229 received anxiety medication for pacing the floors back and forth and getting very anxious. She emphasized he had been a lot better since he was started on medication for anxiety. During an interview on 02/15/2017 at 2:24 PM, the Director of Nursing (DON) revealed her expectation would be that the care plan should reflect the patient. During an interview on 02/16/2017 at 9:35 AM, the Administrator revealed her expectation would be that any antianxiety medication should be care planned.	F 279	resident care plans was completed for all residents who use anti-anxiety medications to ensure use of medication was documented on each care plan. There were no other care plan issues identified. Audit was completed by the Director of Nursing. 3. Systemic Change: The Minimum Data Set (MDS) Nurses and Unit Managers were re-educated by the Director of Nursing regarding the importance of documenting any use of an anti-anxiety medication on a residents care plan on 2/24/17. The Director of Nursing will audit all new residents care plans to ensure any resident who receives an anti-anxiety medication has an appropriate care plan for its use for the next 12 weeks. The Director of Nursing will also complete random audits of care plans for residents who use anti-anxiety medications, completing 3 per week for the next 12 weeks to ensure all anti-anxiety medications are documented on each care plan. 4. Monitoring of the change to sustain compliance ongoing: Monthly for the next 3 months the Director of Nursing will report audit findings from the weekly care plan audits to the Quality Assurance Performance Improvement Committee. The Quality Assurance	

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F 279	Continued From page 6	F 279	Performance Improvement Committee will review the audits and make any needed recommendations to ensure compliance is sustained ongoing and determine the need for further auditing beyond 3 months.	
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an	F 285		3/3/17

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F 285	Continued From page 7	F 285		

independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

(2) Exceptions. For purposes of this section-

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under

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F 285	Continued From page 8 paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to make a referral for a reevaluation after a significant change in condition for 1 of 1	F 285	The statements included are not an admission and do not constitute agreement with the alleged deficiencies	

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F 285	Continued From page 9 sampled residents (Resident # 3) reviewed for Preadmission Screening Resident Review Level II status. The Findings included: Resident #3 had a diagnosis of Bipolar Disorder. Review of the medical record revealed Resident #3 was determined to have a Level II Preadmission Screening Resident Review, (PASSR) dated 1/18/16. Further record review revealed the resident had a Significant Change in Status Assignment completed on 6/7/16. In an interview on 2/16/17 at 8:46 AM the Minimum Data Set (MDS) Nurse #2 indicated that she was aware the PASSR Authority was to be notified when a resident with a Level II PASSR had a significant change in status. She indicated that typically the Social Worker (SW) made the referral to the PASSR Authority, however the SW at the time of her significant change in status was no longer at the facility. During an interview on 2/16/17 at 9:33 AM the Administrator stated that she expected staff to do their job and should notify the PASSR Authority when a Level II resident had a Significant Change in Status.	F 285	herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F285 1. Corrective action for affected resident: A referral for reevaluation to the Pre-Admission Screening and Resident Review Authority was made on 2/23/17 for resident #3. 2. Corrective action for those residents identified as having the potential to be affected: All residents with Level II Pre-Admission Screening and Resident Review were reviewed for significant change assessments and corresponding notification to Pre-Admission Screening and Resident Review when appropriate, for the last year. One other resident was found to be affected by this action and Pre-Admission Screening and Resident Review was notified of change on 2/23/17. 3. Systemic Change:	

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F 285	Continued From page 10	F 285	Education was provided to the Social Workers on 2/24/17 by the Administrator regarding the need to notify the Pre-Admission Screening and Resident Review Authority when a Level II resident has a significant change in status. The Administrator will audit all significant change Minimum Data Set assessments for the next 12 weeks to identify any resident with a Level II Pre-Admission Screening and Resident Review who has received a significant change and verify with the Social Services Manager that the Pre-Admission Screening and Resident Review Authority has been notified of this change. Verification will be in the form of documentation received from the Pre-Admission Screening and Resident Review Authority. 4. Monitoring of the change to sustain compliance ongoing: Monthly for the next 3 months the Administrator will report audit findings to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will review the audits and make any needed recommendations to ensure compliance is sustained ongoing and determine the need for further auditing beyond 3 months.	
F 364 SS=D	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		3/3/17

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F 364	Continued From page 11 (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to prepare foods prepared in a form to meet the needs of residents receiving pureed diets. The findings included: Review of the undated facility SNP Recipe Book for Pureed Vegetables under Directions, revealed item #3 "Ensure mixture achieves moist mashed potato or pudding like consistency." The Academy of Nutrition and Dietetics defines a Puree diet as, a diet consisting of foods that are easy to swallow. Foods should be "pudding like. Pureed foods prepared in advance are the consistency of pudding or moist mashed potatoes." During the meal observation on 2/13/17 at 11:55 AM dietary staff were observed plating up the noon meal. The cook was observed to plate up a puree meal onto a divided plate and hand to staff that covered the plate and placed on the meal cart. The dietary staff then plated up two additional puree meals onto divided plates and handed to staff to cover and placed onto the meal cart. The puree chicken and spinach were observed to be runny with a thin consistency and touched all the sides of the divided plate.	F 364	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F364 1. Corrective Action for affected resident: The puree chicken and spinach were removed and reconstituted to the correct mashed potato consistency on 2/13/17. 2. Corrective action for those residents identified as having the potential to be affected:	

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F 364	Continued From page 12 In an interview on 2/13/17 at 11:59 AM the Certified Dietary Manger revealed that puree foods should have a mash potato consistency. The CDM had staff remove the puree chicken and spinach and prepared to a mashed potato consistency. In an interview on 2/13/17 at 12:00 PM the cook stated puree food should look thicker, but she had not made the puree foods for lunch that day.	F 364	All residents who receive a puree diet have the potential to be affected. The consistency of the puree chicken and spinach were corrected at the time of the observation, so no residents were directly affected by this practice on 2/13/17. 3. Systemic change: All Cooks were re-educated on 2/24/17 regarding the proper way to prepare and serve puree food with the correct consistency of mashed potatoes. Education was provided by the Certified Dietary Manager with oversight by the Dietician. The Dietician will complete 3 random audits weekly for the next 12 weeks of the puree food to verify proper consistency is being prepared and served. 4. Monitoring of the change to sustain compliance ongoing: Monthly for the next 3 months the Dietician will report audit findings to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will review the audits and make any needed recommendations to ensure compliance is sustained ongoing and determine the need for further auditing beyond 3 months.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		3/3/17

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	345049	A. BUILDING _____ B. WING _____	02/16/2017

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F 371	Continued From page 13 (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition by failing to clean 2 of 2 ovens, failed to clean the walk in cooler floor, failed to allow 6 of 10 divided plates to completely air dry and failed to clean the lowerator. The Findings included: Review of the PM Cook Nutrition Services Cleaning Schedule dated 4/1/15 under Instructions: read as 1. "Complete cleaning assignments according to the cleaning	F 371	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged	

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F 371	Continued From page 14 procedures for each type of equipment." The posted cleaning schedule for February under oven/range was initialed as having been cleaned. 1. During the initial kitchen tour on 2/13/17 beginning at 9:15 AM the double oven was observed. The bottom of the ovens were observed with black food spills covering the front portion of the ovens and black charred food particles and multiple pieces of foil were located towards the back portion of the ovens. Inside the walk in cooler, a 4 inch by 6 inch dried milk puddle was observed beneath the milk riser near the wall and 2inch by 3 inch dried milk spill was located by the right front leg. A second observation of the kitchen on 2/15/17 revealed the double oven was in the same condition. The walk in cooler was observed with 8 dried quarter size drops of milk under the milk riser near the wall and 6 dime size dried drops of milk by the right front leg of the milk stand. In an interview on 2/15/17 at 9:56 AM the CDM stated that the ovens were on the cleaning schedule and he expected staff to follow the cleaning schedule. In an interview on 2/15/17 at 10:09 AM the CDM stated that staff had mopped up the milk and he was not sure why it still leaked. Review of the Machine Dishwashing Racking Procedure reviewed on 9/27/16 under section Unracking Dishes, item #4 read as: "Air dry dishes. Do not wipe with a dishtowel. Stack when dry." 2. During the meal observation on 2/13/17 at	F 371	deficiencies cited have been or will be completed by the dates indicated. F371 1. Corrective action for affected resident: On 2/16/17 the double oven, cooler and plate lowerator were cleaned by the kitchen staff and Certified Dietary Manager. 2. Corrective action for those residents identified as having the potential to be affected: Kitchen sanitation has the potential to affect all residents. The plate lowerator was added to the regular cleaning schedule and staff was educated regarding the proper procedure to clean this piece of equipment. 3. Systemic change: All Dietary staff were re-educated on the importance of proper cleaning of all kitchen equipment, maintaining a clean and sanitary kitchen and the proper drying of all dishes. Education was provided by the Certified Dietary Manager on 2/24/17. The Administrator will audit the cleanliness of the kitchen equipment through random three times a week audits of at least 3 pieces of equipment at a time. The audit will also include observation at least three times a week at	

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F 371	Continued From page 15 12:11 PM divided plates were observed stacked and ready for use beside the tray line. 6 of the 10 divided plates were observed with water pooled inside. Staff were observed to pick up a divided plate shake the water off, dish up food and hand the divided plate to staff that covered the plate and placed on the meal cart. In an interview on 2/13/17 at 12:17 PM the Certified Dietary Manager (CDM) stated that the plates should have been completely dry before use. In an interview on 2/15/17 at 9:49 AM the CDM stated that staff did not let the divided plates air dry long enough. He indicated he had educated staff on the correct way to allow dishes to air dry completely. 3. During the meal observation on 2/13/17 at 12:22 PM the 3 compartment lowerator was observed. Inside the cylinder walls and bottom were observed with dried dark food spills and underneath the lid perimeter were dark dried food spills. During a second observation on 2/15/17 at 9:43 AM the lowerator was observed to be in the same condition. In an interview on 02/15/2017 at 9:55:27 AM the CDM stated that the lowerater was not on the cleaning schedule but was cleaned every 15 days. He indicated he would add the lowerator onto the cleaning schedule.	F 371	varying meal service times of the condition of the plates ready for meal service. Audits will continue 3 times per week for 12 weeks. 4. Monitoring of the change to sustain compliance ongoing: Monthly for the next 3 months the Administrator will report audit findings to the Quality Assurance Performance Committee. The Quality Assurance Performance Committee will review the audits and make any needed recommendations to ensure compliance is sustained ongoing and determine the need for further auditing beyond 3 months.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance.	F 520		3/3/17

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F 520	Continued From page 16 (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 observations, record review, and staff	F 520	The statements included are not an	

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F 520	Continued From page 17 interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place. This failure was related to F278 being cited on three consecutive annual recertification surveys. This was originally cited during the facility's 5/20/15 annual recertification survey, re-cited during an annual recertification on 3/10/16, and cited again on the current 2/16/17 annual recertification survey. The most recent re-cited deficiency was in the area of Assessment Accuracy. The facility's continued failure during the recertification surveys showed a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag is cross referenced to: F278: Assessment Accuracy: Based on observations, staff and resident interviews, and record review the facility failed to accurately code the presence of a prosthesis as a mobility device on the most recent comprehensive MDS for 1 of 13 sampled residents, (Resident #219). The facility was recited for F278 on the current recertification survey for failing to code the presence of a prosthesis. F278 was originally cited during the May 2015 recertification survey for failing to accurately code dialysis (Resident #129) and failing to code a Level II Preadmission Screening and Resident Review (Resident #25). F278 was also cited during the March 2016 recertification survey for failing to accurately code a Level II Preadmission Screening and Resident Review (Resident #17).	F 520	admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F520 1. Corrective action for affected resident: No residents were named in this citation, however, facility residents have the potential to be affected. 2. Corrective action for those residents identified as having the potential to be affected: On 2/24/17 the Minimum Data Set (MDS) Nurses were re-educated by the Director of Nursing regarding correct coding and accuracy of the MDS to include the use of a limb prostheses. 3. Systemic change: The Director of Nursing will audit all MDS assessments for residents using a limb prostheses weekly for the next 12 weeks	

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F 520	Continued From page 18 During an interview on 2/16/17 at 8:48 AM the Administrator stated there was ongoing audits where MDS consultants came to the facility and audited the MDS assessments. She stated that apparently the facility was not catching everything.	F 520	to ensure proper coding of the MDS. Education will be provided by the Administrator to the Quality Assurance Performance Committee on the intent of the citation F278 and the monitoring tool put in place to ensure accuracy. 4. Monitoring of the change to sustain compliance ongoing: Monthly for a minimum of 3 months the Director of Nursing will report audit findings from MDS coding to the Quality Assurance Performance Committee. The Quality Assurance Performance Committee will review the audits to make recommendations to ensure compliance is sustained ongoing and determine the need for further auditing beyond the three months.	