DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(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 1/06/18 through 1/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID QJEF11	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted from 06/24/19 through 06/27/19. There was a total of four allegations investigated and they were all unsubstantiated.	F 000		
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 staff interviews, the facility failed to complete the Minimum Data Set (MDS) related to a significant change as required within 14 days for 1 of 1 resident reviewed for Hospice (Resident #7). The findings included:	F 637	Disclaimer: We respectfully request this plan of correction be considered our allegation of substantial compliance. Preparation and/or completion of this plan of correction in general, or any corrective action set forth, herein, in particular, does not constitute an admission of agreement	7/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/22/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 637	Continued From page 1 Resident #7 was admitted to the facility on 02/08/19 with diagnoses which included dysphagia, atrial fibrillation, hypertension, squamous cell carcinoma, and chronic obstructive pulmonary disease. Review of Resident #7's physician orders revealed Resident #7 was admitted to Hospice on 03/14/19. Review of Resident #7's MDS records revealed the most recent MDS was submitted on 03/11/19. No MDS assessments were submitted after 03/11/19. The Significant Change in Status Assessment (SCSA) was not completed and submitted within 14 days after Resident #7 was admitted to Hospice on 03/14/19. During an interview conducted on 06/25/19 at 1:31 PM, the MDS Coordinator stated she was responsible for the completion and submission of Resident #7's MDS and confirmed that the last MDS submitted for Resident #7 was on 03/11/19. She acknowledged that since Resident #7 admitted to Hospice on 03/14/19, it was an error that the SCSA MDS was not in place by 03/28/19. The MDS Coordinator added that she was the only MDS coordinator who had handled all the MDS tasks with assistance from a staff member one day per week and the workload had been overwhelmingly heavy. In the past, she had been notified by nursing staff verbally regarding resident significant changes. However, she had not been notified of Resident #7's Hospice admission on 03/14/19. During an interview conducted on 06/25/19 at 2:08 PM, the Director of Nursing (DON) stated	F 637	by Mountain View Manor of the conclusions set forth in the Statement of Deficiencies (Form 2567). The Plan of Correction and specific correction action are prepared and/or executed solely as a provision of Federal and/or State law. Hospice/Sig Change TAG 1. A significant change Minimum Data Set (MDS) assessment for resident # 7 was opened by the /MDS Coordinator on 6/25/19 and completed by the Interdisciplinary Team (IDT) on 7/2/19. The assessment was transmitted by the MDS Coordinator on 07/09/2019. Resident # 7 will continue to have MDS assessments completed by the IDT and submitted by the MDS Coordinator in a timely manner per the Resident Assessment Instrument (RAI) guidelines. 2. Residents who are receiving Hospice services are at risk to be affected by the same practice. An MDS audit of residents receiving Hospice services was completed by a registered nurse on 7/2/2019. The audit verified that a significant change MDS was completed when the resident elected to receive Hospice services. No other corrective action required. The four other residents who currently receive Hospice services had a significant change completed in a timely manner when they elected to receive Hospice benefits. 3. The Director of Nursing (DON) provided education to the MDS Coordinator and the IDT on 7/2/19 on the requirement to complete a significant change MDS when a resident elects or discontinues Hospice	

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F 637	Continued From page 2 that the SCSA MDS should be in place within 2 weeks after Resident #7 had admitted to Hospice. The MDS Coordinator had been provided with assistance from several different staff in the past few months. The root cause of this incident was mainly due to lack of an effective communication to ensure MDS Coordinator being fully informed of all the changes with residents. It was her expectation for the MDS Coordinators to follow the Centers of Medicare & Medicaid Services (CMS) rules and regulations to complete MDS as required accurately and in timely manner.	F 637	services. A pre and posttest was given by the DON to the IDT team on 07/11/2019 to assess learning. Employee orientation for any new members of the IDT will include training on completing a significant change assessment when a resident elects or discontinues Hospice services. An MDS audit was completed by a registered nurse on 07/02/2019. The registered nurse verified during the audit that a significant change MDS was completed when the resident elected to receive Hospice Services. No further corrective action was required. A significant change communication form was revised on 06/26/2019 to include an option for any resident that elects to receive Hospice services. The form is completed by the licensed nursing staff as a means of communication between the licensed nursing staff and the IDT/MDS Coordinator. The licensed nurses will complete this form whenever a change in condition is noted or if the resident elects or discontinues Hospices Services. The form will be kept at the nurses' station for use on any shift. The form will be completed by the licensed nurse and given to the MDS Coordinator. If the MDS Coordinator is not available, the form may be given to the Assistant Director of Nursing (ADON) or placed in the MDS Coordinator's mailbox. Once the MDS Coordinator receives the form, the clinical record can be reviewed and the ARD for the significant change MDS can be set per RAI guidelines by the MDS Coordinator.	

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F 637	Continued From page 3	F 637	In addition to the form, the clinical team will review telephone orders in the clinical meeting. The review will include any new orders that may have been written to elect or discontinue Hospice Services. Any new telephone order related to election or discontinuance of Hospice Services will be communicated to the MDS Coordinator. If the MDS Coordinator is not available, the form may be given to the Assistant Director of Nursing (ADON) or placed in the MDS Coordinator's mailbox. The licensed nurses' education provided by the DON started on 06/26/2019 when the form was initiated. The inservice education by the DON/ADON will continue until licensed nurses have received the education. The education will be completed by 07/25/2019. A weekly audit was initiated on 7/09/2019 by the Assistant Director of Nursing to verify that any resident who elects Hospice benefits has a significant change MDS completed. The audits will continue weekly for a minimum of four weeks or until substantial compliance has been achieved. Corrective action will be taken for any identified deficient practice. 4. The DON and/or ADON will review the results of the weekly audits for any trends or patterns and report to the Quality Assurance Performance Improvement Committee. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members. The Quality Assurance Committee will review the results of the audits and direct corrective action as necessary. The	

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F 637	Continued From page 4	F 637	Quality Assurance Committee may approve changes in the frequency of the audits and/or discontinue the audits once the new system has been deemed effective to maintain substantial compliance. 5. Completion date is 07/25/2019.	
F 640 SS=E	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	F 640		7/25/19

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F 640	Continued From page 5 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: Based on record reviews and staff interviews, the facility failed to complete and transmit 1 discharge minimum data set (MDS) assessment, 2 significant change MDS assessments, and 2 annual MDS assessments to the Centers for Medicare and Medicaid Services (CMS) within the required timeframe for 5 of 5 residents reviewed for Resident Assessments (Residents #51, #2, #5, #3 and #4). Findings included: 1. Resident #51 was admitted on 1/14/19 with diagnoses including Alzheimer's Disease and dementia. Review of Resident #51 Minimum Data Set (MDS) assessment revealed the resident's last	F 640	1. MDS assessments for resident # 2, #3, #4, and #5 were completed on 07/03/2019 by the IDT. An MDS assessment was completed for resident # 51 on 07/11/2019. The assessments were transmitted on 07/11/2019 by the MDS Coordinator. Resident #2, #3, #4, #5, and # 51 will continue to have MDS assessments completed and transmitted in a timely manner per RAI guidelines. 2. All residents have the potential to be affected by the same practice. An MDS audit of current residents was completed by 7/2/2019 by a registered nurse for timeliness of completion and submission of the MDS per RAI guidelines. Corrective action will be taken for any MDS assessment that was not completed in a	

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F 640 Continued From page 6

transmitted MDS was dated 1/20/19 and coded an admission assessment. Resident #51 had a discharge assessment dated 2/9/19 that had not been completed or transmitted as of 6/26/19.

An interview with the MDS Coordinator on 6/26/19 at 12:00 PM revealed she was responsible for making sure the MDS assessments were locked and transmitted. The MDS Coordinator stated she needed more help to get the MDS assessments completed and transmitted within the required time frames. The MDS Coordinator stated she was responsible for Resident #51's discharge MDS assessment dated 2/9/19 that was not completed or transmitted timely.

An interview with the Director of Nursing on 06/27/19 at 1:23 PM revealed the full time MDS Coordinator was responsible for completing and transmitting the MDS assessments in a timely manner to be in compliance with the required time frames. The Director of Nursing stated the MDS Coordinator had help from Nurse #1, who worked one 8 hour day per week to complete 5 to 6 quarterly assessments and Nurse #2 worked 4 to 5 hours a couple afternoons per week to help complete the MDS assessments.

2. Resident #2 was admitted on 1/5/19 with diagnoses including a hip fracture and dementia.

Review of Resident #2's last transmitted Minimum Data Set (MDS) assessment was dated 1/22/19 and coded an admission assessment. Resident #2 had a significant change assessment dated 4/18/19 that had not been completed or transmitted as of 6/26/19.

F 640

timely manner.
3. The Director of Nursing provided education to the MDS Coordinator and the IDT on 07/02/2019 on timely completion and submission of the MDS per RAI guidelines. A pre and posttest was given by the DON to the MDS Coordinator on 07/11/2019 to assess learning.
Employee orientation will include education by a registered nurse on accurate coding of Section M of the MDS for new MDS Coordinators.
An MDS audit was completed by a registered nurse on 07/02/2019. The audit consisted on reviewing current residents for timely completion of the MDS schedule per RAI guidelines. Corrective action will be taken for any resident identified to have an MDS assessment not completed timely.
The MDS Coordinator will give the DON and/or ADON an MDS schedule at the beginning of the week and update the DON and/or ADON at the end of the week as to what assessments have been completed and transmitted. The DON and/or ADON may use the schedule as a reference tool when checking the software for completion and submission of the MDS. This process was initiated on 07/09/2019.
A weekly MDS audit will be completed by a registered nurse to verify that the MDS schedule has been completed timely per RAI guidelines and that the MDS assessments were transmitted. The weekly audits were initiated on 07/09/2019 and will continue weekly for a minimum of four weeks or until substantial compliance

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F 640	Continued From page 7 An interview with the MDS Coordinator on 6/26/19 at 12:00 PM revealed was responsible for making sure the assessments were locked and transmitted. The MDS Coordinator stated she needed more help to get the MDS assessments completed and transmitted within the required time frames. The MDS Coordinator stated she was responsible for Resident #2's significant change MDS assessment dated 4/18/19 that was not completed or transmitted time. An interview with the Director of Nursing on 06/27/19 at 1:23 PM revealed the full time MDS Coordinator was responsible for completing and transmitting the MDS assessments in a timely manner to be in compliance with the required time frames. The Director of Nursing stated the MDS Coordinator had help from Nurse #1, who worked one 8 hour day per week to complete 5 to 6 quarterly assessments and Nurse #2 worked 4 to 5 hours a couple afternoons per week to help complete the MDS assessments. 3. Resident #5 was admitted on 6/27/14 with diagnoses including atrial fibrillation, heart failure, anxiety and depression. Review of Resident #5's last transmitted Minimum Data Set (MDS) assessment was dated 2/12/19 and coded as a quarterly assessment. Resident #5 had an annual assessment dated 5/15/19 that had not been completed or transmitted as of 6/26/19. An interview with the MDS Coordinator on 6/26/19 at 12:00 PM revealed she was responsible for making sure the assessments were locked and transmitted. The MDS Coordinator stated she needed more help to get	F 640	has been achieved. Corrective action will be taken for any identified deficient practice. 4. The DON and/or ADON will review the results of the weekly audits for any trends or patterns and report to the Quality Assurance Performance Improvement Committee. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members. The Quality Assurance Committee will review the results of the audits and direct corrective action as necessary. The Quality Assurance Committee may approve changes in the frequency of the audits and/or discontinue the audits once the new system has been deemed effective to maintain substantial compliance. 5. Completion date is 07/25/2019.	

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the MDS assessments completed and transmitted within the required time frames. The MDS Coordinator stated she was responsible for Resident #5's annual MDS assessment dated 5/15/19 that was not completed or transmitted timely.

An interview with the Director of Nursing on 06/27/19 at 1:23 PM revealed the full time MDS Coordinator was responsible for completing and transmitting the MDS assessments in a timely manner to be in compliance with the required time frames. The Director of Nursing stated the MDS Coordinator had help from Nurse #1, who worked one 8 hour day per week to complete 5 to 6 quarterly assessments and Nurse #2 worked 4 to 5 hours a couple afternoons per week to help complete the MDS assessments.

4. Resident #3 was admitted 11/17/18 with diagnoses including heart failure, hypertension, diabetes, and malnutrition.

Review of Resident #3's last transmitted Minimum Data Set (MDS) assessment was dated 2/14/19 and coded a discharge assessment. Resident #3 had a significant change assessment dated 5/1/19 that had not been completed or transmitted as of 6/26/19.

An interview with the MDS Coordinator on 6/26/19 at 12:00 PM revealed she was responsible for making sure the assessments were locked and transmitted. The MDS Coordinator stated she needed more help to get the MDS assessments completed and transmitted within the required time frames. The MDS Coordinator stated she was responsible for Resident #3's significant change MDS

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assessment dated 5/1/19 that was not completed or transmitted timely.

An interview with the Director of Nursing on 06/27/19 at 1:23 PM revealed the full time MDS Coordinator was responsible for completing and transmitting the MDS assessments in a timely manner to be in compliance with the required time frames. The Director of Nursing stated the MDS Coordinator had help from Nurse #1, who worked one 8 hour day per week to complete 5 to 6 quarterly assessments and Nurse #2 worked 4 to 5 hours a couple afternoons per week to help complete the MDS assessments.

5. Resident #4 was admitted 5/26/17 with diagnoses including Alzheimer's disease, dementia, anxiety and depression.

Review of Resident #4's last transmitted Minimum Data Set (MDS) assessment was dated 2/11/19 and coded as a quarterly assessment. Resident #4 had an annual assessment dated 5/14/19 that had not been completed or transmitted as of 6/26/19.

An interview with the MDS Coordinator on 6/26/19 at 12:00 PM revealed she was responsible for making sure the assessments were locked and transmitted. The MDS Coordinator stated she needs more help to get the MDS assessments completed and transmitted within the required time frames. The MDS Coordinator stated she was responsible for Resident #4's annual MDS assessment dated 5/14/19 that was not completed or transmitted timely.

An interview with the Director of Nursing on

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F 640	Continued From page 10 06/27/19 at 1:23 PM revealed the full time MDS Coordinator was responsible for completing and transmitting the MDS assessments in a timely manner to be in compliance with the required time frames. The Director of Nursing stated the MDS Coordinator had help from Nurse #1, who worked one 8 hour day per week to complete 5 to 6 quarterly assessments and Nurse #2 worked 4 to 5 hours a couple afternoons per week to help complete the MDS assessments.	F 640		
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 interview the facility failed to accurately code the Minimum Data Set (MDS) in Section J for pressure ulcers on 3 consecutive MDS assessments for 1 of 1 resident reviewed for pressure ulcers (Resident #91). Resident #91 was admitted to the facility 01/12/2015 with an admitting diagnosis of Alzheimer's Dementia. Review of a doctor's order dated 10/30/2018 revealed an order to apply skin protectant ointment topically to buttocks every shift for preventive measures. Review of a doctor's order dated 12/05/2018 revealed an order to apply a paste on gauze strips to excoriated and open areas on the buttock/sacral area every shift, and to change	F 641	1. A modification Minimum Data Set (MDS) assessment for resident # 91 was completed on 7/16/19 to include wounds by the MDS Coordinator. The modified assessment was transmitted by the MDS Coordinator on 07/16/2019. Resident # 91 was discharged from the facility on 01/23/2019 and no further corrective action may be taken. 2. Residents who have wounds are at risk to be affected by the same practice. An MDS audit of residents with wounds was completed on 7/2/19 by a registered nurse. Corrective action will be taken by a registered nurse for any MDS assessment that is not coded correctly related to the presence of wounds. 3. The Director of Nursing provided education to the MDS Coordinator and the IDT on 7/2/19 on coding of Section M	7/25/19

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(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 11
after peri-care when soiled.

Review of the Treatment Record revealed Resident #91 was being treated for pressure related skin breakdown. His most recent treatment was started on 12/05/2018 for one Stage 2 pressure ulcer on the sacrum measuring 0.5cm (centimeters) wide x 2.5 cm length x 0.1 cm deep

Review of the discharge MDS dated 12/06/2018 revealed Resident #91 anticipated a return to the facility and was coded in Section J that he had no unhealed pressure ulcers.

Review of the admission MDS dated 12/13/2018 revealed in Section J that Resident #91's skin had no unhealed pressure ulcers.

Review of the discharge MDS dated 01/23/2019 revealed in Section J that Resident #91's skin had no unhealed pressure ulcers.

Review of a Care Plan dated 12/07/2018 revealed Resident #91 was to be on a turn and reposition program effective 05/01/2015 and updated each quarter due to risk for pressure related skin breakdown. The goal was to have no pressure related skin breakdown for 90 days. The approaches/interventions included: 1. Provide pressure relieving cushion for the wheelchair and bed as needed. 2. Turn at least every 2 hours. 3. Initial log sheet to verify that turning and repositioning was performed for their shift. 4. Check for incontinence every 2 hours and change if wet/soiled. 5. Staff will cleanse and dry well after each incontinent episode and apply barrier cream as needed. 6. The licensed nurses will monitor for risks monthly on the pressure sore

F 641

related to the presence of wounds. A pre and posttest was given by the DON to the MDS Coordinator on 07/11/2019 to assess learning.
Employee orientation will include education by a registered nurse on accurate coding of Section M of the MDS for new MDS Coordinators.
An MDS audit related to wounds was completed by the registered nurse comparing the wound report and the clinical record for the past 60 days to MDS assessments completed during that time period. Corrective action was taken for any assessments that did not include the correct coding in Section M related to the presence of wounds.
The MDS Coordinator will be given a wound report each week by a registered nurse who completes the wound report as a reference to compare to the clinical record when coding section M on the MDS. The wound nurse and/or other registered nurse completing the wound report received education by the DON on 07/11/2019. The process where the MDS Coordinator receives a weekly wound report started on 07/18/2019.
A weekly MDS audit will be completed by a registered nurse to compare the wound report, the clinical record, and MDS assessments completed in that time period. The weekly audits were initiated on 07/18/2019. The audits will continue weekly for a minimum of four weeks or until substantial compliance has been achieved per the QA committee.
Corrective action will be taken for any identified deficient practice.

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	345193	A. BUILDING ______ B. WING ______	C 06/27/2019

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F 641	Continued From page 12 risk assessment. An interview with the MDS Coordinator on 06/27/2019 at 2:01 PM revealed she had not coded pressure ulcers in the J section on the last 3 MDS assessments for Resident #91 that had been transmitted as complete. She revealed she did weekly chart audits and obtained her information for input to the MDS assessment and did not know how she had missed coding the pressure ulcers for Resident #91. She stated that she would start the correction process and re-submit the assessments. An interview with the Director of Nursing on 06/26/019 at 2:30 PM revealed she was not aware the MDS Coordinator was not coding pressure ulcers in Section J of the assessments for Resident #91 correctly. She further revealed that the MDS Coordinator had been doing the MDS assessments for the last 3 years, and it was her expectation that the MDS should have been coded properly. An interview with the Administrator on 06/27/2019 at 2:59 PM revealed that it was his expectation that all the MDS assessments should be coded accurately. He stated the Quality Assessment and Assurance interventions that were put in place after the recertification and complaint survey of 06/29/2018 were being monitored to ensure accuracy of assessments and did not know how this got past the QAPI meetings when it was supposed to be monitored, most likely a system failure for monitoring the plan of corrections.	F 641	4. The DON and/or ADON will review the results of the weekly audits for any trends or patterns and report to the Quality Assurance Performance Improvement Committee. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members. The Quality Assurance Committee will review the results of the audits and direct corrective action as necessary. The Quality Assurance Committee may approve changes in the frequency of the audits and/or discontinue the audits once the new system has been deemed effective to maintain substantial compliance. 5. Completion date is 07/25/2019.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		7/25/19

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F 867	Continued From page 13 §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 interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the recertification survey of 06/29/18. This was for one deficiency that was originally cited in May 2018 and was subsequently recited on the current recertification of 06/27/2019. The repeated deficiency was in the area of Accuracy of 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. The findings included: This tag is cross referenced to: 1. F-641: Accuracy of Assessments. Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) in Section J for pressure ulcers on 3 consecutive MDS assessments for 1 of 1 resident reviewed for pressure ulcers. During the recertification and complaint survey of 06/29/18 the facility failed to accurately code Minimum Data Sets for 2 of 5 residents reviewed for unnecessary medications and 1 of 1 resident	F 867	1. A significant change Minimum Data Set (MDS) assessment for resident # 7 was opened by the MDS Coordinator on 6/25/19 and completed by the Interdisciplinary Team (IDT) on7/2/19. Resident # 7 will continue to have MDS assessments completed by the IDT and submitted by a registered nurse in a timely manner per the Resident Assessment Instrument (RAI) guidelines. A modification Minimum Data Set (MDS) assessment for resident # 91 was completed on 07/16/2019 to include wounds by the MDS Coordinator. Resident # 91 was discharged from the facility on 01/23/2019 and no further corrective action may be taken. MDS assessments for resident # 2, #3, #4, and #5 were completed on 07/03/2019 by the IDT. An MDS assessment was completed for resident # 51 on 07/11/2019. The assessments were transmitted on 07/11/2019 by a registered nurse. Resident #2, #3, #4, #5, and # 51 will continue to have MDS assessments completed and transmitted per RAI guidelines. 2. All residents have the potential to be affected by the same practice. An MDS audit of current residents was completed	

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F 867	Continued From page 14 reviewed for use of a urinary catheter. An interview with the Administrator on 06/27/2019 at 02:59 PM revealed that it was his expectation that all the MDS assessments were being coded accurately. He further revealed that the QAA committee failed to monitor the MDS assessments per the interventions that were put in place from the last recertification and complaint survey from 06/29/2018.	F 867	by 07/02/2019 by a registered nurse for timely encoding and transmission of the MDS. An MDS audit was completed by a registered nurse on 07/02/2019 on the current residents receiving Hospice and if a significant change was completed after the resident elected Hospice benefits. An MDS audit for the past 60 days of residents with wounds was completed on 07/02/2019 by a registered nurse reviewing MDS coding related to wounds. Corrective action will be taken for any MDS assessment that was not completed or submitted in a timely manner. 3. The Administrator provided education to the QA team on 07/18/2019. A pre and posttest was given to assess learning. New members that are added to the QA team will have education provided by the Administrator or DON during their orientation period. MDS Assessments will be audited for timely completion/submission and accuracy of Section M by a registered nurse beginning on 07/02/2019 and continuing through 07/25/2019. Audits will transition to be completed on a monthly basis at that time for a minimum of 3 months or until the QA committee deemed that substantial compliance for accuracy and timely completion/submission. Corrective action will be taken for any MDS assessment that was not completed/submitted in a timely manner or for coding inaccuracies. 4. The DON and/or ADON will review the results of the weekly audits for any trends or patterns and report to the Quality Assurance Performance Improvement	

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F 867	Continued From page 15	F 867	Committee. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members. The Quality Assurance Committee will review the results of the audits and direct corrective action as necessary. The Quality Assurance Committee may approve changes in the frequency of the audits and/or discontinue the audits once the new system has been deemed effective to maintain substantial compliance. 5. Completion date is 07/25/2019.	