STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 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" 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 staff interviews and record review the facility failed to identify a significant change in status for 1 of 22 sampled residents (Resident #13) who's Minimum Data Set (MDS) was reviewed. Findings included: Resident #13 was admitted to the facility on 7/19/16. Diagnoses included fracture of the right wrist and hand, generalized muscle weakness, generalized anxiety, depression and hypertension. The Admission MDS dated 7/25/16 indicated the resident was cognitively intact, required extensive assistance for bed mobility, transfer and toilet use, totally dependent on staff for locomotion, dressing and personal hygiene independent with eating, The resident was coded as always continent of bowel and bladder. Walking had not occurred.	F 274	Roanoke River Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Roanoke River Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure	2/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/08/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 274	Continued From page 1 The 10/3/16 quarterly MDS indicated Resident #13 was moderately cognitively impaired and required extensive assistance for bed mobility, transfer, and dressing, limited assistance with walking, limited assistance with locomotion, extensive assistance with dressing, supervision with eating and was totally dependent for toilet use and personal hygiene. The resident was coded as occasionally incontinent of bowel and bladder with no toileting plan attempted. This MDS reflected a decline in cognition and bowel and bladder incontinence. Walking improved from not occurring to the resident required limited assistance. Locomotion improved from totally dependent to limited assistance. The 1/3/17 quarterly MDS coded the resident as cognitively intact. She required supervision with bed mobility, extensive assistance with transfer, personal hygiene and toilet use. Locomotion had improved to supervision. The resident's continence had declined to always incontinent of bowel and bladder. The MDS identified Resident #13 as improving in 2 areas and declining in 2 areas. The MDS Coordinator was interviewed on 1/19/17 at 5:20 PM. She explained a significant change in status MDS was completed if a resident improved or declined in two or more areas of function. She reviewed the admission MDS and compared the MDS with the 10/3/16 quarterly MDS. The MDS nurse stated since the resident had been in therapy, there was an expectation her locomotion and walking would improve, but acknowledged the expected improvement had not been care planned. She acknowledged the resident had declined in cognition and bowel and	F 274	and/or any other administrative or legal proceeding. F274 483.20(b) (2) (ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A significant change assessment was completed on 2/3/17 by the MDS nurse for resident #13 to identify the resident□s improvement in 2 areas and decline in 2 areas. 100% audit was completed, 2/3/17, of all current resident most current MDS, to include residents #13, by the DON and ADON to identify any significant changes in resident status. A significant change assessment will be completed by the MDS nurses by 2/16/17 for any identified areas of concern noted during the audit. 100% in-service was completed with the MDS nurses regarding the definition of a significant change, how to identify a significant change in resident status and how to complete a significant assessment was completed on 2/3/17 by the MDS consultant. The MDS nurses have attended the State level MDS training on 2/7/17 and 2/8/17 which includes identifying a resident□s significant change in status and how to complete a significant change assessment. 10% of completed MDS□s, to include resident□s #13, will be reviewed to ensure significant changes are identified and a significant change assessment was completed when identified by the ADON 3	

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F 274	Continued From page 2 bladder continence and acknowledged therapy had not affected this area. The MDS Coordinator then compared the 10/3/16 quarterly MDS with the 1/3/17 quarterly MDS and acknowledged there had been improvement or decline in 2 or more areas of function and she should have completed a significant change in status for Resident #13.	F 274	X□s a week X□s 4 weeks, then weekly X□s 4 weeks and then monthly X□s 1 utilizing a MDS Sig. Change QI tool. All identified areas of concern will be addressed immediately by the ADON by retraining the MDS nurse and completion of a significant change assessment by the MDS nurse with oversite from the ADON. The DON will review and initial the MDS Sig. Change QI tool weekly X□s 8 weeks and then monthly X□s 1 to ensure any areas of concerns have been addressed. The Executive QI committee will meet monthly and review audits of MDS Sig. Change tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.	
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.	F 278		2/17/17

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F 278	Continued From page 3 (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 record review, resident observation, and resident and staff interviews the facility failed to accurately code the dental status for 2 of 3 residents reviewed for dental status and services (Resident #124 and Resident #87) and the use of antianxiety medication for 1 of 5 residents reviewed for unnecessary medications (Resident #28). Findings included: 1. Resident #124 was admitted on 11/10/2015. Her admitting diagnoses included functional quadriplegia, Alzheimer's disease and anxiety. Her most recent Annual Minimum Data Set (MDS) dated 11/17/2016 indicated she was cognitively intact. She required supervision with eating and extensive to total assistance with all other activities of daily living. She was noted to have no natural teeth or tooth fragments (edentulous). An observation of and an interview with Resident	F 278	F278 483.20(G)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED Resident # 124 and #87 MDS was modified on 2/2/17 to reflect accurate coding of dental status by the MDS nurses. Resident #28 MDS was modified on 1/20/17 to reflect accurate coding of antianxiety medication by the MDS nurses. 100% audit of all current resident most current MDS will be reviewed, to include residents #124, 87 and # 28, by the DON and ADON to ensure all MDS□s completed are coded accurately to include all diagnosis, medications, and correct dental status and services completed by	

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F 278	Continued From page 4 #124 was conducted on 1/17/2017 at 4:20 PM. Resident #124 was observed to have teeth but some were missing. Resident #124 stated she had her own natural teeth, was missing a few and denied having any pain, discomfort or difficulty with chewing food. An interview was conducted with MDS nurse #1 on 1/19/2017 at 4:51 PM. The MDS nurse stated residents' dental status is determined by actually looking into their mouths and asking if they had any pain or difficulty chewing. The nurse stated she had miscoded Resident #124's dental section on her latest annual assessment. An interview with the Administrator (AD) was conducted on 1/20/2017 at 12:34 PM. The AD stated it was her expectation that the MDS be coded correctly and accurately. 2. Resident #87 was admitted to the facility on 3/30/15 with diagnoses including hypertension, neuralgia, neuritis, and functional quadriplegia. Review of Resident #87's most recent annual Minimum Data Set (MDS) assessment dated 7/2/16 revealed the resident was assessed as having no obvious or likely cavity or broken natural teeth. Review of the resident's most recent MDS dated 1/1/17 coded as a quarterly assessment revealed the resident was assessed as moderately cognitively impaired. During observation of Resident #87's teeth on 1/19/17 at 2:13 PM, a tooth in the resident's right bottom teeth had a cavity. The resident also had a broken top right tooth. During an interview on 1/19/17 at 2:18 PM Nurse	F 278	2/15/17 using a MDS Accuracy QI tool. Modifications will be completed by the MDS nurses during the audit for any identified area of concern with the oversite from the DON and/or ADON. 100% in-service of the MDS nurses regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately to include all diagnosis, medications, and dental status and services are coded correctly on the MDS was completed on 1/27/17 by the MDS consultant. 10% of completed MDS□s, to include resident□s #124, #87 and #28, will be reviewed to ensure accurate coding of the MDS to include diagnosis, medications and dental status and services by the ADON 3 X□s a week X□s 4 weeks, then weekly X□s 4 weeks and then monthly X□s 1 utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the ADON by retraining the MDS nurse and completing necessary modification to the MDS. The DON will review and initial the MDS Accuracy QI tool weekly X□s 8 weeks and then monthly X□s 1 to ensure any areas of concerns have been addressed. The Executive QI committee will meet monthly and review audits of MDS Accuracy tool and address any issues, concerns and/or trends and to make changes as needed, to include continued	

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#1 stated Resident #87 had a cavity in his lower right tooth and the resident's right top tooth was broken.

During an interview on 1/19/17 at 3:20 PM the Administrator stated that Resident #87 had a cavity to the lower right tooth and a broken top right tooth. She further stated that the Minimum Data Set dated 7/2/16 coded as an annual assessment was incorrect and she expected the cavity and broken tooth to be captured in the assessment.

During an interview on 1/19/17 at 4:52 PM MDS Nurse #1 stated that the MDS dated 7/2/16 was incorrect and that Resident #87 did have a cavity and broken teeth which should have been captured by the MDS.

3. Resident # 28 was admitted to the facility on 9/12/07 with diagnoses that included generalized anxiety.

Review of the November 2016 Medication Administration Record (MAR) revealed the resident received Lorazepam (an antianxiety medication) 0.5 milligrams twice daily starting in June 2016.

The quarterly Minimum Data Set (MDS), dated 11/18/16, did not document the resident had received an antianxiety medication during the assessment period.

On 1/20/17 at 5:20 PM, the MDS Coordinator was interviewed. She stated the assessment period for Resident #28's 11/18/16 MDS would have included 11/12/16 through 11/18/16. In completing the MDS, the MDS Coordinator stated she reviewed the MAR for medications the resident received during the assessment period. The MDS Coordinator reviewed the MAR for Resident #28 and acknowledged the Lorazepam

frequency of monitoring monthly 3 months.

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F 278	Continued From page 6 should have been included as an antianxiety medication on the 11/18/16 MDS. She then reviewed the 11/18/16 MDS and acknowledged the Lorazepam had not been included. The MDS nurse stated she was unsure why the antianxiety medication had not been included on the MDS and acknowledge the MDS was not accurate.	F 278		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to keep the area under the fingernails free of debris for 3 of 6 residents (Residents #s 43, 77 and 113) reviewed as needing extensive assistance with activities of daily living (ADLs). The findings included: 1) Resident #43 was readmitted to the facility on 10/19/15. Her diagnoses included dementia, schizophrenia and diabetes. A review of the annual Minimum Data Set (MDS) dated 10/21/16 revealed Resident #43 was severely cognitively impaired, required total care for most activities of daily living including bathing. Resident #43's care plan dated 11/30/16 revealed a potential for skin impairment related to sensitive skin and frequent skin irritations. The interventions included to provide nail care as resident allowed and to use a specific soap product. The care plan also indicated the resident frequently refused nail care. An observation of Resident #43's fingernails on 1/17/17 at 11:11 AM revealed dark brown debris	F 312	F312 483.24 (a) (2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Resident #43, 77 and 113 fingernails, to include under the nails, were cleaned on 1/20/17 by the Director of Nursing. 100% audit was completed on 1/27/17 of all current residents fingernails, to include residents #43, #77 and #113 by the Director of Nursing for debris, to include under fingernails. The Director of Nursing cleaned the residents fingernails during the time of the audit that were identified as areas of concern. 100% of licensed nurses and nursing assistants, to include NA #1, NA #2 and NA #3 were inserviced on checking residents fingernails, to include under the fingernail, keeping residents fingernails free of debris by the Staff Facilitator,	2/17/17

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F 312	Continued From page 7 under the nails on her right hand. An observation of Resident #43's fingernails on her right hand on 1/18/17 at 10:11 AM revealed they contained dark brown debris under the nails. An observation of Resident #43's fingernails on her right hand on 1/19/17 at 8:40 AM revealed they continued to contain dark brown debris under the nails. During an interview on 1/19/17 at 8:50 AM Nursing Assistant (NA) #1 stated Resident #43 received her bath on the 11:00 PM to 7:00 AM shift so the bath was already completed before she arrived. She stated nail care was part of the bath. On 1/19/17 at 3:45 PM NA #2 stated she was preparing Resident #43 for a shower because the resident was on the shower list for today. NA #2 then stated the resident had received a bath from the other shift this morning and that nail care was part of the bath. Upon observation of the resident's fingernails with NA #2 the resident continued to have debris under her fingernails. On 1/19/17 at 3:55 PM the Director of Nursing (DON) stated that nail care was part of the daily bath care and she expected the resident's nails to be clean. After the interview the DON observed the debris under the fingernails of Resident #43 prior to the resident receiving the shower. She reported she had no explanation why the resident's fingernails remained dirty since the previous Tuesday (1/17/17) as the resident had received a daily bath and nail care was part of the daily bath. On 1/20/17 at 11:35 AM NA #3 stated she frequently worked with Resident #43 and had not known the resident to reject care. She added if care was rejected then she would stop, exit the room and return later to complete the task. She stated it was important to ensure the residents'	F 312	completed on 2/02/17. All newly hired licensed nurses and nursing assistants will receive the education regarding checking resident□s fingernails, to include under the fingernail and keeping residents fingernails free of debris, during orientation by the Staff Facilitator. Fingernail audits will be conducted on 10% of residents to include night and weekends to ensure staff are checking residents nails for debris to include under the fingernails and providing nail care to residents, to include residents #43, # 77 and #113 by Assistant Director of Nursing, the QI nurse, and the Staff Facilitator 5 times a week for 4 weeks, then weekly for 4 weeks and then monthly for 1 month utilizing a Nail Care Audit QI tool. The Assistant Director of Nursing, Staff Facilitator and/or QI Nurse will retrain the license nurse and/or the nursing assistant and provide nail care to the resident during the audit for any identified area of concern. The Director of Nursing will review and initial the results of the Nail Care Audit QI tool weekly for 8 weeks and then monthly for 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review audits of Resident Care Audit QI tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.	

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nails were clean. NA #3 stated she had provided nail care and applied polish the fingernails of resident #43.
2) Resident #77 was admitted to the facility on 9/30/16. Her diagnoses included schizophrenia, dementia and malaise.
A review of the quarterly Minimum Data Set (MDS) dated 5/12/16 revealed she was severely cognitively impaired had no behaviors or rejection of care. She was totally dependent on staff for bathing and personal hygiene.
Resident #77's care plan updated on 9/8/16 revealed she was at risk for unmet needs or compromised dignity related to dementia and schizophrenia. The interventions included to provide praise for ADL attempts and task accomplishments.
On 1/18/17 at 10:18 AM Resident #77 was observed to have black debris under her fingernails on both hands.
On 1/19/17 at 9:05 AM Resident #77 was observed in the hall near the nursing station with other residents. She held out her hand to the surveyor. She continued to have back debris under her fingernails.
On 1/19/17 at 3:45 PM NA #3 stated nail care was part of the daily bath.
On 1/19/17 at 3:55 PM the DON stated that nail care was part of the daily bath care and she expected the resident's nails to be clean. The DON observed the debris under the fingernails of Resident #77.
3) Resident #113 was admitted to the facility on 8/18/16. His diagnoses included cardiovascular accident with hemiparesis.
The quarterly Minimum Data Set (MDS) dated 1/15/17 revealed Resident #113 was moderately cognitively impaired. He had no behaviors or rejection of care. He required extensive

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F 312	Continued From page 9 assistance with most of his ADLs and was totally dependent on staff for bathing. Resident #113's care plan revealed a focus of hemiplegia/paresis left side. The interventions included he required extensive assistance with some of his ADL care. A review of a nursing progress note dated 1/5/17 stated Resident #113 had "no rejection of evaluation or care". An observation of the fingernails for Resident #113 on 1/17/17 at 12:53 PM revealed the nails on both hands contained dark black debris. On 1/19/17 at 3:45 PM NA #3 stated nail care was part of the daily bath. On 1/19/17 at 3:55 PM the DON stated nail care was part of the daily bath care and she expected the resident's nails to be clean. On 1/19/17 at 4:03 PM the DON's observation of Resident #113's fingernails revealed they continued to contain black debris.	F 312		
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist	F 412		2/17/17

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F 412	Continued From page 10 the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interview, and record review, the facility failed to provide routine dental services for 2 of 3 residents reviewed for dental status and services (Resident #87 and Resident #88). Findings included: 1. Resident #87 was admitted to the facility on 3/30/15 with diagnoses which included hypertension, neuralgia, neuritis, and functional quadriplegia. Resident #87's pay source was Medicaid. Review of the resident's most recent Minimum Data Set assessment dated 1/1/17 coded as a quarterly assessment revealed the resident was moderately cognitively impaired. Resident #87 required total assistance from one person with personal hygiene which included dental care. Review of the facility's list of residents to be seen by the dentist on 3/17/16 revealed that Resident #87 was on the list but had not been seen by the dentist.	F 412	F 412 483.55 (b) (1) (2) (5) Routine/Emergency Dental Services in NFS Resident #87 was seen at an outside dental provider for dental services on 2/2/17. Resident #88 will be seen by the contracted dental provider for dental services on 2/13/17. A 100% audit of all current residents, to include resident #87 and #88, was completed on 1/28/17 by the Social Worker and the MDS RN to ensure all residents have had no dental issues using the facility resident census. There were no issues noted by the SW and MDS RN at that time. The contracted dental company will come to facility on 2/13/17 to assess current residents, to include resident #87 and #88, for needed dental care and services. Any services needed will be addressed at that time by the Social Worker per the dental consultation and using a Dental Services QI tool. The Director of Nursing will audit to ensure ALL residents were	

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F 412	Continued From page 11 During an interview on 1/19/17 at 2:05 PM the Quality Improvement Nurse stated that residents made the facility aware of dental issues or staff referred residents with dental issues. She further stated that once the facility was aware, steps were taken to get the residents a dental appointment. She stated she did not know how residents received routine dental care who were unable to make the facility aware that they wanted it. During observation of Resident #87's teeth on 1/19/17 at 2:13 PM, a tooth in the resident's right bottom teeth had a cavity. The resident also had a broken top right tooth. During an interview on 1/19/17 at 2:18 PM Nurse #1 stated Resident #87 had a cavity in his lower right tooth and the resident's right top tooth was broken. During an interview on 1/19/17 at 2:49 PM the Administrator stated that the facility had a contract with the same dental service provider since 2005. She stated that the facility sent a list of all residents to the dental provider one month before they arrived in the facility. The dentist last saw residents on 3/17/16. The Administrator stated there was no documentation that Resident #87 had been seen by a dentist during the previous year. She stated that after the visit on 3/17/16, the dentist told the Director of Nursing and the Administrator that he was not able to see all residents but would come back in few weeks to see the rest of the residents on the list. The Administrator stated the dentist never came back. She further stated that her expectation was that residents received routine dental services.	F 412	seen to ensure an oral cavity inspection was completed by the contracted dental company using the facility resident census. The Administrator and the Director of Nursing was in-serviced by the Facility Nurse Consultant, completed 2/7/17, regarding: The facility must ensure that services are available for residents to provide either by employing a staff dentist or through a contract service for routine dental visits, which is an annual inspection of the oral cavity. 100% inservicing for all nursing staff, licensed nurses and CNA□s, on reporting gum/mouth issues and identifying oral problems to the Nursing Supervisor and the identified residents will be referred to dental services will completed on 2/02/17. The Director of Nursing will audit the dental consultations for all residents, to include resident #87 and #88,by the contracted dental company, or any other outside dental services, and utilize the Dental Services QI Tool for any recommendations of needed services weekly X□s 4 then monthly X□s 2 months to ensure routine dental services are being provided. The Administrator will review the Dental Services QI Tool weekly X□s 4 then monthly X□s 2 months for completion and to ensure all areas of concern were addressed. The Quality Improvement Executive Committee will review all Dental Services QI Tool results monthly x 3 months for any recommendations, take action as appropriate, and to monitor for continued compliance.	

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2. Resident #88 was re-admitted to the facility on 4/9/15 with diagnoses that included diabetes and hypertension.

The Annual Minimum Data Set (MDS) dated 7/28/16 indicated Resident #88 was cognitively intact had no natural teeth and required extensive assistance with all activities of daily living..

The 1/6/17 Quarterly MDS indicated the resident was cognitively intact with no behaviors. Resident #88 was coded as requiring extensive assistance with personal care.

Review of the electronic medical record and the resident's chart kept at the nurse's station failed to reveal documentation that indicated the resident had received routine dental care.

Resident #88 was interviewed on 1/19/17 at 9:23 AM. He stated he had previously had dentures, but prior to admission to the facility, the top denture plate had been stolen. Since his admission to the facility, he had not been offered dental services and had not been seen by a dentist. The resident stated he would like to be evaluated by a dentist.

The Social Worker was interviewed on 1/19/16 at 2:00 PM. She stated a dentist came to the facility every 6 months to examine residents and make recommendations. She stated after recommendations were made, she was responsible for making any needed appointments. After the consult with the dentist, the consults sheets were scanned and placed in the electronic medical record. The Social Worker stated she was not familiar with the process of choosing which residents would be seen during

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F 412	Continued From page 13 the dental visits. The Administrator was interviewed on 1/19/17 at 2:49 PM. She stated the contract dental services usually made visits to the facility twice yearly. Prior to the dentist arrival, a list of all residents was sent to the contract dentist. On arrival, the Unit Manager updated the list and identified payer source. The Administrator stated typically all residents were seen. The last dental visit was reported as 3/17/16 and at that time about half the residents were seen. The Administrator stated the dentist explained he would return in a few weeks to see the remainder of the residents, but he had not returned. The Administrator stated she had called the service today (1/19/16) and found out there had been a change of ownership, but no reason was given why the dentist did not return. Resident #88 was not listed as a resident that had been seen in March 2016. At 3:20 PM, the Administrator added she was unable to find any follow up from the previous Administrator after the dentist had not returned. She stated Resident #88 had initially been admitted in 2014 and she had been unable to find documentation of a dental visit for Resident #88 since his initial admission.	F 412		
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. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;	F 520		2/17/17

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F 520	Continued From page 14 (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 record review and staff interviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitoring practices to address interventions put into effect after the 2/26/2015 and 1/07/2016 recertification surveys. During the	F 520	F520 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 1. Resident # 124 and #87 with	

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F 520	Continued From page 15 surveys of 2/26/2015 and 1/07/2016 the facility was cited at F 278 for inaccurate assessments. During the recertification survey of 1/20/2017, the facility was recited for accuracy of assessments. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: During the current survey of 1/20/2017, the facility was cited a deficiency at F278 for failing to accurately code the Minimum Data Set (MDS) dental status for 2 of 3 residents reviewed for dental status and services (Resident #124 and Resident #87) and failed to accurately code the use of antianxiety medication for 1 of 5 residents reviewed for unnecessary medications (Resident #28). During the recertification survey of 1/07/2016, the facility was cited a deficiency at F278 for failing to correctly code the MDS for 10 of 10 residents identified as being Preadmission Screening and Resident Review (PASRR) level 2 (Resident #16, #34, #40, #41, #43, #49, #53, #61, #98, #99) and failed to correctly code the use of diuretic medication on the MDS for 1 of 5 residents reviewed for unnecessary medications (Resident #4). During the recertification survey of 2/26/15, the facility was cited a deficiency at F278 for incorrectly coding the use of a diuretic medication on the MDS for 1 or 5 residents (Resident #138). An interview with the Administrator (AD) was conducted on 1/20/2017 at 12:34 PM. The AD stated the QAA Committee had used the same monitoring tool which had been used on an earlier F278 citation. The AD stated the previous Director of Nursing and the previous Assistant	F 520	miscoding for dental status and services had MDS modifications completed on 2/2/17 for the information needed for the dental status and services by the MDS nurses. Resident #28 had MDS modification completed on 1/20/17for the addition of the use of the antianxiety medication by the MDS nurses. 2. 100% audit of all current resident most current MDS will be reviewed, to include residents #124, 87 and # 28, by the DON and ADON to ensure all MDS's completed are accurate to include all diagnosis, medications, and correct dental status and services are coded correctly, will be completed on 2/15/17 using a MDS Accuracy QI tool. Any issues will be addressed and documented at that time. 100% in-service of the MDS nurses to ensure all MDS assessments are completed accurately to include all diagnosis, medications, and dental status and services are coded correctly on the MDS was completed on 1/27/17 by the MDS consultant. The Administrator and DON were inserviced by the Facility Consultant and was completed on 2/7/17 that through the Use of the Quality Improvement Program, the facility will: • Recognize concerns in the resident care or environmental issues • Develop a plan of action for the resolution of those concerns • Train staff member on the plan. • Put the plan into effect and evaluate the plan to ensure that the concerns are resolved and do not reoccur • Measure outcomes in the plan of	

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F 520	Continued From page 16 Director of Nursing had done the MDS monitoring until they left employment. The MDS nurses had been auditing themselves and this had not worked.	F 520	action if positive outcomes are not noted. Review of the last 3 months of QA committee meeting minutes were completed on 2/6/17 by the Facility Consultant with no issues noted on review. 3. 10% of completed MDS's, to include resident's #124, #87 and #28, will be reviewed to ensure MDS accuracy for all diagnosis, medications and dental status and services by the ADON 3 X's a week X's 4 weeks, then weekly X's 4 weeks and then monthly X's 1 utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the ADON by retraining appropriate staff making the coding error and the MDS nurse will make modifications to the MDS. The DON will review and initial the MDS Accuracy QI tool weekly X's 8 weeks and then monthly X's 1 to ensure any areas of concerns have been addressed. QA committee monthly meeting minutes will be reviewed and initialed by the Facility Consultant to ensure implemented procedures and monitoring practices to address interventions, to include MDS, are followed and maintained monthly X3 months. 4. The Executive QI committee will meet monthly and review audits and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly X3 months.	