STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING & REHABILITATION-HENDERSON	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

(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 interviews, and record review the facility failed to accurately code	F 278	This Plan of Correction is the center's credible allegation of compliance.	8/7/17

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

Electronically Signed | 08/03/2017

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F 278	Continued From page 1 the presence of behaviors and failed to accurately code a resident as edentulous on annual Minimum Data Set (MDS) assessments for 2 of 15 MDS assessments reviewed (Resident #79, Resident #2). Findings included: 1. Resident #79 was admitted on 11/12/2015. Her diagnoses included psychosis, anxiety, anorexia, epilepsy, depression, anemia and dementia. Resident #79's most recent annual MDS assessment dated 5/02/2017 did not indicate she had any behavioral symptoms during the assessment look back period (4/26/2017 to 5/02/2017). Nursing documentation dated 4/27/2017 indicated Resident #79 had initially accepted her oral medication but then spit the medication into a tissue and stated that she would not take it. The nurse tried to coax her into handing the medication back and Resident #79 began swinging at the nurse with a closed fist. Resident #79 had a cup full of spit in her other hand and was trying to throw it on the nurse. Nursing documentation dated 4/28/2017 indicated Resident #79 was agitated and yelling. Nursing documentation dated 4/30/2017 indicated Resident #79 had been in her room attempting to spit on her roommate. Nursing documentation dated 5/01/2017 indicated Resident #79 had been agitated and yelling. An interview with the social worker (SW) was conducted on 7/12/2017 at 3:10 PM. The SW	F 278	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. MDS Accuracy 278 1. Residents affected: An MDS assessment for Resident # 79 was immediately accurately reassessed, updated, modified by MDS nurse and resubmitted. An MDS assessment for resident # 2 was immediately reassessed, updated, modified by MDS Nurse and then resubmitted. Both modifications completed on July 12, 2017. 2.Interventions for the residents with the potential to be affected: An audit was completed for current residents with behaviors. The MDS team(consisting of MDS Nurse, Social Worker, Activities Director, Dietitian) reviewed completed MDS and those with upcoming assessments exhibiting behaviors. The MDS assessments were modified as needed. Dental assessments of residents were audited by Nurse Management and completed for current residents. The Nurse Management Team/DNS reviewed the completed assessments and upcoming assessments	

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F 278	Continued From page 2 stated she completed the behavioral section of the MDS assessment. The SW stated she missed documenting Resident #79's behaviors on the annual MDS assessment. An interview with the MDS nurse was conducted on 7/12/2017 at 4:15 PM. The MDS nurse stated the social worker completed the behavioral section of the MDS assessment. She stated each person contributing to the assessment was accountable for the accuracy of the information they enter into the MDS. An interview with the director of nursing (DON) was conducted on 7/12/2015 at 5:10 PM. The DON stated she would expect the MDS to be accurate and all available information reviewed when completing the MDS assessment. The DON stated she would expect behaviors to be coded if they occurred during the look back period. 2.) Resident #2 was admitted to the facility on 7/15/16. Active diagnoses included dysphagia, hypertension, anemia, hyperlipidemia, and muscle weakness. Review of Resident #2's most recent annual Minimum Data Set assessment dated 5/16/17 revealed the resident was coded as not edentulous (lacking teeth). During observation on 7/12/17 at 10:20 AM Resident #2 was observed to be edentulous. During an interview on 7/12/17 10:22 AM Nurse Aide #1 stated Resident #2 did not have teeth. During an interview on 7/12/17 at 2:58 PM the MDS Coordinator stated she coded the Minimum	F 278	to determine the need for modification. Modifications with accurate reassessments were performed as appropriate, updated and resubmitted. 3. Systemic Change: Education was provided to current MDS staff and reinforcement of the education had been completed regarding MDS assessment completion expectation for accuracy. The education was provided by SDC and District Director of Case Management on July 17, 2017 . Daily discussion of assessments due will be completed during morning clinical meeting with the IDT team. Discussion to ensure clinical services are provided and reviewed specifically to include behaviors and dental updates for assessments. The RAI manual has been redistributed to current staff and will be provided to any new oncoming staff at orientation and reviewed to ensure assessment accuracy. Weekly monitoring of MDS completed will be reviewed/ completed by the Nurse Management Team at the weekly Medicare meeting for 12 weeks and after this random monitoring of MDS for 12 months will be completed by the IDT team which includes the MDS team, ED and DNS . 4.Monitoring The MDS team/DNS will report the audit findings to the QA committee monthly for twelve (12) months. The QA committee will review the audits and ensure compliance is ongoing and determine the need for further audits beyond the twelve	

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F 278	Continued From page 3 Data Set assessment dated 5/16/17 for Resident #2 as not edentulous. She further stated that was incorrect. During an interview on 7/12/17 at 5:07 PM the Director of Nursing stated her expectation was that the MDS Coordinator would assess the resident visually and if there were no teeth she would document that the resident had no teeth on the Minimum Data Set assessment.	F 278	(12) month period.	
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 (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	F 279		8/7/17

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F 279	Continued From page 4 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 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 record review and staff interviews the facility failed to develop a care plan to address psychotropic drug use for 1 of 5 residents reviewed for psychotropic medication use. (Resident #79)	F 279	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute	

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F 279	Continued From page 5 Findings included: Resident #79 was admitted on 11/12/2015. Her diagnoses included psychosis, anxiety, anorexia, epilepsy, depression, anemia and dementia. Resident #79's most recent annual MDS assessment dated 5/02/2017 indicated she had received antipsychotic and antianxiety medications. A care area assessment (CAA) had triggered because of Resident #79's psychotropic and antianxiety medication use. The CAA work sheet dated 5/10/2017 indicated Resident #79 had received psychotropic medications daily including quetiapine (a medication to treat psychosis) and clonazepam (a medication to treat anxiety). Her diagnoses included anxiety and psychosis. Care plan considerations included avoiding complications and at risk for side effects from the medications. Resident #79's care plans were reviewed. No care plans were observed to address antipsychotic or antidepressant medication use complications or side effects. An interview with the MDS nurse was conducted on 7/12/2017 at 4:15 PM. The MDS nurse stated she would have expected a care plan to have been developed some time ago regarding Resident #79's psychotropic medication use. An interview with the director of nursing (DON) was conducted on 7/12/2015 at 5:10 PM. The DON stated when the CAA for psychotropic	F 279	admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Comprehensive Care Plan F 279 1.Residents affected: Resident # 79 had a comprehensive care plan immediately completed (July 17, 2017) by DNS and Nurse Managers for antipsychotic and anti anxiety medications as well as addressing the behaviors noted for the resident. The care plan was reviewed by the IDT (MDS Coordinator, Social Worker, Activities Director, Dietitian, DNS, Nurse Managers) team and family was informed of the additions to care plan. The MD was notified of the revisions to the care plan made by the IDT team. 2.Interventions for the residents with the potential to be affected: An audit was completed on July 21, 2017 by DNS and Nursing Management for current residents with behaviors as well as antipsychotic and anti- anxiety medications ensuring comprehensive care plans were in place for each. Education was provided to the IDT team by SDC and District Director of Case Management in regards to care plans for residents with the above medications and noted behaviors. This audit will continue	

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F 279	Continued From page 6 medication trigged, she would have expected the care plan team to discuss the triggered area and develop a care plan. The DON also stated she would expect use of psychotropic medications to be care planned.	F 279	to be part of the education process for current staff and newly hired members of the IDT team upon orientation. 3.Systemic Change: Education was provided by the SDC on July 17, 2017 to current MDS team (MDS Nurse, Social Worker, Activities and Dietitian) and reinforcement of the education had been completed regarding review of residents with antipsychotic medications and anti-anxiety medications as well as noted behaviors and the completion of the comprehensive care plan. The residents with the above medications and behaviors will be reviewed at the daily clinical morning meeting to ensure care plans are in place as well as the weekly Medicare meeting. The IDT team will perform audits at the clinical morning meeting as follows three (3) days per week for four weeks, then two (2) days per week for four weeks, then weekly for four weeks as well as weekly at the Medicare meeting for eight (8) weeks and randomly after this period. 4.Monitoring The Director of Nursing will report the audit findings to the QA committee monthly for three (3) months. The QA committee will review the audits and ensure compliance is ongoing and determine the need for further audits beyond the three (3) month period.	
F 412 SS=E	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	F 412		8/7/17

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F 412	Continued From page 7 (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 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 #24 and Resident #72). The findings included: A review of the facility's Dental Services Policy dated 9/26/03 revealed routine dental services were to be provided to residents annually.	F 412	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal	

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F 412	Continued From page 8 1) Resident #72 was readmitted to the facility on 3/8/15 with diagnoses which included dysphagia, diabetes mellitus, heart failure and ischemic heart disease. A review of the annual Minimum Data Set (MDS) dated 5/9/17 revealed Resident #72 was cognitively intact. She had no natural teeth or fragments, required limited assistance with eating and was receiving a mechanically altered diet. The Care Area Assessment triggered for dental care but was not carried forward to the care plan. On 7/11/17 at 9:19 AM Resident #72 stated she was supposed to get dentures but she could not get from the transport van into the dentist chair so she never received any dentures. She also reported she had not seen a dentist since being in the facility. During an additional interview on 7/12/17 at 2:30 PM Resident #72 stated she had an appointment with the dentist in June but was told by the transportation aide (TA) that since she could not transfer from her wheelchair into the office chair she would not be able to go to the appointment. Resident #72 stated she never left the facility to go to the appointment. She then reported that her natural teeth had fallen out on their own and she had never seen a dentist. Resident #72 said her meats were always chopped and she could not chew solid meats so she wanted dentures because she wanted to be able to eat solid meats. On 7/12/17 at 2:43 PM an interview was conducted with the Director of Nursing. She stated she did not know how the facility offered	F 412	and state law. F412 Dental Services 1.Residents affected: Resident #72 had her appointment rescheduled during the survey process and was seen by dentist July 18, 2017 for evaluation. She returned for denture fitting on 8/03/17. Resident number 24 had appointment immediately scheduled: appointment date: 8/3/2017. Resident #24 had previous appointments for the following dates: 10/20/15, 11/17/15, 12/15/15, 1/12/16 and 1/26/16 with no current reports of any dental issues. The families of the residents were informed of the resident status. 2.Interventions for the residents with the potential to be affected: The Nurse Management team completed dental assessments on current residents. The dental assessments involved checking for broken/missing teeth, pain: residents also interviewed to assess any dental issues. Current residents in need of appointments have had appointments scheduled between 8/7/17 and 8/8/17. Education provided by SDC to current staff in regards to resident dental assessment and provision of timely services; education will also be provided to new staff upon orientation. Dental contracts have been reviewed and obtained to ensure annual and as needed services are provided to residents. Dental	

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F 412	Continued From page 9 residents routine dental care and as far as she knew, the facility did not have routine dental services offered during her year of working at the facility. On 7/12/17 at 3:25 PM the Administrator stated Resident #72 was on the appointment list to be seen by a dentist on 6/1/17 but no paperwork was found about the appointment so, she called the dentist office and the dentist office reported Resident #72 was not seen. The Administrator said she thought the last time any dentist visited the facility for routine dental care was in 2015. During an interview on 7/12/17 at 3:49 PM the Administrator stated the last time the residents were seen for routine dental care was more than a year ago. She further stated dental appointments were made for residents who had specific dental issues. The Administrator stated she called the contracted dental provider who last came to the facility and they told her that they no long saw long term care residents and were not able to provide her with the documentation of the last visit. The Administrator stated it was her expectation that residents be offered routine dental services annually. On 7/12/17 at 5:03 PM the scheduler reported Resident #72 told the nurse she wanted dentures so an appointment was made with the local dentist for June 1, 2017 and the appointment was logged into the appointment book. The scheduler reported she finds out from the therapy department how the resident can be transported and that Resident #72 was a wheel chair transport. She then added that the TA fills out the transportation log. She said she was not aware that Resident #72 did not go to the appointment	F 412	contract executed 8/1/17. 3.Systemic Change: Dental assessments will be completed by DON and Unit Manager upon admission of resident; residents will be scheduled as needed for dental appointments upon admission to ensure annual and as needed services are provided. The Management team will utilize the tracking tool/audit to ensure current residents and new admits have an annual dental appointment; and or any identified dental need. Appointments will be discussed daily during stand up. Scheduler will immediately notify Nurse Management of any identified issues regarding appointments scheduled outside facility. Dentist will be scheduled provide routine dental services to residents annually and as needed. Current staff education by SDC on resident dental assessment and the completion of the resident assessment had been completed; education with new staff will be provided in the orientation process. 4.Monitoring The DON will report the audit findings to the QA committee monthly for twelve (12) weeks. The QA committee will review the audits and ensure compliance is ongoing and determine the need for further audits beyond the twelve (12) week period.	

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F 412	Continued From page 10	F 412		

until yesterday.

On 7/13/17 at 8:27 AM the TA stated he knew the dental office did not have the ability to transfer Resident #72 from her wheel chair into their office chair. The TA said he knew there was not a lift at that dentist office so he did not take the resident to the appointment. He then said he could not remember if he reported it to the resident's nurse.

On 7/13/17 at 10:36 AM the dietary cook reported she was familiar with Resident #72 and reported the resident did not like chopped meats and preferred to have meats which were not chopped up. She said she frequently made the resident a grilled cheese sandwich or a ground beef sandwich because that is what the resident would request instead of the ground meat she had received at the meal.

On 7/13/17 at 11:00 AM the Administrator stated she was unable to determine why Resident #72 had an appointment with the dentist. She stated the resident had not seen a dentist at any time and there was not record of the resident being seen by a dentist since admission to the facility.

2) Resident #24 was admitted to the facility 8/22/12. Active diagnoses included urinary tract infection, seizure disorder, anxiety disorder, and asthma. Resident #24's pay source was Medicaid.

A review of Resident #24's chart revealed there was no documentation that the resident had received dental services since 1/26/16.

A review of the resident's most recent Minimum

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F 412	Continued From page 11 Data Set assessment dated 4/25/17 revealed the resident was assessed as cognitively intact. Resident #24 required total assistance with personal hygiene which included dental care. During an interview on 7/10/17 at 4:00 PM Resident #24 stated she would like to see a dentist for routine care but had not been offered dental care by the facility in the past year. She further stated one tooth had begun to hurt last week which made it more difficult to eat but she had not told the facility. During an interview on 7/12/17 at 2:43 PM the Director of Nursing stated that she did not know how the facility offered residents routine dental care. She further stated that as far as she knew, the facility did not have routine dental services during her year working for the facility. During an interview on 7/12/17 at 3:49 PM the Administrator stated the last time the residents were seen for routine dental care was more than a year ago. She further stated dental appointments were made for residents who had specific dental issues. The Administrator stated she called the contracted dental provider who last came to the facility and they told her that they no long saw long term care residents and were not able to provide her with the documentation of the last visit. The Administrator stated it was her expectation that residents be offered routine dental services annually.	F 412		
F 490 SS=E	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that	F 490		8/7/17

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	345344	A. BUILDING _____ B. WING _____	07/13/2017

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F 490	Continued From page 12 enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews with residents and staff and record review the facility's administration failed to utilize its resources to govern the operations of the facility effectively when it failed to renew the dental contract which resulted in residents not receiving routine dental services (Residents #24 and Resident #72. The findings included: This is cross referenced to F 412: Based on record review and interviews with residents and staff the facility failed to provide routine dental care for 2 (Resident #24 and Resident #72) of 3 residents reviewed for dental status. During an interview on 7/12/17 at 3:49 PM the Administrator stated the last time the residents were seen for routine dental care was more than a year ago. She further stated dental appointments were made for residents who had specific dental issues. The Administrator stated she called the contracted dental provider who last came to the facility and they told her that they no long saw long term care residents and were not able to provide her with the documentation of the last visit. The Administrator stated it was her expectation that residents be offered routine dental services annually.	F 490	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F490 1.Residents affected: Resident #72 had her appointment rescheduled during the survey process and was seen by dentist July 18, 2017 for evaluation. She returned for denture fitting on 8/03/17. Resident number 24 had appointment immediately scheduled: appointment date: 8/3/2017. Resident #24 had previous appointments for the following dates: 10/20/15, 11/17/15, 12/15/15, 1/12/16 and 1/26/16 with no current reports of any dental issues. The families of the residents were informed of the resident status. 2.Interventions for the residents with the potential to be affected:	

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F 490	Continued From page 13	F 490	The Nurse Management team completed dental assessments on current residents. The dental assessments involved checking for broken/missing teeth, pain: residents also interviewed to assess any dental issues. Current residents in need of appointments have had appointments scheduled between 8/7/17 and 8/8/17. Education provided by SDC to current staff in regards to resident dental assessment and provision of timely services; education will also be provided to new staff upon orientation. Dental contracts have been reviewed and obtained to ensure annual and as needed services are provided to residents. Dental contract executed 8/1/17. 3.Systemic Change: Dental assessments will be completed by DON and Unit Manager upon admission of resident; residents will be scheduled as needed for dental appointments upon admission to ensure annual and as needed services are provided. The Management team will utilize the tracking tool/audit to ensure current residents and new admits have an annual dental appointment; and or any identified dental need. Appointments will be discussed daily during stand up. Scheduler will immediately notify Nurse Management of any identified issues regarding appointments scheduled outside facility. Dentist will be scheduled provide routine dental services to residents annually and as needed. Current staff education by SDC on resident dental assessment and	

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F 490	Continued From page 14	F 490	the completion of the resident assessment had been completed; education with new staff will be provided in the orientation process. 4.Monitoring The DON will report the audit findings to the QA committee monthly for twelve (12) weeks. The QA committee will review the audits and ensure compliance is ongoing and determine the need for further audits beyond the twelve (12) week period.	
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 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	F 520		8/7/17

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F 520	Continued From page 15 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 failed to maintain implemented procedures and to monitor the interventions the committee put into place following the recertification survey of 8/4/16 in the area of assessment accuracy (F278). The continued failure of the facility during two federal surveys demonstrates a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag was cross referenced to: F278 - Based on observations, staff interviews and record review the facility failed to accurately code the presence of behaviors and failed to accurately code a resident as edentulous on the annual Minimum Data Set (MDS) assessments for 2 of 15 MDS assessments reviewed (Resident # 79 & Resident #2).	F 520	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. QA Tag F520 483.75 1. Residents affected: Current residents have the potential to be affected. A modified MDS was completed for residents affected and with the potential for residents to be affected.	

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F 520	Continued From page 16 During the recertification survey of August 2106 the facility was cited for failing to accurately code an antiplatelet drug and coded it as an anticoagulant medication for 1 of 5 residents. During an interview with the Administrator on 7/13/17 at 1:15 PM she reported the facility's Quality Assurance (QA) Committee met monthly and the physician attended quarterly. She stated the facility had identified issues and gave an example of one in which an action plan was developed, in-service education was completed and another nurse was hired. The Administrator stated an assessment schedule was changed and the facility observed an improvement based on the changes they implemented. The Administrator said she expected the MDS to be accurate.	F 520	2.Interventions for the residents with the potential to be affected: An emergency AD HOC PI was conducted on 7/13/17 to review the Quality Assurance process. The AD HOC PI consisted of the QA committee members, including ED, DNS and all department managers. A QA meeting was held on 8/27/17 to ensure the committee has addressed the MDS assessments for accuracy to include residents with behavior, as well with dental assessment of residents. Education was provided to the ED/DNS on the completion of the QAPI process by the District Director of Clinical Operations. 3.Systemic Change: Monthly the QA committee meeting will be conducted to review and discuss the facilities adherence to monitoring the accuracy of the MDS. The QA minutes are being shared with the Divisional Vice President and the district staff for review. The District Director of Case Management will audit the QA minutes to ensure the MDS accuracy is audited for completeness. The DNS, SDC and Unit Manager will perform audits of the MDS process weekly to determine accuracy in coding of behaviors and antipsychotic medications for 12 weeks, followed by random checks for a period of 12 months. 4.Monitoring The Executive Director will report the audit findings to the QA committee monthly for 12 months. The ED will send the monthly	

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F 520	Continued From page 17	F 520	QA minutes to the DVP for review and monitoring. The DDCM, DDCO and DVP will review the minutes to ensure MDS accuracy is addressed during the meeting process. The QA committee will review the audits and ensure compliance is ongoing and determine the need for further audits beyond the 12 month period.	