STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. BUILDING _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALSTON BROOK	4748 OLD SALISBURY ROAD LEXINGTON, NC 27295

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 06/10/19 through 06/13/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # C4RW11.	E 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		7/8/19

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

Electronically Signed | 07/03/2019

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F 583	Continued From page 1 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review observation, and staff interview, the facility failed to ensure privacy during wound assessment and dressing change for 1 of 2 residents (Resident #37) observed for pressure ulcers. Findings included: Resident #37 was admitted to the facility 4/15/10. Review of a quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 4/5/19 revealed Resident #37 had severe cognitive impairment and displayed no behaviors or rejection of care. Active diagnoses included, but were not limited to Alzheimer's disease, dementia without behavioral disturbance, and depression. Resident #37 had 1 stage 2 pressure ulcer. A care plan dated 4/5/19 read, "At risk for skin breakdown/excoriation d/t (due to) decreased bed mobility, incontinence, use of splints to legs and hx (history) of pedal edema. She has hx of fungus to her toes, folds and redness to her heels and buttocks. She has edema to LE (lower extremity). PU (pressure ulcer) stage 2 to left butt. A wound assessment of Resident #37's heel written by the Wound Care Nurse and dated 6/11/19 read, in part, "Unstageable r/t (related to) SDTI (suspected deep tissue injury). Status "Improved". Identified 5/25/19. Not present upon admission. Length 2cm (centimeters) x (by)	F 583	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Resident #37 and her roommate were not able to state how they felt about lack of privacy due to their cognition. The primary Treatment Nurse and the weekend Treatment Nurse have been re-educated on resident privacy practices in conjunction with performing any kind of treatment. All training/re-education will be completed by July 8, 2019. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. The primary Treatment Nurse and the weekend Treatment Nurse have been re-educated on resident privacy practices in conjunction with performing any kind of treatment. The facility has conducted training on resident rights with an emphasis on resident privacy for all staff members. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT	

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F 583	Continued From page 2 Width 2.5cm. Weak, palpable pulses. Normal surrounding tissue." An observation was conducted on 6/11/19 at 10:00AM of a wound check and dressing change of Resident #37's heel was performed by the wound care nurse and Nurse Practitioner. Resident #37 was seated in a wheelchair with her roommate directly across and facing her. The privacy curtain which separated the residents remained opened throughout the wound assessment and dressing change of her heel. Neither resident was able to state how they felt about a lack of privacy relation to their cognition. An interview was conducted with a Nursing Assistant (NA #1) on 6/11/19 at 3:35PM. She stated resident privacy and dignity was maintained by closing the door, pulling the curtain and closing the blinds during care. Also, make sure the resident was covered during care. An interview was conducted with the/Wound Care Nurse on 6/11/19 at 3:40PM. She stated for resident privacy you pulled the curtains, and closed the door and blinds. She also stated she typically completed wound care in a private area of the resident's room. She stated she cannot say why she had not ensure Resident #37's privacy during her morning wound care and assessment. She stated, "I usually make sure to pull the curtain. I don't know why I didn't this time. I guess it was just poor judgment." An interview was conducted with the Director of Nursing on 6/11/19 at 3:55PM. She stated her expectation to maintain resident privacy and dignity was to knock before entering, introduce yourself, speak to the resident about what you	F 583	THE DEFICIENT PRACTICE WILL NOT RECUR. The Director of Nursing or Designee will monitor treatments to ensure resident privacy practices are being protected. 1. Monitor two (2) treatments per week for four (4) weeks; then 2. Monitor one (1) treatment per week for four (4) weeks; then 3. Monitor one (1) treatment monthly until resolved by the Quality Assurance Committee. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or Designee will monitor treatments to ensure resident privacy practices are being protected. 1. Monitor two (2) treatments per week for four (4) weeks; then 2. Monitor one (1) treatment per week for four (4) weeks; then 3. Monitor one (1) treatment monthly until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED.	

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F 583	Continued From page 3 were about to do, and make sure the privacy curtain was pulled. She also stated she expected the staff to keep the resident informed throughout the procedure.	F 583	All training/re-education will be completed by July 8, 2019.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to complete a significant change MDS (Minimum Data Set-a tool used for resident assessment) within 14 days after a significant change for 1 of 2 residents (Resident #28) reviewed. Findings included: Resident #28 was admitted to the facility 1/15/19 and re-admitted from an acute care hospital on 4/18/19 and 5/3/19. Review of a Quarterly MDS dated 4/4/19 revealed Resident #28 was cognitively intact and had no behaviors or rejection of care. All Activities of	F 637	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. A Comprehensive Assessment after a Significant Change was completed June 14, 2019 and submitted on June 26, 2019 for Resident #28. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE.	7/8/19

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F 637	Continued From page 4 Daily Living (ADLs) required extensive assistance, except eating which was completed with supervision. Resident #28 was occasionally incontinent of urine and always incontinent of bowel and had no limb impairments. Active diagnoses included anemia, diabetes mellitus, depression, heart disease, insomnia, lobar pneumonia, myelopathy, benign prostatic hyperplasia, and muscle spasm of the back. Resident #28 had no swallowing disorder and received 25% (percent) or less of parenteral/IV (intravenous) feeding. Review of a 5 Day MDS dated 5/10/19 revealed resident #28 required extensive assistance for eating, was frequently incontinent of urine, and active diagnoses included anemia, diabetes mellitus, depression, heart disease, insomnia, lobar pneumonia, myelopathy, benign prostatic hyperplasia, and muscle spasm of the back. As well as, urinary tract infection, paroxysmal atrial fibrillation, abnormalities of gait and mobility, muscle weakness, diabetes mellitus with diabetic polyneuropathy, and dysphagia. Resident #28 was assessed as having had a swallowing disorder with coughing and/or choking with meals and medications, had a feeding tube, and received parenteral/tube feeding for 51% or more of his nutrition. A care plan dated 5/24/19 read, in part, "NPO (nothing by mouth) at this time and has a PEG (Percutaneous Endoscopic Gastrostomy-feeding) tube. Recent aspiration pneumonia-at risk for further aspiration." An interview was conducted with Resident #28 on 6/10/19 at 9:00AM. He stated he had a cervical fusion in April and that was when they inserted his	F 637	Both MDS Nurses were re-educated on Chapter 2 of the RAI Manual on completion of A Significant Change Assessment on June 26, 2019. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. The facility has implemented a system by which both MDS Nurses when doing an assessment will print the Quality Indicator Worksheet on each resident and must review each worksheet to determine if a significant change has occurred and submit a significant change assessment if required. The MDS Nurse□s will file these worksheets in a notebook divided into significant change completed assessments and regular assessments. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or her Designee will complete a Quality Assurance Worksheet on at least 10% of all regularly scheduled assessments to include the Quality Indicator Worksheets from the MDS notebook to determine that all Significant Changes were identified and submitted as follows: 1. Review 10% per week for four (4) weeks; then 2. Review 10% bi-weekly until resolved	

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F 637	Continued From page 5 feeding tube. An interview was conducted with the MDS Coordinator on 6/12/19 at 9:30AM. She stated a significant change MDS would be completed if it was established the change was not temporary. She also stated regarding Resident #28, "The feeding tube would be a significant change, and the last area (ADLs) when he came back he had a feeding tube and we were feeding him through the tube so he was an extensive assist and that was a change. He is physically able to feed himself, but wasn't giving himself tube feeding formula. When he didn't improve within the 2 week (14 day) time frame that we monitored? him we should have set a date for a significant change MDS at that point. When he came back from the hospital we didn't know how long he would have a feeding tube so we should have done a significant change MDS."	F 637	by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new monitoring system will be put into place by July 8, 2019.	
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.	F 640		7/8/19

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F 640	Continued From page 6 §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. (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: The facility failed to transmit a discharge return not anticipated Minimum Data Set (MDS) for 1 of 1 resident reviewed (Resident #1) for timeliness of MDS submission.	F 640	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.	

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F 640	Continued From page 7 Findings included: Resident # 1 was admitted to the facility 01/08/2019 with diagnoses that included atrial fibrillation, hypertension, congestive heart failure, arthritis and anxiety. An admission MDS for Resident # 1 dated 01/08/2019 revealed that resident # 1 was cognitively intact and planned to discharge to the community. A review of the MDS transmission/ submission record for Resident # 1 revealed that a discharge MDS was completed for Resident # 1 dated 01/31/2019 but the discharge MDS had not been received in the MDS data base by day 14 of MDS completion or at any time after that. On 06/12/2019 at 2:30 PM an interview was conducted with MDS nurse #1. MDS nurse # 1 revealed that she had completed the discharge MDS for Resident # 1 and had meant to include it in a submission file to be sent to the data base, but for some reason it was missed and not added to the file and had not been added to any file since that time. On 06/12/2019 at 4:23 PM an interview with the facility administrator revealed that if an MDS record was not submitted to the data base for any reason the electronic computer system used by the facility would detect the closed/ completed file and automatically send it to the data base as required.	F 640	Resident #1 Assessment was transmitted on June 21, 2019. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. Both MDS Nurses were re-educated on Chapter 5 of the RAI Manual on proper transmission of resident assessments on June 26, 2019. In addition the facility has implemented a system by which all resident assessments will be logged on the Alston Brook MDS Transmission Log/QA. This Log contains the following information: Resident name, Type assessment, ARD, PASRR Level, Wound Type, RN sign by date, CAA completed, Transmitted by and Date transmitted. In addition this Log contains a QA Check Completed by and date completed. The MDS Nurses will enter all resident assessments on this Log and must indicate when each assessment is transmitted, and by whom it was transmitted. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. The facility has implemented a system by which all resident assessments will be logged on the Alston Brook MDS Transmission Log/QA. This Log contains	

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F 640	Continued From page 8	F 640		

the following information: Resident name, Type assessment, ARD, PASRR Level, Wound Type, RN sign by date, CAA completed, Transmitted by and Date transmitted. In addition this Log contains a QA Check Completed by and date completed. The MDS Nurses will log all resident assessments on this Log and must indicate when each assessment is transmitted and by whom it was transmitted.

INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED.

The Director of Nursing or Designee will review the Alston Brook MDS Transmission Log/QA and compare the Alston Brook MDS Transmission Log with the CMS Submission Report – Final Validation Report to ensure all Resident Assessments are submitted in a timely manner and sign and date as follows:
1. Review/Compare Transmission Log one time per week for four (4) weeks; then
2. Review/Compare Transmission Log bi-weekly for four (4) weeks; then
3. Review/Compare Transmission Log monthly until resolved by the Quality Assurance Committee.

On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes.

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F 640	Continued From page 9	F 640	INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new tracking system will be put into place by July 8, 2019.	
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 record reviews, staff interviews and observations the facility failed to accurately code the Minimum Data Sets (MDSs) of 6 of 7 residents reviewed for MDS accuracy. Residents # 5, # 16, # 39, # 69 and # 76 were not coded at A 1500 with a level II PASSR (Preadmission Screening and Resident Review) on comprehensive MDSs. Resident # 19 was coded at M 0300 and M 0310 with incorrect ulcer types on the quarterly MDS dated 03/28/2019. Findings included: 1. Resident # 5 was admitted to the facility on 12/01/2018 with diagnoses that included hypertension, Bipolar disorder, atrial fibrillation, anxiety, narcolepsy and epilepsy. A review of an admission (comprehensive) MDS for Resident # 5 dated 12/07/2018 revealed that Resident # 5 was not coded at A1500 for Preadmission Screening and Resident Review (PASSR) and that Resident # 5 was not coded at A1510 Level II Preadmission Screening and	F 641	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. A correction assessment was completed June 12, 2019 and submitted on June 14, 2019 on Residents #5, #16, #39, and #69 to indicate correct Level II PASRR. A correction assessment was completed June 12, 2019 and submitted on June 26, 2019 on Residents #76 to indicate correct Level II PASRR. A correction assessment was completed and transmitted on June 14, 2019 on Resident #19 to indicate correct ulcer type. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. Both MDS Nurses were re-educated on	7/8/19

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F 641	Continued From page 10 Resident PASSR Conditions or Conditions related to ID (intellectual disability) or DD (developmental disorder) at A1550. Resident # 5 was coded as cognitively intact. An interview conducted with the facility social worker (SW) on 06/12/2019 at 11:14 AM revealed that she was responsible to update current PASSR status levels as directed by the admission coordinator (AC). The SW revealed that she did not code the MDS with PASR status and that the DS nurses completed that section of the MDS. The SW revealed that PASSR levels were updated or recorded on each resident face sheet in the medical record. The SW was not aware that there were 6 residents in the facility with Level II PASSR numbers. On 06/12/2019 at 11:35 AM an interview was conducted with the facility AC. The AC revealed that on admission, she obtained each PASSR level status for each resident which she shared with the SW and other team members in the weekday morning meetings. The AC revealed that she was responsible to enter each resident's PASSR level in the medical record and that then the information was electronically documented on the resident's face sheet of the medical record. The AC revealed that she did not communicate PASSR status with MDS nurses other than in the morning meeting and that the AC did not know how the information was recorded on MDSs. The AC revealed that the facility had only 1 resident with a Level II PASSR number and that the number was a lifetime number. The AC was not aware that the facility had 6 residents with Level II PASSR numbers. An interview conducted with MDS nurse #1 was	F 641	Chapter 3 Section A of the RAI Manual on proper coding of the PASRR and Chapter 3 Section M on proper coding of wounds. Re-education was completed on June 26, 2019. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. The facility has implemented a process where the Admissions Coordinator will maintain a Level II PASRR Log on all Level II PASRR residents within the facility. In addition the New Admissions Report has been revised to include on all new admissions the PASRR number and Level of the PASRR on all residents. The New Admissions Report is widely distributed throughout the facility by e-mail to include the MDS Nurses each time a new admission is admitted into the facility. This e-mail will notify the MDS Nurses of any new Level II PASRR entering the facility to be reported on the resident assessment. The MDS Nurses are responsible to Log and track all Level II PASRR resident assessments on the Alston Brook MDS Transmission Log/QA. The facility developed a Practitioner Weekly Wound Rounding Report to be utilized by the Treatment Nurses and Practitioner on each resident requiring wound care. This is a comprehensive current assessment and treatment tool that reflects the most current status of	

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F 641	Continued From page 11 conducted on 06/12/2019 at 2:30 PM. MDS nurse # 1 revealed the PASSR levels were discussed by the SW or the AC during the weekday morning meetings and the MDS nurses were responsible to code PASSR levels on comprehensive MDSs. MDS nurse #1 revealed that she did not review resident face sheets for PASSR status when she completed an MDS and had only looked for formal documentation form the North Carolina Department of Health and Human Services Division of Medical Assistance for PASSR Notification information. MDS nurse # 1 revealed that the facility did not share PASSR status of residents other than the morning meeting or by the form on the resident medical record. MDS nurse #1 was not aware of 6 residents in the facility with Level II PASSR numbers. On 06/12/2019 at 2:30 PM MDS nurse # 2 was interviewed and revealed that she was just learning the MDS coding process and that she did not recall that she had coded any residents with PASSR Level II status on an MDS that she completed. MDS nurse # 2 revealed that her MDSs were reviewed by a corporate nurse and that the corporate nurse did not tell MDS nurse # 2 that any PASSR Level II residents were miscoded under A 1500. Both MDS nurse # 1 and # 2 revealed that after the MDSs were approved by the corporate nurse the MDS nurses transmitted the MDSs as coded. On 06/12/2019 at 4:23 PM an interview was conducted with the facility administrator. The administrator revealed that he expected that MDSs be coded accurately and according to the Resident Assessment Instruction (RAI) manual. The facility administrator revealed that he believed that resident MDSs were not coded	F 641	each resident wound in order to accurately support MDS proper coding on resident assessment. Upon completing this report, the Treatment Nurse is responsible to place each individual report in a binder that will be made available to the MDS Nurses to ensure they have the most current information for reporting on the resident assessment. The MDS Nurses are responsible to log and track all resident wound assessments on the Alston Brook MDS Transmission Log/QA. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Administrator or his Designee will be responsible to ensure that the Admissions Coordinator is maintaining the Level II PASRR Log and utilizing the revised New Admission Report. The Administrator or his designee will review the Log and Admission Report on a regular basis as follows: 1. Review the Log and Admissions Report once a week for 4 weeks; then 2. Review the Log and Admissions Report bi-weekly for 4 weeks; then 3. Review the Log and Report Admissions monthly until resolved by the Quality Assurance Committee. The Director of Nursing or her Designee is responsible to ensure that all Level II PASRRS are properly reported on the resident assessment. The Director of Nursing or Designee will compare the	

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F 641	Continued From page 12 correctly due to poor education and training. The facility administrator revealed that he had just been made aware that the facility had 6 residents with Level II PASSR numbers. 2. Resident # 16 was readmitted to the facility on 07/25/2018 with diagnoses that included intellectual disabilities, muscle weakness, epilepsy and major depression. A review of a significant change MDS dated 01/06/2019 for Resident # 16 revealed that Resident # 16 was not coded at A1500 with Preadmission Screening and Resident Review (PASSR) and that Resident # 16 was not coded at A1510 Level II Preadmission Screening and Resident PASSR Conditions or Conditions related to ID (intellectual disability) or DD (developmental disorder) at A1550. Resident # 16 was coded as unable to participate in the cognition assessment. An interview conducted with the facility social worker (SW) on 06/12/2019 at 11:14 AM revealed that she was responsible to update current PASSR status levels as directed by the admission coordinator (AC). The SW revealed that she did not code the MDS with PASR status and that the DS nurses completed that section of the MDS. The SW revealed that PASSR levels were updated or recorded on each resident face sheet in the medical record. The SW was not aware that there were 6 residents in the facility with Level II PASSR numbers. On 06/12/2019 at 11:35 AM an interview was conducted with the facility AC. The AC revealed that on admission, she obtained each PASSR level status for each resident which she shared with the SW and other team members in the	F 641	Level II PASRR Log to the Alston Brook MDS Transmission Log/QA to ensure Level II PASRRS are reported properly as follows: 1. Review/Compare the PASRR Log and Transmission Log once a week for 4 weeks; then 2. Review/Compare the PASRR Log and Transmission Log bi-weekly for 4 weeks; then 3. Review/Compare the PASRR Log and Transmission Log monthly until resolved by the Quality Assurance Committee. The Director of Nursing or her Designee is responsible to ensure that Wounds are properly reported on the resident assessment. The Director of Nursing or Designee will compare the Practitioner Weekly Wound Rounding Reports to the Alston Brook MDS Transmission Log/QA to ensure Wounds are reported properly as follows: 1. Review/Compare the Practitioner Weekly Wound Rounding Reports and Alston Brook MDS Transmission Log/QA once a week for 4 weeks; then 2. Review/Compare the Practitioner Weekly Wound Rounding Reports and Alston Brook MDS Transmission Log/QA bi-weekly for 4 weeks; then 3. Review/Compare the Practitioner Weekly Wound Rounding Reports and Alston Brook MDS Transmission Log/QA monthly until resolved by the Quality Assurance Committee.	

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F 641	Continued From page 13 weekday morning meetings. The AC revealed that she was responsible to enter each resident's PASSR level in the medical record and that then the information was electronically documented on the resident's face sheet of the medical record. The AC revealed that she did not communicate PASSR status with MDS nurses other than in the morning meeting and that the AC did not know how the information was recorded on MDSs. The AC revealed that the facility had only 1 resident with a Level II PASSR number and that the number was a lifetime number. The AC was not aware that the facility had 6 residents with Level II PASSR numbers. An interview conducted with MDS nurse #1 was conducted on 06/12/2019 at 2:30 PM. MDS nurse # 1 revealed the PASSR levels were discussed by the SW or the AC during the weekday morning meetings and the MDS nurses were responsible to code PASSR levels on comprehensive MDSs. MDS nurse #1 revealed that she did not review resident face sheets for PASSR status when she completed an MDS and had only looked for formal documentation form the North Carolina Department of Health and Human Services Division of Medical Assistance for PASSR Notification information. MDS nurse # 1 revealed that the facility did not share PASSR status of residents other than the morning meeting or by the form on the resident medical record. MDS nurse #1 was not aware of 6 residents in the facility with Level II PASSR numbers. On 06/12/2019 at 2:30 PM MDS nurse # 2 was interviewed and revealed that she was just learning the MDS coding process and that she did not recall that she had coded any residents with PASSR Level II status on an MDS that she	F 641	On a quarterly basis the Administrator and Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new tracking system will be put into place by July 8, 2019.	

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completed. MDS nurse # 2 revealed that her MDSs were reviewed by a corporate nurse and that the corporate nurse did not tell MDS nurse # 2 that any PASSR Level II residents were miscoded under A 1500. Both MDS nurse # 1 and # 2 revealed that after the MDSs were approved by the corporate nurse the MDS nurses transmitted the MDSs as coded.

On 06/12/2019 at 4:23 PM an interview was conducted with the facility administrator. The administrator revealed that he expected that MDSs be coded accurately and according to the Resident Assessment Instruction (RAI) manual. The facility administrator revealed that he believed that resident MDSs were not coded correctly due to poor education and training. The facility administrator revealed that he had just been made aware that the facility had 6 residents with Level II PASSR numbers.

3. Resident # 39 was admitted to the facility on 09/04/2015 with diagnoses that included cerebral palsy, anxiety and depression.

A review of an MDS dated 09/04/2015 revealed that resident # 39 was cognitively intact and was coded at A1500 with no Preadmission Screening and Resident Review (PASSR). Resident # 39 was not coded at A1510 with a Level II Preadmission Screening and Resident Review (PASSR) Conditions and Resident # 39 was not coded at A 1550 with Conditions Related to ID (intellectual disability) or DD (developmental disorder).

An interview conducted with the facility social worker (SW) on 06/12/2019 at 11:14 AM revealed that she was responsible to update current

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PASSR status levels as directed by the admission coordinator (AC). The SW revealed that she did not code the MDS with PASSR status and that the DS nurses completed that section of the MDS. The SW revealed that PASSR levels were updated or recorded on each resident face sheet in the medical record. The SW was not aware that there were 6 residents in the facility with Level II PASSR numbers.

On 06/12/2019 at 11:35 AM an interview was conducted with the facility AC. The AC revealed that on admission, she obtained each PASSR level status for each resident which she shared with the SW and other team members in the weekday morning meetings. The AC revealed that she was responsible to enter each resident's PASSR level in the medical record and that then the information was electronically documented on the resident's face sheet of the medical record. The AC revealed that she did not communicate PASSR status with MDS nurses other than in the morning meeting and that the AC did not know how the information was recorded on MDSs. The AC revealed that the facility had only 1 resident with a Level II PASSR number and that the number was a lifetime number. The AC was not aware that the facility had 6 residents with Level II PASSR numbers.

An interview conducted with MDS nurse #1 was conducted on 06/12/2019 at 2:30 PM. MDS nurse # 1 revealed the PASSR levels were discussed by the SW or the AC during the weekday morning meetings and the MDS nurses were responsible to code PASSR levels on comprehensive MDSs. MDS nurse #1 revealed that she did not review resident face sheets for PASSR status when she completed an MDS and had only looked for

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formal documentation form the North Carolina Department of Health and Human Services Division of Medical Assistance for PASSR Notification information. MDS nurse # 1 revealed that the facility did not share PASSR status of residents other than the morning meeting or by the form on the resident medical record. MDS nurse #1 was not aware of 6 residents in the facility with Level II PASSR numbers.

On 06/12/2019 at 2:30 PM MDS nurse # 2 was interviewed and revealed that she was just learning the MDS coding process and that she did not recall that she had coded any residents with PASSR Level II status on an MDS that she completed. MDS nurse # 2 revealed that her MDSs were reviewed by a corporate nurse and that the corporate nurse did not tell MDS nurse # 2 that any PASSR Level II residents were miscoded under A 1500. Both MDS nurse # 1 and # 2 revealed that after the MDSs were approved by the corporate nurse the MDS nurses transmitted the MDSs as coded.

On 06/12/2019 at 4:23 PM an interview was conducted with the facility administrator. The administrator revealed that he expected that MDSs be coded accurately and according to the Resident Assessment Instruction (RAI) manual. The facility administrator revealed that he believed that resident MDSs were not coded correctly due to poor education and training. The facility administrator revealed that he had just been made aware that the facility had 6 residents with Level II PASSR numbers.

4. Resident # 69 was admitted to the facility on 04/27/2019 with diagnoses that included muscle weakness, schizophrenia and major depression.

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An MDS for Resident # 69 dated 05/14/2019 revealed that Resident # 69 had moderate cognitive impairment and was coded at A1500 with no Preadmission Screening and Resident Review (PASSR). Resident # 69 was not coded at A1510 with Level II Preadmission Screening and Resident Review (PASSR) Conditions and Resident # 69 was not coded at A 1550 with Conditions Related to ID (intellectual disability) or DD (developmental disorder).

An interview conducted with the facility social worker (SW) on 06/12/2019 at 11:14 AM revealed that she was responsible to update current PASSR status levels as directed by the admission coordinator (AC). The SW revealed that she did not code the MDS with PASR status and that the DS nurses completed that section of the MDS. The SW revealed that PASSR levels were updated or recorded on each resident face sheet in the medical record. The SW was not aware that there were 6 residents in the facility with Level II PASSR numbers.

On 06/12/2019 at 11:35 AM an interview was conducted with the facility AC. The AC revealed that on admission, she obtained each PASSR level status for each resident which she shared with the SW and other team members in the weekday morning meetings. The AC revealed that she was responsible to enter each resident's PASSR level in the medical record and that then the information was electronically documented on the resident's face sheet of the medical record. The AC revealed that she did not communicate PASSR status with MDS nurses other than in the morning meeting and that the AC did not know how the information was recorded on MDSs. The

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AC revealed that the facility had only 1 resident with a Level II PASSR number and that the number was a lifetime number. The AC was not aware that the facility had 6 residents with Level II PASSR numbers.

An interview conducted with MDS nurse #1 was conducted on 06/12/2019 at 2:30 PM. MDS nurse # 1 revealed the PASSR levels were discussed by the SW or the AC during the weekday morning meetings and the MDS nurses were responsible to code PASSR levels on comprehensive MDSs. MDS nurse #1 revealed that she did not review resident face sheets for PASSR status when she completed an MDS and had only looked for formal documentation form the North Carolina Department of Health and Human Services Division of Medical Assistance for PASSR Notification information. MDS nurse # 1 revealed that the facility did not share PASSR status of residents other than the morning meeting or by the form on the resident medical record. MDS nurse #1 was not aware of 6 residents in the facility with Level II PASSR numbers.

On 06/12/2019 at 2:30 PM MDS nurse # 2 was interviewed and revealed that she was just learning the MDS coding process and that she did not recall that she had coded any residents with PASSR Level II status on an MDS that she completed. MDS nurse # 2 revealed that her MDSs were reviewed by a corporate nurse and that the corporate nurse did not tell MDS nurse # 2 that any PASSRR Level II residents were miscoded under A 1500. Both MDS nurse # 1 and # 2 revealed that after the MDSs were approved by the corporate nurse the MDS nurses transmitted the MDSs as coded.

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On 06/12/2019 at 4:23 PM an interview was conducted with the facility administrator. The administrator revealed that he expected that MDSs be coded accurately and according to the Resident Assessment Instruction (RAI) manual. The facility administrator revealed that he believed that resident MDSs were not coded correctly due to poor education and training. The facility administrator revealed that he had just been made aware that the facility had 6 residents with Level II PASSR numbers.

5. Resident # 76 was admitted to the facility 12/30/2011 with diagnoses that included intellectual disabilities, borderline intellectual function and convulsions.

A review of an annual MDS dated 05/15/2018 revealed that Resident # 76 had severe cognitive impairment and was coded at A1500 with no Preadmission Screening and Resident Review (PASSR). Resident # 76 was not coded at A 1510 with Level II Preadmission Screening and Resident Review (PASSR) Conditions and Resident # 76 was not coded at A 1550 with Conditions Related to ID (intellectual disability) or DD (developmental disorder).

An interview conducted with the facility social worker (SW) on 06/12/2019 at 11:14 AM revealed that she was responsible to update current PASSR status levels as directed by the admission coordinator (AC). The SW revealed that she did not code the MDS with PASR status and that the DS nurses completed that section of the MDS. The SW revealed that PASSR levels were updated or recorded on each resident face sheet in the medical record. The SW was not aware that there were 6 residents in the facility with

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Level II PASSR numbers.

On 06/12/2019 at 11:35 AM an interview was conducted with the facility AC. The AC revealed that on admission, she obtained each PASSR level status for each resident which she shared with the SW and other team members in the weekday morning meetings. The AC revealed that she was responsible to enter each resident's PASSR level in the medical record and that then the information was electronically documented on the resident's face sheet of the medical record. The AC revealed that she did not communicate PASSR status with MDS nurses other than in the morning meeting and that the AC did not know how the information was recorded on MDSs. The AC revealed that the facility had only 1 resident with a Level II PASSR number and that the number was a lifetime number. The AC was not aware that the facility had 6 residents with Level II PASSR numbers.

An interview conducted with MDS nurse #1 was conducted on 06/12/2019 at 2:30 PM. MDS nurse # 1 revealed the PASSR levels were discussed by the SW or the AC during the weekday morning meetings and the MDS nurses were responsible to code PASSR levels on comprehensive MDSs. MDS nurse #1 revealed that she did not review resident face sheets for PASSR status when she completed an MDS and had only looked for formal documentation form the North Carolina Department of Health and Human Services Division of Medical Assistance for PASSR Notification information. MDS nurse # 1 revealed that the facility did not share PASSR status of residents other than the morning meeting or by the form on the resident medical record. MDS nurse #1 was not aware of 6 residents in the

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facility with Level II PASSR numbers.

On 06/12/2019 at 2:30 PM MDS nurse # 2 was interviewed and revealed that she was just learning the MDS coding process and that she did not recall that she had coded any residents with PASSR Level II status on an MDS that she completed. MDS nurse # 2 revealed that her MDSs were reviewed by a corporate nurse and that the corporate nurse did not tell MDS nurse # 2 that any PASSRR Level II residents were miscoded under A 1500. Both MDS nurse # 1 and # 2 revealed that after the MDSs were approved by the corporate nurse the MDS nurses transmitted the MDSs as coded.

On 06/12/2019 at 4:23 PM an interview was conducted with the facility administrator. The administrator revealed that he expected that MDSs be coded accurately and according to the Resident Assessment Instruction (RAI) manual. The facility administrator revealed that he believed that resident MDSs were not coded correctly due to poor education and training. The facility administrator revealed that he had just been made aware that the facility had 6 residents with Level II PASSR numbers.

6. Resident #19 was admitted to the facility on 10/3/18 with diagnoses of peripheral vascular disease, diabetes, hemiplegia, and depression.

Resident #19's most recent Minimum Data Set Assessment, a quarterly assessment dated 3/28/19, revealed she was moderately cognitively impaired and required extensive assistance with turning in bed, transferring and toileting. The assessment further revealed Resident #19 had 8 unstageable deep tissue injury wounds.

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ALSTON BROOK	4748 OLD SALISBURY ROAD LEXINGTON, NC 27295

(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 641	Continued From page 22	F 641		

A care plan dated 4/8/19 revealed Resident #19 had a deep tissue injury to her left heel, left foot, left great toe, left second toe, right great toe and right calf.

A physician note dated 3/21/19 written by the Physician revealed Resident #19 had 2 deep tissue injury wounds and 4 arterial wounds during his assessment of the wounds.

During an interview with the Wound Nurse on 6/12/19 at 10:48 am she stated Resident #19's wounds were all arterial wounds. She stated when Resident #19 had first acquired the wounds the Wound Nurse had recorded them as pressure ulcers in the Wound Assessment notes in electronic documentations system and she was not able to change the assessment of the wounds in the system. She stated they were still listed as Deep Tissue Injury Pressure Ulcers in the electronic documentation system.

On 6/13/19 at 10:02 am an interview with the Minimum Data Set (MDS) Nurse revealed the Physician had changed the assessment of Resident #19's wounds to arterial wounds on the 3/21/19 Physician's Note. The MDS Nurse stated their electronic documentation system did not allow the Wound Nurse to change the assessment of the wounds in the computer system so the MDS Nurse was not aware the assessment of the wounds had changed. The MDS Nurse stated the administrative team met weekly to discuss wounds but the MDS Nurse did not participate in the weekly meetings.

An interview with the Administrator on 6/13/19 at 11:02 am revealed his expectation was the MDS

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F 641	Continued From page 23 Nurse and the Wound Nurse would report and document patient information accurately. During an interview with the Nurse Practitioner on 6/13/19 at 11:02 am she stated Resident #19's wounds are arterial wounds. She stated Resident #19 was seen by a Vascular Surgeon and the assessment of the wounds changed. She stated the Physician had documented the change in Resident #19's wounds on the 3/21/19 progress note.	F 641		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		7/8/19

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F 732	Continued From page 24 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post current census and nursing staff data for reviewed posted staffing dated from 05/11/2019 through 06/13/2019. Findings included: On 06/10/2019 at 10:49 AM A form titled Report of Nursing Staff Directly Responsible for Resident Care dated 06/10/2019 and observed posted in the entrance lobby of the facility revealed the facility census listed for the entire date of 06/10/2019 was 93 residents. The facility administrator had confirmed on entrance to the facility that the resident census was 90. The direct care nurse staff was posted for the entire day that included licensed nurses and nurse assistants (NAs) scheduled to work on the day shift (7:00 AM- 3:00PM), evening shift (3:00 PM - 11:00PM) and the night shift (11:00Pm - 7:00 AM). The facility census number was not changed or updated during frequent observations of said form for the day (until 4:00PM). A review of the form titled Report of Nursing Staff	F 732	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. No residents were directly affected. The Staffing Coordinator and all Nurse Managers will be re-educated by July 8, 2019 as to the proper posting and maintaining daily staffing hours and proper retention of posted daily nurse staffing data for a minimum of 18 months. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. No residents were directly affected. The Staffing Coordinator and all Nurse Managers will be re-educated by July 8, 2019 as to the proper posting and maintaining daily staffing hours and proper retention of posted daily nurse	

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F 732	Continued From page 25 Directly Responsible for Resident Care dated from 05/11/2019 through 06/13/2019 revealed that the from was completed daily and that there were no changes made to reflect the exact facility resident census when there were any census changes during the 24 hour day posted and the forms did not reflect changes in the nurse staffing numbers if they were changed during the 24 hour time frame of each day. The forms reviewed revealed that nurse staff worked form 7:00AM - 7:00PM, 7:00 PM - 11:00 PM, 7:00PM - 7:00 AM or 11:00 PM - 7:00 AM on both Saturdays and Sundays. On 06/13/2019 at 9:59 AM an interview was conducted with the facility Personnel Manager (PM). The PM revealed that she was responsible for completion of the master schedule of nurse staff and that staffing numbers may have been changed if needed based on census number and resident acuity. The PM revealed that when she came to work on weekday mornings she received the current facility census number from the medical record person or the admission coordinator and that the PM placed that census number on the form titled Report of Nursing Staff Directly Responsible for Resident Care and then placed nurse staff numbers for each shift as they appeared on the master schedule. The PM revealed that she did not change the facility resident census number as the census number changed throughout the day and only posted any change in resident census on the posted form the next morning. The PM revealed that the licensed nurse weekend supervisor did the same on the weekends. The PM revealed that she was not aware that the resident census needed to be changed at the time or shift that the census changed. The PM also revealed that she did	F 732	staffing data for a minimum of 18 months. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. The facility has created a new Daily Nursing Staff Hours/Census Report which includes, facility name, current date, total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift, Registered nurses, LPN's, CNA's, and Resident census. The form is broken down into each shift. The first shift posting is the responsibility of the Staff Coordinator or designee, second and third shift posting is the responsibility of the Nurse Manager or designee. The weekend shifts posting is the responsibility of the Nurse Manager or designee. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or her Designee is responsible to ensure that the Daily Nursing Staff Hours/Census Report is posted on a daily basis and properly updated each shift. In addition, ensure proper retention of posted daily nurse staffing data for a minimum of 18 months. The Director of Nursing or her Designee	

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F 732	Continued From page 26 change the nurse staff numbers as often as she was able and that she did not save the previously posted form, she printed the staff changes and replaced the form posted in the lobby and shredded the original form. The PM was unable to verify that either she or the weekend nurse updated the form that was posted to reflect the current facility census or nurse staffing present in the facility at any time and that she was not informed that the form was required to show any changes in census or nurse staffing and that it was to be updated at any time during a 24 hour day. On 06/13/2019 at 11:22 AM an interview was conducted with the Director of Nurses (DON). The DON revealed that her expectation was that the posted staff form in the facility front lobby be updated to reflect nurse staff present and the correct facility census at any time during the day. The DON revealed the form needed to reflect these numbers in real time at any time.	F 732	will complete an Alston Brook Staffing and Census QA to ensure compliance as follows: 1. Review the Daily Nursing Staff Hours/Census Report randomly 3 days a week for 4 weeks; then 2. Review the Daily Nursing Staff Hours/Census Report randomly 3 days a week bi-weekly for 4 weeks; then 3. Review the Daily Nursing Staff Hours/Census Report randomly 5 times monthly until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. All re-education and new tracking system will be put into place by July 8, 2019.	