STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING ______ B. WING ______	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE LANDING NURSING AND REHABILITATION CENTER	**1084 US 64 EAST PLYMOUTH, NC 27962**

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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 record review and staff interviews, the facility failed to accurately code the minimum data	F 278	F-278	7/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/13/2017

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 278	Continued From page 1 set (MDS) for diagnoses for 2 of 3 MDS assessments reviewed (Resident #1 and Resident #2). 1. Resident #1 had been admitted on 5/31/2017. Her admitting diagnoses included cerebral infarction (stroke), muscle weakness, abnormalities of gait and mobility, lack of coordination, dysphagia (difficulty swallowing), hypertension, diabetes type II, muscle spasm and gastroesophageal reflux disease. Resident #1's comprehensive admission MDS assessment dated 6/07/2017 did not include any diagnoses. An interview with the MDS coordinator was conducted on 6/28/2017 at 12:01 PM. The MDS coordinator stated the diagnoses part of the MDS usually prepopulates from the resident information in the computer. She stated she should have verified the information was correct on the MDS. An interview with the director of nursing (DON) was conducted on 6/28/2017 at 12:01 PM. The DON stated the MDS assessment should be correct and include diagnoses. 2. Resident #2 had been admitted on 6/01/2017. Her admitting diagnoses included non-traumatic intracranial hemorrhage, dysphagia (difficulty swallowing), muscle weakness, hypertension, lack of coordination, abnormalities of gait and mobility. Resident #2's comprehensive admission MDS assessment dated 6/08/2017 did not include any diagnoses.	F 278	Resident #1 most recent Minimum Data Set (MDS) assessment was modified according to the Resident Assessment Instrument (RAI) manual on 06/28/17 by the MDS Nurse with oversite by the Director of Nursing (DON) to accurately reflect the resident to include diagnosis of cerebral infarction (stroke), muscle weakness, abnormalities of gait and mobility, lack of coordination, dysphagia (difficulty swallowing), hypertension, diabetes type II, muscle spasm, and gastroesophageal reflux disease. Resident #2 most recent MDS assessment was modified according to the Resident Assessment Instrument (RAI) manual on 06/28/17 by the MDS nurse with oversite by the Director of Nursing (DON) to accurately reflect the resident to include diagnosis of non-traumatic intracranial hemorrhage, dysphagia (difficulty swallowing), muscle weakness, hypertension, lack of coordination, and abnormalities of gait and mobility. 100% audit of all residents' most recent MDS assessments to include Resident #1 and Resident #2 was completed to ensure all diagnoses are accurately coded according to the Resident Assessment Instrument (RAI) manual by MDS Consultant and completed on 7/11/17. Any issues noted during the audit were immediately addressed with modifications of the MDS to accurately reflect the resident to include diagnosis on 7/11/17	

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F 278	Continued From page 2 An interview with the MDS coordinator was conducted on 6/28/2017 at 12:01 PM. The MDS coordinator stated the diagnoses part of the MDS usually prepopulates from the resident information in the computer. She stated she should have verified the information was correct on the MDS. An interview with the director of nursing (DON) was conducted on 6/28/2017 at 12:01 PM. The DON stated the MDS assessment should be correct and include diagnoses.	F 278	by the MDS nurse with oversite by the MDS Consultant. The MDS Coordinator, the MDS nurses, and the Director of Nursing (DON) were in-serviced by the MDS Consultant on ensuring all diagnoses are accurately coded on the MDS assessment according to the Resident Assessment Instrument (RAI) manual and when diagnosis do not prepopulate, it is the MDS nurses responsibility to manually enter the diagnosis to accurately reflect the resident on 07/11/17. All newly hired MDS nurses will be in-serviced by the Director of Nursing during orientation on ensuring diagnoses are accurately coded on the MDS assessment according to the Resident Assessment Instrument (RAI) manual and when diagnosis do not prepopulate, it is the MDS nurses responsibility to manually enter the diagnosis to accurately reflect the resident. 10% of all residents MDS assessments will be audited to include Resident #1 and Resident #2 to ensure all diagnoses are coded on the MDS assessments according to the Resident Assessment Instrument (RAI) manual that accurately reflects the resident by the Quality Improvement Nurse (QI Nurse) weekly x 8 weeks then monthly x 1 month utilizing the MDS Coding Accuracy Audit Tool. Any areas of concern will be addressed immediately to include providing additional training with the MDS nurses by the DON QI Nurse, regarding ensuring that the	

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F 278	Continued From page 3	F 278	resident MDS assessments is accurately coded for diagnoses according to the Resident Assessment Instrument (RAI) manual and modification to the MDS assessment as necessary. The Director of Nursing will review and initial the MDS Coding Accuracy Audit Tools for completion to ensure all areas of concern were addressed weekly x 8 weeks then monthly x 1 month. The Director of Nursing will be responsible for forwarding the results of the MDS Coding Accuracy Audit Tools to the Executive QI Committee. The Executive QI committee will meet monthly and review audits of the MDS Coding Accuracy Audit Tool and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 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. (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	F 520		7/19/17

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F 520	Continued From page 4 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 Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures, monitor interventions and revise the action plan developed for the 3/31/2017 recertification survey in order to achieve and sustain compliance in the area of assessment accuracy (F278). This deficiency was cited again during a complaint investigation survey of 6/28/2017.	F 520	F 520 The Administrator and Director of Nursing (DON) were educated by the corporate consultant on the QI process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QI process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include Minimum Data Set (MDS) coding accuracy for	

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F 520	Continued From page 5 Findings included The tag is cross referenced to: F278 Based on record review and staff interviews, the facility failed to accurately code the minimum data set (MDS) for diagnoses for 2 of 3 residents reviewed (Residents #1 and #2). During the recent survey of 3/31/2017 the facility was cited F278 for failing to accurately code a quarterly MDS for the presence of hallucinations for 1 of 18 residents (Resident #77). An interview with the director of nursing (DON) and the administrator (AD) was conducted on 6/28/2017 at 1:00 PM. The DON stated the previous citation had been regarding behaviors and the Quality Improvement (QI) committee had focused on that part of the MDS for correction. The DON stated the MDS should be accurate.	F 520	diagnoses on the MDS assessments on (07/13/17). The Administrator and DON were educated by the corporate consultant on the QA process to include identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program on (07/13/17). The DON\Quality Improvement (QI) nurse completed 100% audit on 06/29/17 of previous citations and action plans within the past year to include Minimum Data Set (MDS) coding accuracy for diagnoses on MDS assessments to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans were reviewed and presented to the QI Committee by the QI nurse on 06/29/17 for any concerns identified. All data collected for identified areas of concerns to include Minimum Data Set (MDS) coding accuracy for diagnoses on the MDS assessments will be taken to the Quality Assurance committee for review monthly x 4 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QI nurse. The corporate consultant will ensure the	

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F 520	Continued From page 6	F 520	facility is maintaining an effective QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include Minimum Data Set (MDS) coding accuracy for diagnoses on MDS assessments are followed and maintained Quarterly x2. The corporate consultant will immediately retrain the Administrator and/or DON for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	