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	345328	A. BUILDING _____ B. WING _____	01/25/2018

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F 641 SS=E	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 observation, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for the presence of an indwelling Foley catheter (Resident #31)and hospice care (Resident #30 and #43) for 3 of 15 sampled residents and Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident identified as PASRR Level II (Resident #17). The findings included: 1. Resident #31 was admitted to the facility on 09/04/17 with diagnoses including Alzheimer's dementia. Review of Resident #31's progress notes dated 11/22/17 documented placement of a 16 French indwelling Foley catheter as a comfort measure as directed by Hospice. Review of the resident's medical orders dated 11/22/17 directed Foley catheter care be performed every shift. Review of the resident's care plan dated 11/24/17 noted the presence of a Foley catheter inserted for wound management, with interventions including maintaining the position of the catheter and tubing per routine nursing standards. Review of nursing notes for Resident #31 from 11/22/17 to present time revealed no documentation of discontinuation of the catheter. Review of Resident #31's most current and	F 641	Plan of Correction for Tag F641 CFR:483.20(g) For each of the coding errors noted during the survey, the MDS's were modified immediately and transmitted to CMS. During the survey, it was noted that CAA's and Care Plans were in place and properly addressed the care needs of the identified residents; therefore, no modification of the CAA's and CarePlans were required. Each of the coding errors that were identified during the survey were input by an MDS coordinator or interim MDS assistant who were both new to the facility, within the first 60-80 days of employment. Despite, a thorough knowledge and experience on the RAI and the Assessment / MDS process, they were nevertheless new to the facility processes, residents, EHR, and MDS assessment Software, contributing to the risk for miscoding. To verify that there were no other inaccuracies on the identified areas of the MDS, and to ensure no other residents were affected in a similar manner, the Leadership Team reviewed MDS's for all residents, ensuring that Hospice, PASRR and catheters were all coded correctly. No other MDS's were found to require	1/26/18

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

Electronically Signed | 02/14/2018

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F 641	Continued From page 1 quarterly Minimum Data Set (MDS) assessment dated 12/04/17 revealed in Section H (Bladder and Bowel) no check mark under appliances for an indwelling catheter. Observation on 01/25/18 at 6:09 AM of Resident #31 receiving wound care revealed the presence of an indwelling urinary catheter, the collection bag to gravity, and straw colored urine collecting in the bag. Interview on 01/25/18 at 3:30 PM with the MDS Coordinator revealed, for MDS assessment data, she either looked at resident charts or staff provided her with needed data. She stated a part time nurse updated care plans and sometimes would fill out MDS assessments, with her assigned tasks based on deadlines and workload. She stated that her review of Section H of Resident #31's MDS assessment revealed no check mark to document the indwelling urinary catheter and the part time nurse would have been responsible for reviewing this section of the MDS. She stated that as that nurse was not present during the interview, she was not sure if the nurse looked at a paper telephone order or if she looked at orders in the electronic record. She stated that nurse should have picked up on this and coded it as such. Interview on 1/25/18 at 5:41 PM was conducted with the Administrator and Director of Nursing present. The Administrator stated his expectation that MDS assessments were to be accurate. 2. Resident #30 was admitted to the facility on 07/23/15 with diagnoses including dementia. Review of Resident #30's hospice certification	F 641	modification. In light of this deficiency we have reviewed our processes, and have evaluated improvements that will provide better access to information for coding. Attending physicians are now noting the life expectancy on the referral orders for Hospice. We are providing easier access to the PASRR system, and further training on EHR and MDS assessment software has occurred. On 1/24, The DON and Administrator discussed the need for accuracy in coding with the MDS coordinator, and with her assistance developed needed changes to processes to better facilitate accurate coding. On 1/24, The MDS Coordinator was provided education by the Medical Records Coordinator Regarding finding Hospice Certifications in the EHR and how the certification procedures differ between Hospice providers. This training also included accessing of other attachments and consults in the EHR, and verification of PASSR status using the the PASSR system so that it can be compared to EHR for accuracy in coding. These changes will improve ease of access to information, reducing the chance of miscoding, and will also facilitate double checking the accuracy of our medical records and of the coding by the MDS coordinator and nursing leadership. Our Nurse Consultant has been scheduled to evaluate and assess the MDS procedures and accuracy and identify any further training needs. The improved procedures, training, and monitoring by nursing leadership and the consultant is expected	

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F 641	Continued From page 2 and plan of treatment dated 11/17/17 revealed a hospice certification period of 11/17/17 through 02/04/18. A physician's addendum note attached to this certification documented the resident as terminally ill with a life expectancy of six months or less if her illness were to run its normal course. Review of the resident's care plan dated 11/29/17 revealed her to be receiving hospice care. Review of Resident #30's most current significant change Minimum Data Set (MDS) assessment dated 12/04/17 revealed Section J (Health Conditions) of the MDS assessment for prognosis was checked no. Section O (Special Treatments, Procedures and Programs) of this MDS assessment did not document hospice care. Interview on 01/25/18 at 3:30 PM with the MDS Coordinator revealed for, MDS assessment data, she either looked at resident charts or staff provided her with needed data. She stated she was responsible for documenting any prognosis under Section J of the MDS and hospice care under Section O. She stated her review of the MDS signature page (Section Z) for Resident #30 revealed she had completed these sections for this resident. She stated hospice notes were sometimes not readily available when she needed to see them and that it was difficult to get hospice certifications, without which she was not permitted to enter information on the MDS. She stated a review of a pending MDS not yet transmitted noted a change in the hospice status of Resident #30, but the prognosis was still not updated. She stated a review of the resident's electronic record showed the hospice certification form was not scanned into the resident's record until 01/23/18 and that this form should not have taken that long to get to the facility.	F 641	to continue to positively impact the accuracy, consistency, and completeness of the MDS assessments. In order to prevent reoccurrence of this type of error in the future, the DON and/or Designee will verify the accuracy for the MDS coding of Section A1500, J-1400, O-0100k, and H-0100 of every assessment of all residents prior to submission for a period of sixty (60) days and randomly thereafter. The DON will report her findings to the QAPI Committee for ongoing monitoring and oversight until the QAPI Committee determines that ongoing, consistent compliance has been achieved.	

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F 641	Continued From page 3	F 641		

Interview on 1/25/18 at 5:41 PM was conducted with the Administrator and Director of Nursing present. The Administrator stated his expectation that MDS assessments were to be accurate.
3. Resident #43 was admitted to the facility 10/30/13 with diagnoses including Parkinson's disease, heart failure, depression, and edema.

A record review of the significant change Minimum Data Set (MDS) dated 9/14/17 indicated Resident #43 was not coded under Section O-Special Treatments and Programs as receiving hospice care.

A review of the Hospice Certification and Plan of Treatment revealed that Resident #43 began receiving hospice services on 8/31/17.

The MDS Coordinator was interviewed 1/24/18 at 4:40 PM regarding the accuracy of Resident #43's significant change MDS. The MDS did not reflect hospice care for Resident #43. The MDS Coordinator stated the MDS should have been coded to reflect Resident #43 was receiving hospice care and was missed for coding. The MDS Coordinator stated the significant change MDS would require a correction to reflect Resident #43 was receiving hospice care.

On 1/24/18 at 5:21 PM an interview with was conducted with the Director of Nursing (DON). The DON stated it was her expectation that the significant change MDS would have been coded accurately to reflect Resident #43 was receiving hospice care.

On 1/24/18 at 5:29 PM an interview was conducted with the Administrator. The

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F 641	Continued From page 4	F 641		

Administrator stated it was his expectation that the significant change MDS would have been coded accurately to reflect Resident #43 was receiving hospice care.
4. Resident #17 was admitted to the facility on 11/18/16 with diagnoses including bipolar disorder, anxiety disorder, and depression.

A review of Resident #17's annual Minimum Data Set (MDS) assessment dated 11/01/17 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 01/23/18 at 4:57 PM an interview was conducted with the MDS Coordinator who stated she was responsible for coding Section A. 1500 PASRR Level II for Resident #17. The MDS Coordinator stated she was not aware Resident #17 was determined as PASRR Level II and missed coding PASRR Level II. The MDS Coordinator verified Resident #17 was determined as PASRR Level II by reviewing the medical record and stated she would need to submit a modification to the annual MDS dated 11/01/17 to reflect Resident #17 was PASRR Level II.

On 01/23/18 at 5:05 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Resident #17's annual MDS assessment dated 11/01/17

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F 641	Continued From page 5 would have been accurately coded to reflect Resident #17 was determined as PASRR Level II. The DON stated her expectation was that the MDS Coordinator would submit a modification to Resident #17's annual MDS dated 11/01/17 to reflect PASRR Level II. On 01/23/18 at 5:09 PM an interview was conducted with the Administrator who stated his expectation was that the annual MDS assessment dated 11/01/17 would have been accurately coded to reflect Resident #17 was determined as PASRR Level II. The Administrator stated his expectation was that the MDS Coordinator would submit a modification to Resident #17's annual MDS dated 11/01/17 to reflect PASRR Level II.	F 641		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the recertification survey of December of 2016 to correct a deficiency that was cited during the recertification survey. This deficiency was cited again on this current recertification survey of January, 2018. The deficiency was in	F 867	It is the policy and practice of the facility to maintain a quality assessment and assurance committee (QAA) consisting of the outlined members that meet to identify issues with respect to which quality assessment and assurance activities are necessary; and develop and implement appropriate plans of action designed to correct identified quality deficiencies. The facility has policies and procedures	2/12/18

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F 867	Continued From page 6 the area of Accuracy of Assessments. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: §483.20(g) (F641) Accuracy of Assessments: Based on observation, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for the presence of indwelling Foley catheter (Resident #31), and hospice care (Resident # 30 and #43) for 3 of 15 sampled residents and Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident identified as PASRR Level II (Resident #17). The Accuracy of Assessments was originally cited during the December 8, 2016 recertification survey for failing to accurately code the MDS for a resident with a catheter. Interview on 1/25/18 at 5:41 PM was conducted with the Administrator, with the Director of Nursing present. The Administrator stated his expectation that MDS assessments were to be accurate and that the facility's Quality Assurance process should have prevented the inaccurate coding of the MDS assessments.	F 867	designed to maintain these goals. Quality assurance monitoring, physician reviews, consultant reviews, and staff training are examples of the many components utilized. Our Quality Assurance monitoring for the cited deficiency in the last certification survey on 1/22/18 involved F641, Accuracy of Assessments. This area was also cited in the Dec. 2016 survey, and the QA monitoring that occurred following the Dec. 2016 survey indicated compliance and improvement in this area. In light of most recent QAA citation, the following steps have been added to the Quality Assurance Monitoring process. • On 2/14/18 the four-point plan of correction to address F641 was submitted to DHHS. The POC addressed 1) The plan of correction for the specific deficiency, 2) The procedure for implementing the plan of correction, 3) The monitoring procedure to ensure that the POC is effective and the specific deficiency remains corrected and/or in compliance with the regulations and 4) The title of the person responsible for implementing the acceptable POC. This Plan of Correction has been integrated into the Quality Assurance system of the facility. • The facility Quality Assessment and Assurance Program (QAA) was re-assessed by the Administrator and Health Services Director on 2/12/18. The following was noted: • Attendees were appropriate and include: Administrator, Medical Director,	

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F 867	Continued From page 7	F 867	Director of Nursing, Consultant Pharmacist, Infection Preventionist, the Dining Director, and the Social Services / Programming Director. • Agenda items were also reviewed: ¿ An Agenda item was added to include audit results for the most recent cited deficiency, F 641 Accuracy of Assessments, and will remain on the agenda until the next certification survey. ¿ An Agenda item was added to include evaluation of the QAA process related to the cited deficiency, F 867 QAA/QAPI, and will remain on the agenda until the next certification survey. • A Performance Improvement plan (PIP) was opened for the Accuracy of Assessment Citation, (F 641) • A Performance Improvement plan (PIP) was opened for the QAA/QAPI citation (F867) • Frequency of meetings is at least monthly, with QAPI sub Committee also meeting on a monthly basis – no changes or issues were identified with meeting frequency. • The QAA committee will continue to analyze trends/possible causal factors and act accordingly to resolve instances of non-compliance and improve overall quality of care. • Progress and results of the ongoing PIPs and Plan of Correction will be reported to the Corporate QAPI committee for further oversight.	