STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(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 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and	F 272		3/3/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/28/2017

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F 272	Continued From page 1 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility to include target behaviors in the care planning process for one of five residents sampled for unnecessary medication reviews. Resident # 53. The findings included: Resident #53 was admitted to the facility on 3/2/16 with diagnosis including Alzheimer's, anxiety, and depression. The admission Minimum Data Set (MDS) dated 3/9/16 indicated Resident #53 had severe impairment of long and short term memory, no moods or behaviors and received an antipsychotic medication Risperdal, an antianxiety medication Xanax and an antidepressant medication Prozac. Review of the Care Area Assessments (CAAS) dated 3/15/16 indicated a review for the use of psychotropic medication use was completed due to receiving an antipsychotic and an antianxiety medication. Review of the summary of the problem revealed the resident had resulting in a hip fracture with surgical repair, had dementia and cognitive deficits. The summary did not address any behaviors or history of behaviors. A	F 272	F 273 The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is 3/3/17. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. All medications for Resident #53 were reviewed with Attending Physician on 2/9/17. Attending Physician made no medication changes. MDS Coordinator updated the care plan to reflect the history of targeted behaviors requiring the use of anti-psychotic medication. All other residents on anti-psychotic medications had their care plans reviewed to ensure appropriate target behavior and medication care plans were in place. No other issues were identified .	

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F 272	Continued From page 2 decision to proceed to care plan was made and referrals included psychiatry, physician nurse practitioner as needed. Review of the initial care plan dated 3/16/16 included a problem of at risk for falls related to psychotropic drug use, history of fall with injury and impaired mobility. The stated goal included for the resident to be free of side effects of the antipsychotic medication. The approaches indicated staff were to complete an assessment for abnormal involuntary movements, obtain labs per physician orders, dosage reductions to be attempted as appropriate, psych consult as needed and behavior management per protocol. The care plan was most recently updated on 1/30/17. The care plan did not address the target behaviors that required the use of the Risperdal. Interview with the MDS nurse on 2/9/17 at 11:00 AM revealed she had not included target behaviors on the care plan. She was aware the resident had agitation/anxiety and had included the behavior on the care plan. At the time of the MDS assessment the resident was not exhibiting any behaviors. The MDS nurse explained the Risperdal was being used for dementia with agitation.	F 272	Laurel Health Care Company□s corporate office Director of Clinical Reimbursement will re-educate all administrative nursing staff and MDS Staff on Care Planning requirements for residents on anti-psychotic/anti-anxiety/anti-depressant medications. Director of Nursing and/or Assistant Director of Nursing will utilize a Quality Assurance monitoring tool weekly x 4 weeks to review MDSs/Care Plans completed during that week for residents on anti-psychotic medications to ensure targeted behaviors are appropriately addressed on the Care Plan. Ongoing compliance will be monitored using the monitoring tool to review 2 MDSs/Care Plans a month for residents receiving anti-psychotic medications x 2 months and Director of Nursing or Assistant Director of Nursing will immediately notify Administrator and MDS Coordinator of any missing target behaviors care plans. Continued compliance will be monitored through the facility□s Quality Assurance Program x 3 months. Additional education and monitoring will be initiated for any identified concerns.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change"	F 274		3/3/17

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F 274	Continued From page 3 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete a significant change in status assessment for 2 of 32 sampled residents (Resident #7 and Resident # 90). The findings included: Resident #7 was admitted to the facility on 09/26/2016 with diagnosis that included thoracic vertebral fracture, obesity, hypertension (HTN), venous insufficiency and lymphedema. The admission Minimum Data set (MDS) dated 10/03/2016, was coded to indicate that Resident #7 was significantly cognitively impaired and scored a zero on the mood interview. Resident #7 required extensive assist of 2 staff for bed mobility and transfers, extensive assist of 1 staff for locomotion off the unit and dressing. Resident #7 required limited assist for eating. Resident #7 also had occasional bladder incontinence. The quarterly MDS dated 01/01/2017, specified that Resident #7 had no cognitive impairment and scored a 3 on the mood interview. Resident #7 required 1 staff extensive assist for bed mobility, transfers and eating, was independent for locomotion off the unit and required extensive	F 274	F 274 The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is 3/3/17. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. MDS Coordinator performed an additional assessment to accurately reflect Resident #7□s significant change in clinical condition. Resident #90□s annual MDS was re-coded to correctly identify it as a significant change assessment. MDS Coordinator reviewed all other current long-term care guests□ most recent quarterly or annual MDS assessments to ensure all other status assessments were coded correctly. No other issues were identified.	

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F 274	Continued From page 4 assist for eating. Resident #7 was always continent of bladder. An interview conducted with the Assistant Director of Nurse (ADON)/ MDS Coordinator #1, MDS Coordinator #2 and the social worker on 02/08/2017 at 9:40 AM revealed that a significant change MDS should have been triggered with the quarterly MDS dated 01/01/2017, but it had been missed. On 02/08/2017 at 10:56 AM, the Director of Nurses (DON) stated that she expected that significant change assessment should have been completed to reflect significant changes in all resident's status. Resident # 90's diagnosis included hypertension (HTN), cerebrovascular accident (CVA), dementia, depression and insomnia. The quarterly Minimum Data Set (MDS) dated 11/10/16, coded Resident #90 as having significant cognitive impairment, moderate hearing impairment, usually able to understand others and did not have or wear corrective lenses. Resident # 90 was able to participate in the mood assessment and was coded as experienced 2- 6 days of little interest or pleasure in doing things,2-6 days of trouble concentrating and 12-14 days of being restless or fidgeting. The mood score from interview of Resident # 90 was coded as a 5. Resident # 90 required limited assist to walk in the corridor and locomotion on and off the unit and was dependent for bathing, had occasional bowel incontinence. Resident # 90 was coded as able to participate in the pain assessment, but responses were coded with dashes and staff was interviewed which revealed	F 274	Laurel Health Care Company□s corporate office Director of Clinical Reimbursement will re-educate all administrative nursing staff and MDS Staff on proper coding of status assessment on MDSs. Director of Nursing and/or Assistant Director of Nursing will utilize a Quality Assurance monitoring tool to review all quarterly and annual assessments weekly x 4weeks. Additionally, for ongoing compliance, Director of Nursing and/or Assistant Director of Nursing will utilize monitoring tool to review 1 assessments monthly x 2 months to ensure proper status assessments are coded and immediately notify Administrator and MDS Coordinator of any errors. Continued compliance will be monitored through the facility□s Quality Assurance Program for 3 months. Additional education and monitoring will be initiated for any identified concerns.	

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F 274	Continued From page 5	F 274		

that Resident # 90 had vocal complaints of pain for 3-4 days. Resident # 90 did not have any shortness of breath and had no falls during the review.

The annual MDS dated 01/20/2017 revealed that Resident # 90 had significant cognitive impairment, had no hearing impairment, always understood others and wore corrective lenses. Resident # 90 was coded as not able to be interviewed for moods and had no mood score. Staff interviewed for Resident # 90's moods revealed that there were 2-6 days of change in sleep pattern, 12-14 days of having trouble concentrating and 2-6 days of restlessness or fidgeting. The mood score from staff interview for Resident # 90 was 5. Resident # 90 had 1-3 days of wandering. Resident # 90 required extensive assist to walk in the corridor and for locomotion on and off the unit and bathing and was continent of bowel. Resident # 90 did participate in the pain interview and rarely experienced pain which was rated as a 6 out of 10 on the pain scale. Resident # 90 was coded as having shortness of breath on exertion, when sitting and when lying flat and had 2 falls with no injury during the review period.

An interview conducted with the Assistant Director of Nurse (ADON)/ MDS Coordinator #1, MDS Coordinator #2 and the social worker on 02/08/2017 at 9:40 AM revealed that a significant change MDS should have been triggered with the quarterly MDS dated 01/01/2017, but it had been missed.

On 02/08/2017 at 10:56 AM, the Director of Nurses (DON) stated that she expected that significant change assessment should have been completed to reflect significant changes in all

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F 274	Continued From page 6 resident's status.	F 274		
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	F 278		3/3/17

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F 278	Continued From page 7 by: Based on record review and staff interview, the facility failed to accurately code an annual comprehensive Minimum Data Set (MDS) assessment to reflect that a resident was taking an antipsychotic for 1 of 5 sampled residents (Resident # 99) reviewed for unnecessary medications. The findings included: Resident # 99 was admitted to the facility on 1/18/16 with diagnoses including, but not limited to: anxiety, Parkinson's disease, dementia with behavioral disturbances, late onset Alzheimer's disease, delusional disorder, pulmonary nodules, and physical decline. Review of an annual comprehensive MDS assessment dated 1/10/17 revealed that the resident was coded with severe cognitive impairment. Behaviors noted during the assessment period included: physical behavior symptoms directed towards others occurred 1-3 days, verbal behavior symptoms directed towards others occurred 1-3 days, and rejection of care occurred 1-3 days. Resident # 99's behaviors significantly interfered with her ability to participate in activities and social interactions. Resident # 99's behaviors had not changed since the previous assessment. During the assessment period Resident # 99 was coded as having received antipsychotics medications 0 out of 7 days, antianxiety medications 7 out of 7 days, and antidepressant medications 7 out of 7 days. Care Area Assessments (CAA) were triggered to be carried to the care plan for psychotropic drug use.	F 278	F 278 The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is 3/3/17. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. MDS Coordinator corrected Resident #99□s annual comprehensive MDS assessment to correctly reflect the ant-psychotic medication administered during the look-back period. MDS Coordinator reviewed all other current long-term care guests□ most recent quarterly or annual MDS assessments to ensure all other antipsychotics administered during their respective lookback periods were coded correctly. No other issues were identified. Laurel Health Care Company□s corporate office Director of Clinical Reimbursement re-educated all administrative nursing staff and MDS Staff on proper coding of anti-psychotic medication on MDSs on 2/24/17. Director of Nursing and/or Assistant Director of Nursing will utilize a Quality	

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F 278	Continued From page 8 A review of Resident # 99's current physician orders revealed that the resident had an active order for Risperdal Consta 12.5 mg injection (an antipsychotic medication) to be administered every 14 days that was written on 10/12/16. A review of the Medication Administration Record (MAR) for January 2017 revealed that Resident # 99 received Risperdal Consta 12.5 mg injection on 1/4/17. An interview with the MDS Coordinator on 2/8/17 at 8:21 AM revealed that the annual comprehensive MDS assessment dated 1/10/17 should have been coded to show that Resident # 99 received an antipsychotic medication 1 out of 7 days. The MDS Coordinator indicated that Resident # 99 received an antipsychotic medication on 1/4/17 which was during the look back period for this assessment. An interview with the DON on 2/8/17 at 3:43 PM revealed that her expectations were for MDS assessments to be accurately coded and anything found to be incorrect to be corrected. An interview with the Administrator on 2/8/17 at 3:49 PM revealed that his expectation would be for the MDS to be accurately coded. The Administrator indicated that he would also expect a correction to be made to the MDS assessment so the assessment would be accurate.	F 278	Assurance monitoring tool to review assessments of residents receiving anti-psychotics completed each week x 4weeks and then 2 assessments monthly x 2 months to ensure proper coding of antipsychotics and immediately notify Administrator, DON, and/or MDS Coordinator of any errors. Continued compliance will be monitored through the facility□s Quality Assurance Program for 3 months. Additional education and monitoring will be initiated for any identified concerns	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional	F 514		3/3/17

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F 514	Continued From page 9 standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: The facility failed to list the diagnosis for the use of Risperdal in the medical record for one of five sampled residents reviewed for unnecessary medications. Resident #53. The findings included:	F 514	F 514 The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is 3/3/17.	

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F 514	Continued From page 10 Resident #53 was admitted to the facility on 3/2/16 with diagnosis including Alzheimer ' s, anxiety, and depression. The admission cumulative diagnosis list included Alzheimer ' s disease and did not include behavioral disturbances. Review of the Psychotropic medication risk assessment dated 3/6/16 indicated the antipsychotic medication Risperdal was for agitation. The list of behaviors to identify target behaviors was blank. The primary physician progress notes indicated Resident #53 had dementia without behavioral disturbances. Interview with the primary physician on 2/09/17 at 12:16 PM revealed Resident #53 did have a history of behaviors. The hospital discharge had included in the diagnosis list dementia without behaviors and that was incorrect. He explained he should have caught that on readmission. His progress notes should have the diagnosis as Alzheimer ' s with behavioral disturbances. Interview with the administrator on 2/09/17 at 12:19 PM revealed the family stated she had behaviors, and there was documentation from several years ago with that diagnosis. A dose reduction had been attempted but it failed and the family did not want to have any further trials due to decompensation.	F 514	Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. Based on staff and family interviews, Resident #53□s attending provider added a diagnosis of dementia with behavior disturbances to Resident #53□s cumulative diagnosis list. Director of Nursing and Assistant Director of Nursing reviewed all other current residents receiving an anti-psychotic medication to ensure proper documentation of appropriate diagnosis and appropriate documentation of behaviors. No other issues were identified. Director of Nursing and Assistant Director of Nursing educated all nursing staff with regard to required diagnoses for usage of anti-psychotic medication and behavior documentation that would indicate continued usage of anti-psychotic medications with attempted gradual dose reduction as directed by physician. Director of Nursing will review each resident on anti-psychotics□ documentation in behavior management book weekly X 1 month. Ongoing monitoring will be done through facility□s monthly Behavior Management meetings. Administrator will be immediately notified	

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F 514	Continued From page 11	F 514	of any issues. Continued compliance will be monitored through the facility□s Quality Assurance Program for 3 months. Additional education and monitoring will be initiated for any identified concerns.	