STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345319	A. BUILDING _____ B. WING _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERBERRY HEALTH CARE	415 ELDERBERRY LANE MARSHALL, NC 28753

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F 000	INITIAL COMMENTS There were no citations as a result of a complaint investigation done in conjunction with the annual recertification survey. Event ID #UOR411	F 000		
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 Sets for 1 of 1 resident reviewed for Hospice (Resident #55) and 1 of 5 residents reviewed for unnecessary medications (Resident #61). Findings included: 1. Resident #55 was admitted to the facility on 07/06/13 and was recently readmitted on 04/02/18 with multiple diagnoses that included cancer, end-stage renal disease and dementia. A review of a physician's order dated 05/04/18 revealed Resident #55 was admitted to hospice services. A review of the significant change Minimum Data Set (MDS) dated 05/16/18 indicated Resident #55 had a life expectancy of less than 6 months but was not coded under section O0100 Special Treatments and Programs as receiving hospice care. An interview on 06/20/18 at 2:15 PM with MDS Nurse #2 revealed a significant change MDS was	F 641	The facility continually strives to ensure the resident's assessments accurately reflects the resident's status through various sources and programs both internal and external including but not limited to MDS audits, chart audits, monthly nursing reviews, pharmacy tracking, pharmacy consultant audits, nurse consultant audits, physician reviews, QAA studies, and other system processes. Various nursing and other Interdisciplinary Team assessments and notes reflected hospices care for resident # 55 and anti-depressant medication treatment for Resident 61. Action Plan- The inadvertent unchecked box on Resident #55's MDS at Section O 0100 Special Treatments and Programs to reflect that Resident #55 was receiving hospice services was corrected on 6/21/18 per RAI manual guidelines to accurately reflect the hospice field. The correction was transmitted to CMS by	7/13/18

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

Electronically Signed | 07/13/2018

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F 641	Continued From page 1 completed when Resident #55 was admitted to hospice services on 05/04/18. MDS Nurse #2 confirmed hospice services was not checked on the MDS assessment dated 05/16/18 for Resident #55 and stated it was an oversight. He added a modification would be submitted. An interview was conducted on 06/20/18 at 3:45 PM with the Director of Nursing who revealed it was her expectation for MDS assessments to be accurately coded. 2. Resident #61 was admitted to the facility 10/24/17 with diagnoses which included dementia without behavioral disturbance, anxiety, depression and hallucinations. Review of physician orders in the medical record of Resident #61 included an order on 3/22/18 for 10 milligrams of Lexapro (an anti-depressant) for depression. Review of the Medication Administration Record for Resident #61 for March-June 2018 noted the 10 milligrams of Lexapro was given on a daily basis. Review of a quarterly Minimum Data Set (MDS) assessment dated 05/25/18 coded Resident #61 as not taking an anti-depressant. On 06/20/18 at 3:30 PM MDS Coordinator #2 showed a worksheet that was used for the 05/25/18 quarterly assessment for Resident #61 and handwritten on the worksheet was information which noted Lexapro was given daily during the assessment time frame. MDS	F 641	MDS Nurse #2 on 6/21/18. The inadvertent unchecked box on Resident #61's MDS Section N Medications to reflect Resident's use of an anti-depressant medication was corrected on 6/21/18 per RAI manual guidelines to accurately reflect the omitted code. The correction was transmitted to CMS by MDS Nurse #2 on 6/21/18. Procedures/Measures MDS Coordinator and MDS Nurse #2 re-evaluated processes used for completing MDS including but not limited to Section N and Section O to avoid and/or reduce potential for inadvertent human error. Data collected for the MDS assessments including but not limited to Section N and O will randomly be reviewed monthly by the Assistant Director of Nursing or their designee. Monitoring- The Quality Assurance Nurse and/or Assistant Director of Nursing will conduct 6 random MDS audits for accuracy including but not limited to Section N and O bi-weekly for 6 weeks then 10 per month for 12 months. Findings will be submitted by the Assistant Director of Nursing for the Quality Assurance (QA) Committee and reviewed monthly for the next year (12) months.	

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F 641	Continued From page 2 Coordinator #2 stated it was an oversight and should have been coded as 7 days of taking an anti-depressant on the 05/25/18 quarterly MDS for Resident #61. On 06/20/18 at 3:45 PM the Director of Nurses (DON) stated the Lexapro should have been coded as seven days taking an anti-depressant during the assessment period on the 05/25/18 quarterly assessment for Resident #61. The DON stated it was her expectation the MDS be an accurate assessment of a resident.	F 641	Person Responsible for Implementing Plan- The Assistant Director of Nursing will be responsible for implementing, monitoring and follow up where necessary.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 756		6/29/18

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F 756	Continued From page 3 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Pharmacist Consultant and physician interviews, the physician failed to provide a timely response to the Pharmacy Consultant's recommendation for a gradual dose reduction of psychoactive medication for 2 of 5 residents reviewed for unnecessary medications (Resident #5 and #49). Findings included: 1. Resident # 5 was admitted to the facility on 05/26/17 with multiple diagnoses that included dementia with behavioral disturbance. Review of Resident #5's medical record revealed the following physician orders: - 09/26/17: Seroquel (antipsychotic medication) 25 milligrams (mg) daily at 2:00 PM for behaviors. - 05/10/18: Seroquel 50 mg twice daily at 9:00 AM and 9:00 PM. Review of the annual Minimum Data Set (MDS)	F 756	The facility continually strives to monitor resident's drug regimen reviews and pharmacy reports regarding recommendations to physicians through multiple sources and programs both internal and external. The facility has policies and procedures designed to maintain the goals. Pharmacy review, consultant reviews, quality assurance monitoring and staff training are examples of the many components utilized to achieve a complete drug regimen review process. Action Plan- The pharmacy consultant's gradual dose reduction (GRD) recommendation for Resident #5 and #49 was reviewed and addressed by the physician on 6/21/18. Procedures/Measures	

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F 756	Continued From page 4 dated 03/20/18 coded Resident #5 with severe impairment in cognition. Further review of the MDS revealed Resident #5 displayed no mood symptoms or behaviors during the assessment period. Review of Resident #5's medical record revealed on 04/19/18 and 05/23/18 the Pharmacist Consultant (PC) recommended consideration of a Gradual Dose Reduction (GDR) for Seroquel. The PC recommended reducing Resident #5's Seroquel to 25 mg every AM and 2:00 PM and 50 mg at night. The physician indicated she was not in agreement with this recommendation on 06/06/18. During an interview on 06/20/18 at 10:25 AM the PC revealed pending GDR recommendations were reviewed during monthly pharmacy reviews to ensure a response was received from the physician. The PC indicated she would expect for the physician to respond to the GDR recommendation prior to the next monthly review and would note in the current month's report if no response was received. The PC confirmed no response was received for Resident #5's GDR recommendation dated 04/19/18 during her monthly review on 05/23/18. She added the physician responded to the GDR recommendation on 06/06/18. During a telephone interview on 06/20/18 at 1:35 PM the Physician revealed she was in the facility once a week and reviewed the pharmacy recommendations as her schedule allowed. The Physician explained during her time in the facility, her priority was addressing the acute needs of the residents and it wasn't always possible for her to review and respond to the PC's	F 756	There was a procedure in place for physician to review pharmacy recommendations. The physicians chose to postpone the review of pharmacy reports. On 6/21/18 the administrator reviewed with the physician and other practice providers the regulatory guidelines for skilled nursing facilities regarding pharmacy review reports and recommendations including but not limited to attending physicians responding in a reasonable timeframe. Modifications were made to the physician visit process, method of communication and follow-up by staff nurse(s) with physicians regarding any recommendations not addressed. Each provider will be responsible for an assigned number of pharmacy reviews during each on site visit by desk nurse. Monitoring- The Director of Nursing and/or their designee will review weekly any pharmacy consultant recommendation(s) that have not been responded to by a resident's physician and provide additional physician contact until a response received for the next 4 quarters. Pharmacy Consultant (PC) will continue to review previous month's recommendations for response(s). PC will discuss with Director of Nursing or their designee any unaddressed	

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F 756	Continued From page 5 recommendations each week. During an interview on 06/20/18 at 3:45 PM the Director of Nursing (DON) explained she placed the PC's medication review reports and/or recommendations in the pharmacy review book located at the nurses' station for the physician to review. She added nursing staff would review the pharmacy book and leave notes for the physician related to GDR recommendations if they disagreed. The DON stated it was her expectation GDR's were addressed within 30 days as stated in the facility's policy. During an interview on 06/21/18 at 1:45 PM the Administrator revealed she would expect the physician to provide a response to the PC's recommendations within 30 days as indicated in the facility's policy. 2. Resident #49 was admitted to the facility on 11/02/15 with multiple diagnoses that included anxiety disorder, depression and bipolar disorder. Review of a physician's order for Resident #49 dated 03/11/16 read, Depakote (mood stabilizer) Extended Release 500 milligrams (mg) twice daily for bipolar disorder. Review of Resident #49's medical record revealed on 03/20/18 the Pharmacist Consultant (PC) recommended consideration of a Gradual Dose Reduction (GDR) for Depakote. The PC recommended reducing Resident #49's Depakote to 250 mg every AM and 500 mg every PM. The physician indicated she agreed with this recommendation on 05/02/18. Review of a physician's order for Resident #49	F 756	recommendation(s) and develop a plan to achieve. Person Responsible for Implementing Plan- The Director of Nursing will be responsible for implementing, monitoring and follow up where necessary.	

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F 756	Continued From page 6	F 756		

dated 05/04/18 read, decrease Depakote to 250 mg every AM and 500 mg every PM.

Review of the annual Minimum Data Set (MDS) dated 05/10/18 coded Resident #49 with intact cognition. Further review of the MDS revealed Resident #49 displayed no mood symptoms or behaviors during the assessment period.

During an interview on 06/20/18 at 10:25 AM the PC revealed pending GDR recommendations were reviewed during monthly pharmacy reviews to ensure a response was received from the physician. The PC indicated she would expect for the physician to respond to the GDR recommendation prior to the next monthly review and would note in the current month's report if no response was received. The PC confirmed no response was received for Resident #49's GDR recommendation dated 03/20/18 during her monthly review on 04/19/18. She added the physician responded to the GDR recommendation on 05/02/18.

During a telephone interview on 06/20/18 at 1:35 PM the Physician revealed she was in the facility once a week and reviewed the pharmacy recommendations as her schedule allowed. The Physician explained during her time in the facility, her priority was addressing the acute needs of the residents and it wasn't always possible for her to review and respond to the PC's recommendations each week.

During an interview on 06/20/18 at 3:45 PM the Director of Nursing (DON) explained she placed the PC's medication review reports and/or recommendations in the pharmacy review book located at the nurses' station for the physician to

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F 756	Continued From page 7 review. She added nursing staff would review the pharmacy book and leave notes for the physician related to GDR recommendations if they disagreed. The DON stated it was her expectations GDR's were addressed within 30 days as stated in the facility's policy. During an interview on 06/21/18 at 1:45 PM the Administrator revealed she would expect for the physician to provide a response to the PC's recommendations within 30 days as indicated in the facility's policy.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		7/13/18

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F 758	Continued From page 8 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Consultant Pharmacist, and physician interviews the facility failed to ensure a physician's order for as needed (PRN) anxiolytic (anxiety reducing) medication was time limited in duration or had justification for continued use for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #41). Findings included: Resident #41 was admitted to the facility on 05/11/16 with diagnoses that included non-Alzheimer's dementia and depression.	F 758	The facility continually strives to monitor resident's medication regimen for necessary psychotropic medication use through various sources and programs both internal and external. The facility has policies and procedures designed to maintain these goals. Pharmacy review, consultant reviews, quality assurance monitoring and staff training are examples of the many components utilized to ensure, when prescribed, a necessary psychotropic medication use regimen. Action Plan-	

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F 758	Continued From page 9 The quarterly Minimum Data Set (MDS) assessment dated 04/26/18 indicated Resident #41 was cognitively intact. Resident #41 received anxiolytic medication on 7 of 7 days. A physician's order dated 05/07/18 and 05/08/18 indicated Klonopin (anxiolytic medication) 0.5 milligram (mg) 1 tablet by mouth every day PRN was ordered for Resident #41. There was no 14 day stop date for the PRN Klonopin order. A physician's order dated 05/07/18 indicated Klonopin 0.5 mg 1 tablet by mouth every day PRN was to be reevaluated in 1 week. A review of Resident #41's medication administration record (MAR) revealed the resident had received Klonopin 3 times in May 2018 and 6 times from 06/01/18 to 06/17/18. On 05/23/18 the Consultant Pharmacist reviewed the Klonopin PRN order without a stop date that was written on 05/07/18 and 05/08/18 for Resident #41. The Consultant Pharmacist recommended per the new regulations that the physician should indicate a 14 day stop date for PRN Klonopin unless a clinical justification was provided for continuing PRN Klonopin greater than 14 days. An interview was conducted with the Consulting Pharmacist on 06/20/18 at 10:24 AM who stated she was aware of the new regulations regarding PRN anxiolytic medication. She stated PRN anxiolytic medication was limited to 14 days unless the prescriber provided a justification to extend the order past 14 days. The Consultant Pharmacist stated Resident #41 was noted with an order dated 05/07/18 and 05/08/18 for	F 758	The Physician Assistant (PA) that wrote the order for Resident #41's anxiety reducing medication (Anxiolytic) accidently omitted a stop date. The physician reviewed the order on 6/21/18 and decided to discontinue use. Procedures/Measures- On 6/21/18 the Administrator and Director of Nursing began re-educating all physicians, practice staff and facility nurses regarding federal regulation changes concerning duration time limits (stop dates) and/or written justification for necessity for continued use of any psychotropic class medication. Existing psychotropic medication orders were checked for appropriate stop dates. Monitoring- A copy of psychotropic medication orders will be given by receiving nurse to the Director of Nursing and/or their designee for monitoring. Director of Nursing will review weekly any pharmacy consultant recommendation(s) that have not been responded to by a resident's physician and provide additional physician contact until a response received. Pharmacy will monitor psychotropic medication orders to ensure a stop date and/or justification for necessity for continued use past initial stop date.	

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F 758	Continued From page 10 Klonopin 0.5 mg 1 tablet by mouth every day PRN with no stop date and the physician had not indicated justification of continued needs beyond 14 days. The Consultant Pharmacist stated the PRN Klonopin order for Resident #41 was not in compliance with the new Centers of Medicare & Medicaid Services (CMS) psychotropic (drug affect mental state) regulations. The Consultant Pharmacist stated she sent a recommendation to the physician on 05/23/18 to consider a 14 day stop date or document the rationale for continued needs beyond 14 days and had not received a response. On 06/20/18 at 11:27 AM a telephone interview was conducted with the physician who stated he began working at the facility in early May 2018 and came to the facility one day per week for ½ day. The physician stated he was not aware of the CMS regulation regarding PRN anxiolytic medication that required a 14 day stop date or justification of continued need beyond 14 days. The physician stated he had not reevaluated Resident #41's use of PRN Klonopin after 1 week and had not provided a justification for the continued use of PRN Klonopin. The physician stated he had not written a 14 day stop date for Resident #41's PRN Klonopin. The Physician stated he did not remember receiving a Consultant Pharmacist recommendation which inquired if he could provide a 14 day stop date on Resident #41's PRN Klonopin or provide justification for continued use of PRN Klonopin beyond 14 days. The physician stated the facility needed a better system of notifying him of Consultant Pharmacist recommendations. The physician stated if he had been aware of the Consultant Pharmacist recommendation dated 5/23/18 regarding Resident #41's PRN Klonopin	F 758	Pharmacy Consultant will continue to monitor psychotropic medication use monthly and report any irregularities. QA team will review pharmacy monthly psychotropic medication use report for inconsistencies. Person Responsible for Implementing Plan- The Director of Nursing will be responsible for implementing, monitoring and follow up where necessary.	

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F 758	Continued From page 11 then he would have addressed the Consultant Pharmacist recommendation. On 06/20/18 at 12:10 PM an interview was conducted with the Administrator who stated she was aware of the new CMS regulations regarding PRN anxiolytic medication which required a 14 day stop date or justification for continued use beyond 14 days. The Administrator stated her expectation was that the physician would have provided a 14 day stop date for Resident #41's PRN Klonopin or have provided justification for continued need of PRN Klonopin beyond 14 days per the new CMS psychotropic medication regulation.	F 758		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		6/30/18

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	345319	A. BUILDING _____ B. WING _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERBERRY HEALTH CARE	415 ELDERBERRY LANE MARSHALL, NC 28753

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F 812	Continued From page 12 by: Based on observations and staff interviews the facility failed to remove a dented can available for use from the dry goods storage room and failed to date opened food items stored in 1 of 1 walk in freezer. Findings included: During the initial tour of the kitchen on 06/18/18 at 10:08 AM an observation of the dry goods storage room revealed a large can of sloppy joe sauce with an approximate 1-inch deep dent along the top rim of the can was stacked among other canned items available for use. The Dietary Manager (DM) was unable to explain why the dented can was stored along with the other canned items and removed the dented can of sloppy joe sauce. During the same tour, an observation of the kitchen walk-in freezer revealed an opened and undated bag of meatballs with approximately one-half remaining in bag. The DM removed and discarded the bag of meatballs and stated the item should have been dated when opened. An interview was conducted with the Dietary Manager (DM) at 10:08 AM who confirmed dented cans should not be used for meal preparation. He explained dented cans were to be removed from the pantry shelves and stored in his office until the items could be returned for a credit. The DM stated dietary staff were expected to label and date all food items with the date they were opened prior to placing the items into the freezer.	F 812	It has been the policy and normal practice of this facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety as reflected through routine Sanitation Inspections. The facility has policies and procedures designed to maintain these goals. Ongoing Health Department inspection, NC DHSR inspections, dietician planning, consultant review, quality assurance monitoring and staff training are examples of the components and monitoring practices. Action Plan- The single dented can in the storage area was removed on 6/1/18 by the Food Service Manager when observed. The can was placed in the appropriate food vendor return box. Surveyor findings indicate immediate corrective action. The unopened package of meatballs was discarded as a precautionary measure on 6/18/18 by the Food Service Manager when observed and identified as lacking a use by date signifying when case was opened. Surveyor findings indicate immediate corrective action. Procedures/Measures- Beginning 6/18/18 the Food Service Manager talked with food service staff regarding being more aware of dented cans and the removal and return procedures either at time of delivery or	

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F 812	Continued From page 13 An interview on 06/21/18 at 1:45 PM with the Administrator revealed she would expect for dented cans to be removed and all food items to be dated when opened.	F 812	especially during general duties in storage areas; included was use by clarification regarding multiple individual packages in a case when a case is opened but individual package is not. Monitoring- Food Service Manager and/or cook will monitor all storage areas for professional standards for food service safety including but not limited to dented cans and labeling/dating at lease 3 times per week for a month; weekly for 3 months and quarterly for 2 quarters. Person Responsible for Implementing Plan- The Food Service Manager will be responsible for implementing, monitoring and follow up where necessary.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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.	F 865		7/13/18

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F 865	Continued From page 14 §483.75(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 facilities 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 08/04/17. This was for one recited deficiency which was originally cited during the annual recertification survey of 08/04/17 and again on the current recertification and complaint survey of 06/21/18. This repeat deficiency was in the area of accuracy of the Minimum Data Set. The continued failure of the facility during two surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 641 Accuracy of the Minimum Data Set Assessment: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Sets for 1 of 1 resident reviewed for Hospice (Resident #55) and 1 of 5 residents reviewed for unnecessary medications (Resident #61). During the recertification survey of August 4, 2017 the facility was cited for failure to accurately assess 2 of 3 sampled residents utilizing the Minimum Data Set (MDS) in the area of pressure ulcers (Resident #90 and Resident #52) and 1 of	F 865	It is the policy and practice of the facility to maintain a quality assurance committee (QA) consisting of the outlined members that meet monthly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action designed to correct identified quality areas where improvement is desire. The facility has policies and procedures designed to maintain these goals. Quality assurance monitoring, physician reviews, consultant reviews, and staff training are example of the many components utilized. Action Plan- The Quality Assurance (QA) Team met on 7/11/18 and reassessed the facility's overall QA program. The team also completed an assessment tool designed to evaluate the effectiveness of a Quality Assurance and Performance Improvement (QAPI) program. Procedures/Measures- MDS QA assessment audits were expanded to a broader review process, focusing on overall accuracy to include more than the areas/section listed under	

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F 865	Continued From page 15 3 sampled residents for dental (Resident #80). On 06/21/18 at 4:24 PM the Administrator stated the facility conducted monthly Quality Assessment and Assurance committee meetings and had looked at MDS accuracy for the area cited on the 2017 survey up through April 2018. The administrator stated MDS accuracy was not reviewed after April 2018 because compliance in the area of coding of dental status and pressure sores had been achieved.	F 865	F641. A Performance Improvement Project (PIP) will continue to be initiated on areas of identified desired performance improvement. Monitoring- Results of audits related to F641 outlined under F641 will be reported to the Quality Assurance (QA) Committee by the Director of Nursing and/or designee on a monthly basis beginning with the July QA committee meeting. The QA committee will continue to analyze trends/possible causal factors and act accordingly to achieve performance improvement and improve overall quality of care. Person Responsible for Implementing Plan- The Director of Nursing will be responsible for implementing, monitoring and follow up where necessary.	