STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 01/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 000	INITIAL COMMENTS The survey team entered the facility on 01/16/18 to conduct a recertification/complaint survey and was unable to return to the facility on 01/17/18 due to adverse weather of snow, ice and unsafe travel conditions. The survey team returned to the facility on 01/18/18 and completed the survey on 01/20/18. There were no citations as a result of the complaint investigation. Event ID #5T8E11.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		2/17/18

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

Electronically Signed | 02/04/2018

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain three resident bedrooms on three halls (#134, #246 and #251) of splintered doors, a water damaged ceiling, unpainted walls and damaged sheet rock and four resident bathrooms on three halls (#241, #242, #251 and #312) of unpainted walls, three burned out light bulbs and an exposed metal object, in a safe, comfortable and homelike environment. The findings included: 1. Resident bedrooms A. On 01/16/18 at 3:12 PM an observation was made of the bedroom door #134 on the hinge side of the door to have several gouged out and splintered wood areas along the edge of the door. Subsequent observation on 01/19/18 at 4:31 PM revealed the condition of the door remained.	F 584	"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 by the provision of Federal and State law." 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) On 1/30/18, Administrator validated that the bedroom door #134 was repaired and replaced with metal corner piece. b.) On 1/26/18, Administrator validated that the ceiling tile in #246 was changed. c.) On 1/30/18, Administrator validated that residents from #251 have been temporarily moved and the room has been taken out of service to repair the	

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F 584	Continued From page 2 On 01/19/18 at 4:31 PM during walking rounds with the Maintenance Supervisor (MS) he stated he could see where someone could get injured from the condition the door was in. B. On 01/19/18 at 4:43 PM an observation was made of the ceiling in room #246 which had water spot damage in the corner of the room. Subsequent observations were made on 01/18/18 at 1:34 PM and 01/19/18 2:54 PM revealed the condition of the ceiling remained unchanged. On 01/19/18 at 4:43 PM during walking rounds with the MS he stated that as many times that he had been in that room he had never noticed the water damage. C. On 01/16/18 at 12:09 PM an observation was made of room #251 to have damaged sheet rock beside bed #1, white spot on wall next to bed #2, white paint around the heat/air unit and white paint on the red light switch near bathroom door. Subsequent observations were made on 01/18/18 at 1:49 PM and 01/19/18 at 2:45 PM remained unchanged. On 01/19/18 at 4:47 PM during walking rounds with the MS he stated room #251 was next to be completely painted and the room would be fixed then. 2. Resident bathrooms A. On 01/16/18 at 10:21 PM in resident bathroom #241 an observation was made of two white paint spots on the wall. Subsequent observations were made on 01/18/18 at 1:12 PM and 01/19/18 at 2:50 PM and the condition of the bathroom remained unchanged.	F 584	damaged sheet rock, white spot on the wall, paint around the PTAC unit, light switch, & bathroom to be repainted to address area under paper towel holder. Administrator validated on 1/20/18 that the lightbulbs had been replaced in the bathroom. All repairs/repainting will be completed by 2/17/18. d.) On 1/27/18, Administrator validated that in #241 the two white spots on the bathroom wall have been repainted. e.) On 1/27/18, Administrator validated that area under the light fixture in bathroom #242 has been repainted. f.) On 1/20/18, Administrator validated that sharp edge that was pulled away from the box in bathroom between #312 and #314 has been repaired. g.) The facility failed to identify environmental issues in a timely manner in rooms #134, #241, #246, #312/314, #251 and #242. 2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: a.) Room #134, 246, 241, 242, and 312/314 have been repaired . room 251 is in the process of being repaired and will be completed by 2/17/18. b.) On 1/26/18 all staff were educated on appropriate walk through for room checks and documentation of noted issues into the Maintenance Log located at each nurses station. 3.) The monitoring procedure to ensure the acceptable plan of correction is	

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F 584	Continued From page 3 On 01/19/18 at 4:35 PM during walking rounds with the MS he stated a towel holder was removed from the wall and the holes were patched last week. The MS added the painter should have painted the spots this week. B. On 01/16/18 at 10:24 AM an observation was made of the light fixture in bathroom #242 which had white paint on the wall at the bottom of the fixture. Subsequent observations were made on 01/18/18 at 1:16 PM and 01/19 18 at 2:52 PM where the condition remained unchanged. On 01/19/18 at 4:40 PM during walking rounds with the MS he stated the light fixture was changed out last week and the wall should have been painted before now. C. On 01/16/18 at 12:09 PM an observation was made of bathroom #251 which had a large yellow unpainted area under the paper towel holder and three of four light bulbs were burned out. Subsequent observations on 01/18/18 at 1:49 PM and 01/19/18 at 2:45 PM were made and the conditions remained unchanged. On 01/19/18 at 4:47 PM during walking rounds with the MS he stated room #251 was next to be completely painted and the bathroom would be fixed then. D. On 01/16/18 at 11:17 PM an observation was made of a metal box mounted on the wall below the window in bathroom which served rooms #312/#314. The metal box had a sharp edge pulled away from the box that stuck out in the open. Subsequent observations were made on 01/16/18 at 2:08 PM and 01/19/18 at 4:25 PM	F 584	effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance: a.) Maintenance Director and Maintenance Technician will monitor maintenance logs Monday-Friday located at each nurses station and respond to noted issues appropriately. b.) Maintenance Director and Administrator will conduct walk through of facility to identify all maintenance related issues and prioritize once per week X6 weeks and then biweekly ongoing to ensure compliance is achieved and maintained. c.) Results of walk through will be submitted to QAPI Committee by the Maintenance Director for review by the QAPI Committee monthly x3 months. The QAPI Committee will evaluate effectiveness and amend as needed. 4.) The title of the person responsible for implementing the acceptable plan of correction: The Administrator will be responsible for the implementation of the acceptable plan of correction. 5.) Dates when corrective action will be completed: February 17, 2018	

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F 584	Continued From page 4 which the condition remained unchanged. On 01/19/18 at 4:25 PM during walking rounds with the MS he stated the metal could be dangerous and he would get it taken care of. On 01/19/18 at 4:05 PM an interview with the MS revealed he had a full time assistant and a part time person that worked three days a week. He stated the facility staff was trained to complete work order forms that were kept at each nurses' station and were checked by himself at least twice a day. The MS stated that the facility did not have current plans to make any major renovations but the Administrator, himself and sometimes the Housekeeping Supervisor made walk through rounds about every two or three weeks for the purpose of identifying potential safety hazards and general maintenance upkeep in the resident's rooms. He stated the last walk through round was made around Christmas time. On 01/20/18 at 11:21 AM an interview with the Administrator revealed the facility did not have current plans for any major renovations but were in the process of completing what would be three relaxation rooms for the residents that would serve multiple functions. The Administrator stated the MS made her aware of the environmental issues revealed to him on 01/19/18 and stated she was not aware of all of the issues but they would be taken care of because she agreed the residents deserved a safe, comfortable and homelike environment.	F 584		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment	F 636		2/17/18

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The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(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 nonlicensed direct care staff

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F 636	Continued From page 6 members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments (CAA) that addressed the underlying causes and contributing factors for the areas of cognition, mood, behaviors and delirium for 5 of 26 sampled residents reviewed for comprehensive assessments (Residents #4, #46, #53, #61, and #67). Findings included: 1. Resident #4 admitted to the facility on 09/12/12 with diagnoses that included anxiety disorder, depression, mood disorder and schizophrenia. Review of the annual Minimum Data Set (MDS) dated 01/03/18 revealed Resident #4 was cognitively intact and had felt down, depressed and/or hopeless 2 to 6 days during the 14 day	F 636	"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 for the in the statement of deficiencies. The plan of correction is prepared by the provision of Federal and State law." 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) On 1/26/18, the Director of Nursing validated that Resident Care Management Director (RCMD) set ARD for a significant correction of prior comprehensive assessment of significant change in status to include CAA for mood to include	

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F 636	Continued From page 7 assessment period. Review of the CAA for mood associated with the annual MDS dated 01/03/18 stated Resident #4 "has periods of depression." The CAA did not include a comprehensive analysis of findings that addressed contributing factors, underlying causes, why the triggered area was a problem for Resident #4 or how the problem affected her day to day routine. During an interview on 01/20/18 at 9:20 AM the MDS Coordinator (MDSC) confirmed a CAA should paint an overall picture of the resident's condition for the triggered care area. The MDSC explained the SW completed Resident #4's CAA for mood and confirmed it did not contain a comprehensive analysis. During interviews on 01/20/18 at 10:01 AM and 10:26 AM the Social Worker (SW) confirmed she completed the CAA for the areas of cognition, mood, behaviors and delirium on comprehensive MDS. The SW explained she was not trained on how to complete a comprehensive CAA and was unaware to include detailed information such as pertinent diagnoses, contributing factors or how the problem affected the resident's day to day routine. During an interview on 01/20/18 at 12:03 PM the Administrator stated it was her expectation for the CAA to be comprehensive and accurately reflect the resident's condition at the time of the assessment. 2. Resident #46 admitted to the facility on 05/15/13 with diagnoses that included Alzheimer's, dementia and depression.	F 636	comprehensive analysis for Resident #4. b.) On 1/26/18, the Director of Nursing validated that Resident Care Management Director (RCMD) set ARD for a significant correction of prior comprehensive assessment of significant change in status to include CAA for cognition to include comprehensive analysis for Resident #46. c.) On 1/26/18, the Director of Nursing validated that Resident Care Management Director (RCMD) set ARD for a significant correction of prior comprehensive assessment of significant change in status to include CAA for delirium to include comprehensive analysis for Resident #61. d.) On 1/26/18, the Director of Nursing validated that Resident Care Management Director (RCMD) set ARD for a significant correction of prior comprehensive assessment of significant change in status to include CAA for cognition to include comprehensive analysis for Resident #53. e.) On 1/26/18, the Director of Nursing validated that Resident Care Management Director (RCMD) set ARD for a significant change MDS to include CAA for cognition to include comprehensive analysis for Resident #67. f.) The facility employs interim Social Services Director who did not have proper knowledge of completing comprehensive CAA. 2.) The procedure for implementing the acceptable plan of correction for he specific deficiency cited:	

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F 636	Continued From page 8 Review of the annual MDS dated 04/07/17 revealed Resident #46 had severe impairment in cognition. Review of the CAA for cognition associated with the annual MDS dated 04/07/17 indicated Resident #46 "was unable to complete a Brief Interview of Mental Status (universal test used to determine cognition status) due to being rarely/never understood." The CAA did not include a comprehensive analysis of findings that addressed underlying causes or how his cognition deficit affected his day to day routine and ability to make decisions. During an interview on 01/20/18 at 9:20 AM the MDS Coordinator (MDSC) confirmed a CAA should paint an overall picture of the resident's condition for the triggered care area. The MDSC explained the SW completed Resident #46's CAA for cognition and confirmed it did not contain a comprehensive analysis. During interviews on 01/20/18 at 10:01 AM and 10:26 AM the SW confirmed she completed the CAA for the areas of cognition, mood, behaviors and delirium on comprehensive MDS. The SW explained she was not trained on how to complete a comprehensive CAA and was unaware to include detailed information such as pertinent diagnoses, contributing factors or how the problem affected the resident's day to day routine. During an interview on 01/20/18 at 12:03 PM the Administrator stated it was her expectation for the CAA to be comprehensive and accurately reflect the resident's condition at the time of the	F 636	a.) The CAA for Resident #14, #46, #61, #53 and #67 were modified to meet regulatory compliance. b.) On 1/29/18, the District Director of Care Management in serviced the RCMD on accurate CAA completion per the RAI manual guidelines. c.) On 1/29/18, Interim Social Services Director was in serviced by RCMD on accurate CAA completion per the RAI manual guidelines. d.) On 1/29/18, all IDT staff and MDS Coordinator who are responsible for completion of CAA on MDS were in serviced by RCMD on accurate CAA completion per the RAI manual guidelines. 3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance: a.) On 1/26/18, the RCMD will completed an audit of all current residents receiving a comprehensive assessment during the last 14 days to verify accurate CAA completion per the RAI manual guidelines. b.) The RCMD and/or MDS Coordinator will randomly audit 3 comprehensive MDS per week for 12 weeks to verify accurate CAA completion per the RAI manual guidelines. Opportunities will be corrected as identified. c.) Results of audits will be submitted to QAPI Committee by the RCMD for review by the QAPI Committee monthly x3 months. The QAPI Committee will	

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F 636	Continued From page 9 assessment. 3. Resident #61 admitted to the facility on 12/04/17 with diagnoses that included dementia, depression and psychotic disorder. Review of the admission MDS dated 12/11/17 revealed Resident #61 had severe impairment in cognition and wandered on a daily basis. Further review revealed she displayed physical and verbal behaviors directed toward others 4 to 6 days and rejected care 1 to 3 days during the 7 day assessment period. Review of the CAAs associated with the admission MDS dated 12/11/17 for Resident #61 revealed the following: a. Cognition indicated Resident #61 "has cognition impairments." The CAA did not include a comprehensive analysis of findings that addressed contributing factors, underlying causes or how her cognitive deficit affected her day to day routine and ability to make decisions. b. Delirium triggered due to inattention and disorganized thinking. The CAA was not completed and contained no analysis of findings. c. Behaviors indicated Resident #61 "has cognition impairments which may cause behaviors." The CAA did not include a comprehensive analysis of findings that addressed contributing factors, underlying causes or how her behaviors affected her day to day routine. During an interview on 01/20/18 at 9:20 AM the MDS Coordinator (MDSC) confirmed the care area of delirium for Resident #61 had triggered	F 636	evaluate effectiveness and amend as needed. 4.) The title of the person responsible for implementing the acceptable plan of correction: The RCMD will be responsible for the implementation of the acceptable plan of correction. 5.) Dates when corrective action will be completed: February 17, 2018	

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and should have been completed. The MDSC reviewed the CAA for cognition for Resident #61 and agreed it did not contain a comprehensive analysis.

During interviews on 01/20/18 at 10:01 AM and 10:26 AM the SW confirmed she completed the CAA for the areas of cognition, mood, behaviors and delirium on comprehensive MDS. The SW explained she was not trained on how to complete a comprehensive CAA and was unaware to include detailed information such as pertinent diagnoses, contributing factors or how the problem affected the resident's day to day routine.

During an interview on 01/20/18 at 12:03 PM the Administrator stated it was her expectation for the CAA to be comprehensive and accurately reflect the resident's condition at the time of the assessment.

4. Resident #53 was admitted to the facility on 02/20/14 with diagnoses which included heart failure and dementia. Her most recent Annual Minimum Data Set (MDS) dated 11/21/17 revealed she had moderate cognitive skills for daily decision making and had short and long term memory problems. The MDS also indicated Resident #53 required extensive assistance with most of her activities of daily living (ADLs) which included bed mobility, transfers, dressing and personal hygiene.

Review of Resident #53's Care Area Assessment (CAA) for Cognition dated 11/21/17 revealed the

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"resident has cognition impairments." The CAA did not include a comprehensive analysis of findings that addressed contributing factors and underlying causes or why the area triggered as a problem in her day to day living.

During an interview on 01/20/18 at 9:20 AM the Minimum Data Set Coordinator (MDSC) confirmed a CAA should paint an overall picture of the resident's condition for the triggered care area. The MDSC explained the Social Worker (SW) completed Resident #53's CAA for cognition and confirmed it did not contain a comprehensive analysis.

During interviews on 01/20/18 at 10:01 AM and 10:26 AM the SW confirmed she completed the CAA for the area of cognition on the comprehensive MDS. The SW explained she was not trained on how to complete a comprehensive CAA and was unaware to include detailed information such as pertinent diagnoses, contributing factors or how the problem affected the resident's day to day routine.

During an interview with the Administrator on 01/20/18 at 12:03 PM she stated it was her expectation for the CAA to be comprehensive and accurately reflect the resident's condition at the time of the assessment.

5. Resident #67 was admitted to the facility on 05/20/16 with diagnoses which included Huntington's disease and dementia. The Annual Minimum Data Set (MDS) dated 05/02/17

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indicated he was severely cognitively impaired and required extensive to total assistance with most of his ADLs.

Review of Resident #67's Care Area Assessment (CAA) for Cognition dated 05/02/17 revealed the "resident has cognition impairments." The CAA did not include a comprehensive analysis of findings that addressed contributing factors and underlying causes or why the area triggered as a problem in her day to day living.

During an interview with Minimum Data Set Coordinator (MDSC) on 01/20/18 at 9:20 AM, she confirmed the CAA should paint an overall picture of the resident's condition for the triggered area. The MDSC explained the Social Worker (SW) completed Resident #67's CAA for cognition and confirmed it did not contain a comprehensive analysis.

During interviews on 01/20/18 at 10:01 AM and 10:26 AM the SW confirmed she completed the CAA for the area of cognition on the comprehensive MDS. The SW explained she was not trained on how to complete a comprehensive CAA and was unaware to include detailed information such as pertinent diagnoses, contributing factors or how the problem affected the resident's day to day routine.

During an interview with the Administrator on 01/20/18 at 12:03 PM she stated it was her expectation for the CAA to be comprehensive and accurately reflect the resident's condition at the time of the assessment.

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F 641	Continued From page 13	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident (Resident #68) identified as PASRR Level II and failed to accurately code the upper extremity impairment for 1 of 1 resident (Resident #74) reviewed for functional range of motion (ROM). Findings included: 1. Resident #68 was admitted to the facility on 06/04/15 with diagnoses including schizophrenia and bipolar disorder. A review of Resident #68's annual Minimum Data Set (MDS) assessment dated 11/03/17 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care. On 01/18/18 at 1:02 PM an interview was conducted with the MDS Coordinator who stated	F 641	"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 by the provision of Federal and State law." 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) On 1/18/18, Director of Nursing validated that the modification of the MDS with ARD 11/3/17 for Resident #68 was completed to accurately reflect Level II PASRR. b.) On 1/19/18, Director of Nursing validated that the modification of the MDS's for Resident #74 with ARD's of 7/3/17 and 9/4/17 were completed to accurately reflect the coding of impairment of upper extremity ROM on one side. c.) The facility failed to accurately code Level II PASRR and upper extremity ROM on (3) completed MDS. 2.) The procedure for implementing the acceptable plan of correction for the	2/17/18

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F 641	Continued From page 14 she was responsible for coding Section A 1500 PASRR Level II for Resident #68. The MDS Coordinator stated she was aware Resident #68 was determined as PASRR Level II and she made an error and missed coding PASRR Level II. The MDS Coordinator stated she would need to submit a modification to the annual MDS dated 11/03/17 to reflect Resident #68 was PASRR level II. On 01/18/18 at 1:09 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Resident #68's annual MDS assessment dated 11/03/17 would have been accurately coded to reflect Resident #68 was determined as PASRR Level II. The DON stated her expectation was that the MDS Coordinator would submit a modification to Resident #68's annual MDS dated 11/03/17 to reflect PASRR Level II. On 01/18/18 at 1:17 PM an interview was conducted with the Administrator who stated her expectation was that the annual MDS assessment dated 11/03/17 would have been accurately coded to reflect Resident #68 was determined as PASRR Level II. The Administrator stated her expectation was that the MDS Coordinator would submit a modification to Resident #68's annual MDS dated 11/03/17 to reflect PASRR Level II. 2. Resident #74 admitted to the facility on 12/16/13 with diagnoses that included dementia and left hand contracture. Review of a care plan initiated on 10/28/15 indicated Resident #74 had a self-care deficit	F 641	specific deficiency cited: a.) The MDS's for Resident #68 and #74 have both been modified to reflect accurate coding of each section. b.) Audit of all current residents having a Comprehensive MDS completed in the past 30 days was completed by the Resident Care management Direcotr (RCMD) to verify accurate assessment of those residents PASRR and range of motion. Corrections were completed as identified per the RAI manual guidelines. This audit was completed by 1/26/18. c.) On 1/29/18, the District Director of Care Management (DDCM) re-educated the Resident Care Management Director (RCMD) on accurate MDS coding related to PASRR and range of motion coding per the RAI manual. d.) On 1/29/18, the RCMD re-educated the MDS Coordinator on accurate MDS coding related to PASRR and range of motion coding per the RAI manual. 3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance: a.) The RCMD will randomly review 3 completed MDS's weekly for 12 weeks to verify accurate coding of PASRR and range of motion. Opportunities will be corrected as identified as a result of these audits. b.) The Director of Nursing will review the random audits and report findings of the audits monthly to the QAPI committee X3 months. The QAPI Committee will	

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F 641	Continued From page 15 related to dementia, decline in cognition and hand contractures. The care plan goal specified Resident #74 would maintain his current level of function in all activities of daily living. Interventions included for staff to attempt left hand guard, apply at bedtime and remove in the morning as resident allowed. Review of the annual Minimum Data Set (MDS) dated 07/03/17 indicated Resident #74 had no impairment in the upper or lower extremities for functional Range of Motion (ROM). Review of the quarterly MDS dated 09/04/17 indicated Resident #74 had no impairment in the upper or lower extremities for functional ROM. During an interview on 01/19/18 at 4:30 PM the MDS Coordinator (MDSC) confirmed Resident #74 had a left hand contracture. The MDSC reviewed the MDS assessments dated 07/03/17 and 09/04/17 and acknowledged both had been inaccurately coded for functional ROM. She explained both MDS assessments should have been coded to reflect he had impairment on one side of the upper extremities. During an interview on 01/20/18 at 12:03 PM the Administrator stated it was her expectation for MDS assessments to be accurately coded.	F 641	evaluate effectiveness and amend as indicated. 4.) The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing will be responsible for the implementation of the acceptable plan of correction. 5.) Dates when corrective action will be completed: February 17, 2018	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		2/17/18

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F 657	Continued From page 16 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to invite 1 of 2 sampled residents to 2 consecutive quarterly care plan meetings (Resident #71). Findings included: Resident #71 admitted to the facility on 07/19/16 with diagnoses that included multiple sclerosis, anxiety and depression. Review of Resident #71's electronic medical record revealed a quarterly Minimum Data Set (MDS) dated 04/23/17 and an annual MDS dated 07/21/17. There was no documentation available	F 657	"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 by the provision of Federal and State law." 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) On 1/30/18, the Administrator validated that a care plan meeting was	

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which indicated the resident or his family member had been invited to attend care plan meetings following the MDS of 04/23/17 or 07/21/17.

Review of the quarterly MDS dated 10/4/17 indicated Resident #74 had moderate impairment in cognition. Further review of the MDS revealed he was able to make self understood and had clear comprehension with his ability to understand others.

During an interview on 01/18/18 at 1:25 PM Resident #71 stated he did not recall being invited to attend care plan meetings.

During an interview on 01/20/18 at 10:26 AM the Social Worker (SW) revealed during the months of February 2017 through October 2017 she had either mailed a letter to the resident's Responsible Party or hand-delivered a letter to alert and oriented residents, inviting them to schedule a care plan meeting. The SW was unable to find any documentation Resident #71 or his family member were notified or invited to attend care plan meetings for MDS of 04/23/17 or 07/21/17.

During an interview on 01/20/18 at 10:30 AM the MDS Coordinator (MDSC) confirmed Resident #71 should have had care plan meetings scheduled for MDS of 04/23/17 and 07/21/17. The MDSC stated after each care plan meeting a note was entered into the resident's medical record indicating the date, who attended and what was discussed. The MDSC was unable to find any documentation Resident #71 or his family member were invited to attend the care plan meetings or the meetings were conducted for MDS of 04/23/17 and 07/21/17.

held for Resident #71.
b.) The Interim Social Services Director failed to notify one resident of care plan meeting following MDS comprehensive assessments dated 4/23/17 and 7/21/17.

2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:
a.) Care plan meeting was held for Resident #72 on 1/30/18.
b.) On 1/29/18, RCMD in serviced Interim Social Services Director of requirements for conducting comprehensive care plan meetings including invitation to family and/or responsible party and documentation of care plan meeting into the electronic record.

3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:
a.) RCMD will audit Social Services Director's care plan meeting calendar weekly X6 weeks, then biweekly x6 weeks to ensure that evidence of invitation and documentation of care plan meeting is in electronic record and follows the MDS calendar.
b.) RCMD will report findings of the audits monthly to the QAPI committee X3 months and then quarterly x3. QAPI Committee will evaluate effectiveness and amend as needed.

4.) The title of the person responsible for implementing the acceptable plan of

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F 657	Continued From page 18 During an interview on 01/20/18 at 12:03 PM the Administrator stated it was her expectation every resident was notified of care plan meetings and documentation of the care plan meeting was placed in their medical record.	F 657	correction: The Resident Care Management Director (RCMD) will be responsible for the implementation of the acceptable plan of correction. 5.) Dates when corrective action will be completed: February 17, 2018	
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews the facility failed to obtain labwork as ordered by the physician for 1 of 7 sampled residents. (Resident #80) The findings included: Resident #80 was admitted to the facility 1/15/16 with diagnoses which included muscle weakness, psychosis, dementia with behavioral disturbance, gastro-esophageal reflux disease (GERD), hypertension, anxiety, adult failure to thrive, Alzheimers and depression. The care plan for Resident #80 dated 3/01/17 included the problem area, Resident #80 has gastro-esophageal reflux disease. Approaches to	F 770	"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 by the provision of Federal and State law." 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) On 1/19/18, Director of Nursing validated the order to discontinue the H. pylori lab order for Resident #80 was received per M.D.	2/17/18

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this problem area included Resident #80 will remain free from discomfort, complications or signs/symptoms related to diagnosis of GERD and obtain and observe lab/diagnostic work as ordered and report results to physician and follow-up as indicated.

A physician progress note in the medical record of Resident #80 dated 12/22/17 read, Patient is being seen today due to his complaint of burning in his feet and reflux; also to medically manage his dementia, anxiety, constipation and failure to thrive. His primary complaint is burning in his feet and also burning substernally. He has a hard time describing his symptoms and appears as though he is having reflux pain. No cough or congestion noted and no chest pain symptoms.. He gets Omeprazole 20 milligrams daily and symptoms suspicious for GERD and reflux. The physician noted he planned to increase Omeprazole to 20 milligrams twice a day for 21 days and then 20 milligrams daily and to check stool for H. pylori. Orders were written on 12/22/17 which included to "Check stool for H pylori."

Review of the electronic December 2017 Medication Administration Record (MAR) for Resident #80 noted the order to check stool for H pylori was entered into the system on 12/22/17 with parameters for the lab to be done by 1/6/18. Of the 14 days the order was active on the MAR there were only two documented entries; one on 12/22/17 and the other on 12/23/17. A nursing progress note on 12/22/17 indicated the stool sample to test for H. pylori was not done because Resident #80 did not have a BM "on my shift." A nursing progress note on 12/23/17 acknowledged the order for the stool sample to test for H. pylori

b.) The facility failed to obtain lab for (1) resident per M.D. order.

2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:
a.) Lab order for Resident #80 was discontinued on 1/19/18.
b.) On 2/1/18, nursing staff was re-educated by the Director of Nursing/designee on requirements for compliance with F770 with emphasis on the facility policy for Diagnostic Management. Agency staff as well as newly hired staff will receive the same education.

3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:
a.) On 1/31/18 a house-wide lab audit was completed by Director of Nursing. No other issues were identified.
b.) Unit Managers will pull the lab report from PCC and reconcile labs with the Laboratory Reconciliation Audit form daily. Additionally, unit managers will advise unit staff of pending samples not yet obtained and track orders until sample results are received in the facility.
c.) The Director of Nursing will randomly monitor corrective actions to ensure the effectiveness of these actions by randomly observing the Lab Reconciliation Audit 1-3x weekly X 4 weeks, then monthly until compliance has been determined.

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F 770	Continued From page 20 but did not indicate why it was not done. Attempts were made to call the agency nurse that wrote the 12/23/17 progress note were unsuccessful. Review of the bowel records for Resident #80 noted bowel movements were recorded on 12/22/17, 12/23/17, 12/26/17, 12/28/17, 12/29/17,1/02/18, 1/03/18, and 1/06/18. Interview with the unit manager (on the unit Resident #80 resided) and the Director of Nursing on 1/19/18 at 11:00 AM noted the 12/22/17 order to test for H. pylori had not been done as ordered. The Director of Nursing stated the facility had a system to check on labwork but, because the 12/22/17 order to test for H. pylori had been entered into the electronic system as "other" instead of "lab" it was not tracked through the system in place. The unit manager and Director of Nursing could not explain why the lab was not done as ordered. The physician of Resident #80 stated the test for H. pylori ordered 12/22/17 should have been done as ordered and noted there was no harm to the resident because of the test not being done.	F 770	d.) Findings will be reported at the monthly QAPI meeting until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing clinical system reviews. 4.)The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing will be responsible for the implementation of the acceptable plan of correction. 5.) Dates when corrective action will be completed: February 17, 2018	