

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345490	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 8/14/2014
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NAME OF PROVIDER OR SUPPLIER AYDEN COURT NURSING AND REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 128 SNOW HILL ROAD AYDEN, NC
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to document accurate information in Minimum Data Set (MDS) assessments for 2 of 16 sample residents (Resident #91 and #104) whose MDS assessments were reviewed. Findings included:</p> <ol style="list-style-type: none"> 1. Resident #91 was admitted to the facility on 02/13/14. The resident's documented diagnoses included end stage renal disease with dialysis, diabetes, and dementia. <p>The resident's 02/20/14 Admission Minimum Data Set (MDS) documented the resident's cognition was moderately impaired, and she was always incontinent of bowel and bladder.</p> <p>The resident's 05/23/14 Quarterly MDS documented the resident's cognition was severely impaired, and she was always incontinent of bowel and bladder.</p> <p>The resident's 08/08/14 Quarterly MDS documented the resident's cognition was moderately impaired, and she was always continent of bowel and bladder.</p> <p>At 10:00 AM on 08/14/14 Nurse #3 stated Resident #91 had always been incontinent of bowel and bladder. She reported this was the main reason the resident just received a new roommate since this continent roommate had an infection in her urine which required that she be paired with a resident who did not get up</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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F 278	<p>Continued From Page 1 and go to the bathroom.</p> <p>At 11:26 AM on 08/14/14 nursing assistant (NA) #6 stated Resident #91 was incontinent of bowel and bladder since admission.</p> <p>At 2:57 PM on 08/14/14 the MDS Coordinator stated the coding for bowel and bladder continence/incontinence on MDS assessments was obtained by interviewing direct care staff. She reported Resident #91 was always incontinent of bowel and bladder. The coordinator commented the resident's 08/08/14 Quarterly MDS contained a data entry error related to the resident's level of bowel and bladder incontinence.</p> <p>2. Resident #104 was admitted to the facility on 04/16/14, and was discharged on 05/06/14. The resident's documented diagnoses included femur fracture, osteoarthritis, and muscle weakness.</p> <p>A 04/23/14 social work progress note documented, "Family states short term for rehab and return to _____ (name of assisted living facility).</p> <p>A 5/06/14 physician order documented Resident #104 was to be discharged to an assisted living facility with home health, therapy services, and a wheelchair.</p> <p>A Discharge Summary documented Resident #104 was discharged to an assisted living facility on 05/06/14.</p> <p>The resident's 05/06/14 Discharge Minimum Data Set (MDS) documented his discharge location was an acute care hospital.</p> <p>At 2:57 PM on 08/14/14 the MDS Coordinator stated discharge locations to be documented on MDS assessments were determined by reviewing the Discharge Summaries and by listening to information presented in daily Medicare meetings. She reported that there was a data entry error on Resident #104's Discharge MDS. She explained documentation revealed the resident was discharged back to an assisted living facility, and did not get discharged to an acute care hospital.</p>
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