STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING _____ B. WING _____	C 02/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AND REHABILITATION	38 CARTERS ROAD GATESVILLE, NC 27938

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the CI investigation of 2/21/2018. NC00130992. Event ID # 6H3I11.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment.	F 640		3/7/18

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

Electronically Signed | 03/02/2018

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F 640	Continued From page 1 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code and transmit a Discharge Tracking Minimum Data Set (MDS) for 2 or 2 residents (Resident #2 and #7) reviewed for resident assessment. The findings included: 1. Resident #2 was admitted to the facility on 4/19/2017 with diagnoses that included diabetes and chronic pain. A quarterly MDS assessment dated 10/26/2017 was the most recent assessment transmitted to the Center for Medicare and Medicaid Services (CMS). A review of a nursing note dated 11/7/2017 revealed the resident was moved to an assisted living (AL) room in the facility, and discharged from skilled nursing. An interview was conducted with the MDS nurse on 2/20/2018 at 9:57 AM. The MDS nurse stated	F 640	1. Resident #2 was discharged from ALF to SNF and now notes and MDS reflect this change. Resident #7 was discharged and in the MDS and completed for transmission per regulations. 2.Encoding and transmission of MDS assessments will be audited and monitored to ensure they are transmitted per RAI regulatory guidelines 3.A complete audit of all assessments will be conducted x2 weeks(2/23/18-3/5/18) after survey to ensure that 100% of all admissions have been completed. It will be audited by the DON monthly thereafter to continue the monitoring process. 3. Upon completion of the audit any assessments that aren't complete will be input into PCC. A printed admission and discharge assessment report will be pulled for the previous 7 days to confirm that the assessments have been	

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F 640	Continued From page 2 it didn't click with her to do a discharge tracking MDS assessment for Resident #2 because he had stayed in the facility on the AL side. On 2/21/2018 at 12:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected the MDS discharge tracking to be completed for residents discharged to the assisted living section of the facility and submitted per regulations. 2. Resident #7 was admitted to the facility on 8/30/2017 with diagnoses that included kidney failure and hypertension. A quarterly MDS assessment dated 11/17/2017 was the most recent assessment transmitted to the Center for Medicare and Medicaid Services (CMS). A review of a nursing note dated 11/30/2017 revealed the resident was discharged home with family. An interview was conducted with the MDS nurse on 2/20/2018 at 9:57 AM. The MDS nurse stated she must have overlooked the discharge tracking MDS assessment for resident #7, as she was a planned discharge. On 2/21/2018 at 12:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected the MDS discharge tracking to be completed and transmitted for residents discharged to home per regulations.	F 640	completed and transmitted. 4. The DON will audit admissions and discharges from the pulled report along with the MDS nurse so that there is another staff member involved in the auditing process. 5. Process has been started 2/23/2018 and we will be at 100% accuracy by 3/5/18 if less than 100% the plan of action will be revised to achieve 100% compliance. PIP developed in QAPI to be evaluated monthly thereafter.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		3/7/18

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F 641	Continued From page 3 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 code the Minimum Data Set (MDS) assessment accurately in the area of level II Preadmission Screening for 2 of 2 residents (Resident #40 and #33) reviewed for Preadmission Screening and Resident Review (PASARR). The findings included: 1. Resident #40 was admitted to the facility on 6/14/17 and most recently readmitted on 12/25/17 with multiple diagnoses that included schizophrenia and intellectual disability. Record review indicated Resident #40 had a level II PASRR. The admission Minimum Data Set (MDS) assessment dated 6/21/17 indicated a "yes" to question A1500 which asked if Resident #40 had been evaluated by a level II PASRR and determined to have a serious mental illness and intellectual disability or a related condition. A review of the significant change assessment dated 1/1/18 indicated a "No" response to question A1500. On 2/19/18 at 2:54 PM the Social Worker (SW) confirmed that Resident #40 was a level II PASRR. The MDS dated 12/25/17 for Resident #40 that indicated she was not a level II PASRR was reviewed with the SW. She confirmed the MDS was coded inaccurately.	F 641	1. Resident #40 MDS question A1500 has been updated to "no" to reflect the patients Level II PASRR. Facility has review Resident #40 to ensure that all information regarding the level II PASRR is accurate. 2. Accuracy of MDS assessments will be audited weekly x 2weeks and monitored to ensure they are completed accurately per RAI regulatory guidelines and back in compliance. 3. A complete audit of all assessments will be conducted to ensure that 100% all assessments have been completed. It will be audited by the DON weekly x2 weeks and then monthly for 3months and then quarterly to continue the monitoring process. QAPI process has been started 2/23/2018 and we will be at 100% accuracy by 3/9/18 if less than 100% the plan of action will be revised to achieve 100% compliance. 4. The SW updates and maintains the list of Level II PASARR numbers and will update MDS, DON, and Administrator weekly. 5. The DON will audit from the pulled report versus the MDS nurse so that there is another staff member involved in the auditing process.	

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F 641	Continued From page 4	F 641		

On 2/20/18 01:37 PM the MDS coordinator revealed she just missed that Resident #40 was a level 11 PAASAR.

The Director of Nursing (DON) on 2/21/18 at 11:43 AM, indicated her expectation was for the MDS to be completed accurately.

2. Resident #33 was admitted to the facility on 10/3/2017 with multiple diagnoses that included major depressive disorder, antisocial personality, and malingerer conscious simulation.

The admission Minimum Data Set (MDS) assessment dated 10/10/2017 indicated a "no" to question A 1500 which asked if Resident #33 had been evaluated by a level II PASARR and determined to have a serious mental illness, intellectual disability or a related condition. A review of the significant change MDS assessment dated 12/25/2017 also indicated a "no" response to question A 1500.

An interview was conducted with the Social Worker (SW) on 2/20/2018 at 9:31 AM. The SW stated Resident #33 came to the facility with a level II PASARR, and she had just reapplied for it on 2/16/2018 as it was to expire on 2/27/2018. The SW indicated she had communicated Resident 33's status to the MDS nurse. The SW stated she called the MDS nurse on the phone, or spoke to her in her office to report who was on the PASARR list, when describing the process she used for communication.

An interview was conducted with the MDS nurse on 2/21/2018 at 10:04 AM. The MDS nurse stated she was given a list from the SW with the residents who were level II PASARR. A review of her most recent list from 9/4/2017 did not have

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F 641	Continued From page 5 Resident 33's name included. The MDS nurse stated she had not coded Resident 33 as a level II PASARR because she didn't know he was a level II. The MDS nurse did not recall a conversation with the SW about Resident 33 having his PASAAR level 2. On 2/21/2018 at 12:00 PM, an interview was conducted with the Director of Nursing (DON), who stated it seemed there was no formal communication system between the SW and MDS nurse. The DON indicated it was her expectation that MDS assessments were completed accurately.	F 641		
F 867 SS=D	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 record review and staff interviews the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place in March 2017. This was for a deficiency that originally was cited on 3/15/2017 and was subsequently recited on the current recertification survey of 2/21/2018. The repeated deficiency was in the area of accuracy of MDS assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 867	1. Resident #33 and Resident #40 both have updated MDS assessments to reflect their Level 2 PASRRs 2. After evaluation of the previous years POC and ineffective follow through we have revamped the process and plan to achieve 100% compliance by March 9th, 2018 with Monthly audits x 3months and quarterly audits following that. 3. A complete audit of all assessments started 2/23/18 will be conducted to ensure that 100% all admissions have been completed weekly x 2 weeks to	3/7/18

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F 867	Continued From page 6 The findings included: This tag is cross reference to: F 641- Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of level II Preadmission Screening for 2 of 2 residents (Resident #33 and #40) reviewed for PASARR. During the recertification survey of 3/17/2017 the facility was cited for failing to accurately code a diagnosis under Section I of the MDS for 5 of 5 records reviewed. An interview was conducted with the Director of Nursing (DON) on 2/21/2018 at 12:00 PM, who stated she expected the MDS assessments to be completed accurately. An interview was conducted on 2/21/2018 at 12:09 PM with the Administrator who also headed the QAA committee. She stated the audits from the previous year were done by the MDS nurse, and that was the problem of having the MDS nurse audit herself.	F 867	ensure compliance of 100% by 3/9/18. 4. It will be audited by the DON monthly to continue the monitoring process. SW will update the Level II PASARR number weekly and update the interdisciplinary team. An audit will be brought to QAPI 1x monthly x3 months to ensure 100% compliance and then quarterly to maintain accuracy. 5. Upon completion of the audit any assessments that aren't complete will be input into PCC. A printed admission and discharge assessment report will be pulled for the previous 7 days to confirm that the assessments have been completed and transmitted. The DON will audit admissions and discharges from the pulled report versus the MDS nurse so that there is another staff member involved in the auditing process.	