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	345262	A. BUILDING _____ B. WING _____	C 09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HE	**1300 DON JUAN ROAD HERTFORD, NC 27944**

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID F02X11.	F 000		
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to	F 159		10/1/15

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

Electronically Signed | 09/25/2015

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F 159	Continued From page 1 the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and review of records, the facility failed to give 1 of 3 sampled residents (Resident #61), reviewed for personal funds, unlimited and free access to his personal funds as desired. Findings included: The Facility's Business Office Requirements, undated, indicated under Management of Personal funds that residents were able to access amounts over $50.00 within a reasonable amount of time (3 days). The requirement form also indicated residents could access amounts that were less than $50.00 within the same day. Resident #61 was admitted on 12/20/13. His most recent Minimum Data Set, a quarterly dated 7/16/15, indicated Resident #61 was cognitively intact. During a resident interview on 8/31/15 at 2:46 PM, Resident #61 stated he had a resident trust account with the facility. He added he was	F 159	Resident #61 was provided with re-education on 9/4/15 regarding facility policy related to management of resident personal funds to include accessing of money by the Administrator. The education included that he could have up to fifty dollars cash when requested but any amount greater than fifty dollars required a check which would be taken to the bank and cashed for him within three business days of the request. Resident #61 stated he did not need any funds on 9/4/15 but was pleased to know the facility policy for future needs. Facility residents and/or responsible parties were educated by the Social Worker and Activity Director regarding the Resident Trust Policy and how to access their funds. This education was completed on 9/24/15. The facility Administrator will conduct two interviews per week with interviewable facility residents times four weeks then two interviews per month	

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F 159	Continued From page 2 unable to get more than $30.00 at a time. The resident stated a few months back, he had requested a larger sum of money and was told he would have to tell staff why he wanted the larger sum of money. Resident #61 stated he was grown and it was his money and he should not have to explain why he wanted his money. Resident #61 stated finally the staff (name unknown) told him they would give him a check; adding with his physical limitations, a check would do no good since he had no way to get the check cashed. The Business Office Manager (BOM) was interviewed on 9/2/15 at 4:00 PM. She acknowledged Resident #61 had a resident trust account with a balance of over $500.00. The BOM stated while she kept up with account balances, the Social Worker (SW) kept the petty cash box and was responsible for giving requested funds to residents and getting the residents to sign receipts. The BOM added that residents were limited to withdrawing $30.00 per day from their trust accounts. The BOM stated she remembered Resident #61 requesting more than $30.00 a few months ago. She added the resident was not given the requested amount of money because she was told by her trainer that residents were not allowed to receive more than $30.00 per day. The BOM stated Resident #61 had requested a large sum of money, more than the $300.00 that was kept in the petty cash box. She added she did not agree with limiting the amount of money a resident received at one time, but she did as she had been instructed. The BOM was interviewed on 9/3/15 on 8:00 AM. The BOM presented and reviewed a copy of the facility policy on dispersing monies held in	F 159	times two months to ensure residents have access to their funds per the facility policy. The interviews will be documented on an interview form. Any violation of this policy reported will require re-education to the appropriate staff member by the Administrator. Members of the Interdisciplinary Team consisting of the Director of Nursing, Assistant Director of Nursing, Social Worker, Business Office Manager, Activity Director and Dietary Manager were provided re-education regarding the policy on Accessing and Managing Resident's Trust on 9/10/15 by the Administrator. The Administrator will report the findings of the weekly audits to the Quality Assurance Performance Committee consisting of the Administrator, Director of Nursing, Social Worker, Activity Director and Medical Director monthly times four months. The Quality Assurance Performance Committee will review and analyze for patterns and trends. The Committee will evaluate the results and implement additional interventions as needed.	

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F 159	Continued From page 3	F 159		

resident trust accounts. She stated prior to reading the policy today, she had not known the policy indicated residents could receive $50.00 in a business day if requested. The BOM again stated prior to reading the policy, she had been instructed to only give $30.00 per day because there was only $300 kept in the petty cash box. She added yesterday, she was told by a corporate representative that residents could receive $50.00 per day. The BOM stated when Resident #61 went to the SW to ask for the money and then the SW came to her, but she had not given the resident the requested money and had not written him a check for the requested money because she had not read the policy and had no idea she could give a resident a check for more than $50.00 if requested.

The SW was interviewed on 9/3/15 at 8:50 AM. The SW stated she was the one that was responsible for dispersing resident trust funds from the petty cash box. She stated if more than $300.00 was requested at one time, she would take the request to the BOM to get authorization and get a check for the resident. The Activity Director (AD) then was responsible for getting the check cashed. The SW stated she had been told not to give residents over $30.00 per day by the Business Office Manager. Any time the resident received over $30.00 per day, it had to be cleared by the BOM. The SW stated she remembered Resident #61 wanted to get a phone off the internet or a credit card so he could buy the phone online. The AD looked for a credit card, but could not find one, so the issue was returned to the SW. The SW stated she was unaware of the facility policy that indicated residents could get up to $50.00 in one business day. She stated she had received 2 days of training and no one

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F 159	Continued From page 4 had shared the policy with her. On 9/3/15 at 10:00 AM, Resident #61 was interviewed. He stated he was unaware anyone from the facility would cash a check for him.	F 159		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to honor residents' preference for showers for 2 of 3 residents (residents #45 and 53) reviewed for choices. #1. Resident #45 was admitted to the facility on 8/12/2010, with diagnoses to include hypertension, chronic obstructive pulmonary disease (COPD), and glaucoma. Her most recent Minimum Data Set (MDS) assessment dated 7/26/2015 revealed her cognition was intact and she required supervision for activities of daily living (ADL). Her decisions to decide what type of bath she chose was very important. The resident's Care Plan for individual preferences was last reviewed on 7/27/2015. The care plan indicated the resident had a specific preference for showers.	F 242	F 242 Residents #45 and #53 were interviewed by the facility Director of Nursing on 9/7/15 to determine preferences related to the type of bath and frequency preferred. Residents #45 and #53 kardexes were updated to reflect showers as their preference for bathing on 9/17/15 by the Director of Nursing. The Director of Nursing and Administrator interviewed the facility residents and/or their responsible parties to determine bathing preferences and frequency preferred on 9/17/15. Each facility resident's kardex will be updated to reflect the resident's choice and completed on 9/16/15 by the Director of Nursing. Newly	10/1/15

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F 242	Continued From page 5 The ADL detail report for bathing was reviewed from 7/1/2015 thru 9/1/2015. There were no showers or refusals of shower documented for that time. On 8/31/2015 at 12:03 PM, an interview was conducted with the resident, who stated she preferred to take a shower. She indicated that at one time she was getting a shower twice a week, but that had stopped and she didn't know why. A review of nursing notes in Resident #45's medical record revealed no indication of resident refusing showers. An interview was conducted with the resident on 9/2/2015 at 8:27 AM. The resident stated she had gotten a shower that morning. She indicated she liked to get a shower, but hadn't had one for a while. She had not known why they showers were stopped. On 9/2/2015 at 2:12 PM, an interview was conducted with the nursing assistant (NA #3). The NA stated the resident was alert, oriented, and an early riser. Therefore the night shift set up her bath for her and she was mostly independent with taking her bath. On 9/2/2015 at 2:50 PM, an interview was conducted with NA #1, who stated the resident took a bath herself, and the 11PM to 7 AM shift would help her with that because she was an early riser. On 9/2/2015 at 4:29 PM, and interview was conducted with the resident who stated she hoped they didn't stop the showers again, because she liked to have one. She indicated 2 showers a week were fine with her, and she could give herself a bath the other days. An interview was conducted with the nurse #1, on 9/3/2015 at 10:12 AM. The nurse stated the staff set up the bath for the resident, who was alert and oriented, and she took her own bath.	F 242	admitted residents will be interviewed to ensure that bathing preferences are captured and entered onto the kardex. All new admitted residents will be asked their bathing preference on admission by the Admission Coordinator or Social Worker then the preference documented on the kardex and the posted preference list. Resident Care Specialists will enter into the electronic medical record daily what type of bath each resident received based on the resident's preference. Any refusals will be reported to the charge nurse and documented in the electronic medical record or in the nurse's notes. The facility direct care staff (Licensed Nurses and Resident Care Specialists)and Social Worker received re-education regarding resident's preferences including honoring resident's choice related to showers, tub baths or bed baths on 9/7/15 and completed on 9/15/15 by the Director of Nursing. Newly hired direct care staff (Licensed Nurses and Resident Care Specialists)will receive the education regarding resident bathing preferences and right to choice during orientation. The facility Director of Nursing or Administrator will complete two resident or family interviews to ensure that bathing preferences are being honored weekly times four weeks then monthly times two months. The resident and family interviews will be documented on a resident interview form. Resident	

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F 242	Continued From page 6 She indicated she didn't know the resident liked a shower. On 9/3/2015 at 10:54 AM, an interview was conducted with the Director or Nursing (DON). The DON stated the treatment nurse and the social worker were responsible for asking residents about their preferences and placing the information on the Kardex to inform the staff caring for them. She indicated the residents should still get a shower even on night shift if they are an early riser. She stated the only reason a scheduled shower would be missed is if the resident refused and then the refusal should be documented. She indicated she didn't know the resident had not had a shower for the last 2 months. #2. Resident #53 was admitted on 11/30/11 with diagnoses that included hypertension, stroke with hemiparesis and arthritis. An annual Minimum Data Set (MDS), dated 7/4/15, indicated Resident #53 was alert and oriented with no behaviors or rejection of care recorded. The resident was identified as requiring extensive assistance with personal hygiene and as totally dependent for bathing. The MDS also identified that it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. The resident's care plan, last reviewed on 7/23/15, indicated Resident #53 required the assistance of staff to complete her activities of daily living. The care plan also indicated Resident #53 chose to be highly involved in her daily care decisions regarding suggested or recommended interventions and has specific	F 242	preferences will be updated by the Administrator or Director of Nursing as changes occur (new admissions/discharges and preference changes)and posted for all licensed staff/resident care specialist to review daily. The facility Director of Nursing will report findings of the audits to the Quality Assurance Committee (consisting of the Administrator, Director of Nursing, Social Worker, Activity Director and Medical Director) monthly. The Quality Assurance Committee will review and analyze for patterns and trends. The Committee will review and evaluate the results and implement additional interventions as needed.	

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F 242	Continued From page 7	F 242		

preferences, which included a preference for showers.

Review of the Resident Care Specialist Assignment Sheet indicated Resident #53 was scheduled to receive showers on Monday and Thursday during the 7:00 AM to 3:00 PM shift.

Review of the Activity of Daily Living Detail Report for 7/1/15 through 9/2/15, indicated the resident had received 1 shower during that time period. There were no refusals of care documented. A review of nurse's notes from 7/1/15 through 9/2/15 failed to reveal documentation that indicated Resident #53 had refused her showers.

On 8/31/15 at 3:24 PM, Resident #53 was interviewed. She stated she enjoyed showers, but was unable to remember the last time she received a shower. Resident #53 added she was sure it was well over a month ago. The resident added she had spoken to several staff members, but a request for a shower had not been honored.

An interview was held with the resident on 9/2/15 at 9:09 AM. She stated she was not asked if she wanted a shower on the past Monday. The resident stated the Resident Care Specialist (RCS) that was working with her today was the same one that had worked with her on Monday.

RCS #5 was interviewed on 9/2/15 at 9:19 AM. The RCS stated resident shower schedules were listed on the Kardex (a form that gives direction for resident care by the RCS). She added that while there were 2 RCSs giving showers today, it was usually the responsibility of the RCS assigned to the resident. The RCS stated Resident #53 had not refused showers. She

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F 242	Continued From page 8 reviewed the assignment sheet and added Resident #53 received showers on Monday and Thursday. RCS #5 stated she had not asked Resident #53 if she wanted a shower on Monday. The RCS added she did not ask Resident #53 because the 11:00 PM to 7 AM shift had already given her a bath and dressed the resident. RCS #5 stated it had been at least 4 weeks since she had offered to shower Resident #53. She added she had not reported to anyone she had not offered Resident #53 a shower although Resident #53's shower was scheduled for the 7:00 AM to 3:00 PM RCS to complete. . An interview with the Director of Nursing (DON) on 9/2/15 at 10:32 AM. She stated she, the treatment nurse and the social worker (SW) were responsible for asking residents about bath preference and placing the information on the Kardex for the RCS. The DON added the RCS was expected to report a shower/bath refusal to the nurse and document the refusal in the care tracker. The DON added the only reason a shower should be missed was if the resident refused. The DON stated she expected residents to be offered showers on their scheduled shower day. She stated Resident #53 was alert and oriented. The DON added she was unaware Resident #53 had only received one shower since 7/1/15. She added Resident #53 was alert and oriented. Nurse #3 was interviewed on 9/2/15 at 10:40 AM. She stated she had received no reports the Resident #53 had refused her showers. The nurse added she was unsure why the resident had not received showers as desired.	F 242		
F 278	483.20(g) - (j) ASSESSMENT	F 278		10/1/15

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F 278 SS=E	Continued From page 9 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 5 of 15 residents who had been reviewed (#73, #22, #45, #14 and #69). Findings included: 1. Resident #73 had been admitted to the facility	F 278	F 278 Minimum Data Set 3.0 assessment modifications were completed and submitted by the Resident Care Management Director (RCMD) on 9/21/15	

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F 278	Continued From page 10 on 5/04/2015. Diagnoses included: congestive heart failure, cerebral vascular accident (CVA), cardiomyopathy, atrial fibrillation, difficulty walking, muscle weakness, hyperlipidemia, hypertension, depression and gastro esophageal reflux disease. The nurse's notes dated 5/05/2015 and 5/09/2015 indicated Resident #73 had urinary incontinence. The Nurse Aide (NA) documentation dated 5/05/2015 to 5/11/2015 indicated Resident #73 had been continent of urine. The May 2015 Medication Administration Record (MAR) indicated Resident #73 had received antipsychotic, antianxiety, antidepressant, anticoagulant and diuretic medications. Resident #73's Admission MDS dated 5/11/2015 indicated the resident was continent of urine, had received antipsychotic, antianxiety and antidepressant medications, but did not indicate anticoagulant or diuretic medication use. The urinary incontinence Care Area Assessment (CAA) dated 5/11/2015 indicated Resident #73 had functional incontinence related to the inability to get to the toilet in time due to physical disability, external obstacles and problems thinking or communicating. Resident #73's care plan dated 5/17/2015 indicated Resident #73 required assistance related to incontinence. The care plan goal indicated Resident #73 would have incontinence episodes managed without signs and symptoms of potential complications, and would have dignity maintained with incontinence care. An interview with nurse aide (NA) #4 on 9/01/2015 at 12:30 PM was conducted. The NA indicated Resident #73 had rare episodes of	F 278	for residents #73 (Assessment Reference Date 5/11/15 Section N/Medications), #22 (Assessment Reference Date 5/14/15 Section H/Incontinence), #45 (Assessment Reference Date 7/26/15 Section I/Diagnosis), and #69 (Assessment Reference Date 7/31/15 Section E/Behaviors). Resident #14's assessment (Assessment Reference Date 7/27/15 Section B/Vision) is coded correctly in that she did not apply her glasses for the vision assessment interview so it was not modified. A significant change assessment was done by the RCMD with an Assessment Reference Date of 9/8/15. Resident #14 did wear her glasses for the resident assessment interview, Section B, and the MDS reflects her visual status wearing glasses. The Resident Care Management Director (RCMD)will utilize a Minimum Data Set audit tool to audit the last sixty days of assessments completed for current residents to identify any coding errors with special focus on Section B/Vision, Section H/Incontinence, Section I/Diagnosis, Section N/Medications and Section E/Behaviors to be completed by 9/25/15. Identified errors will be corrected with modifications submitted by 9/30/15. The facility MDS nurses and Social Worker were re-educated on 9/25/15 by the Administrator on how to accurately code and interview residents to complete the MDS per the RAI Manual with special focus on Section B/Vision, Section	

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F 278	Continued From page 11 urinary incontinence. An interview with nurse #2 on 9/03/2015 at 11:24 AM was conducted. The nurse indicated Resident #73 had occasional urinary incontinence episodes. The nurse also indicated she had cared for Resident #73 since his admission and had not observed any changes in his toileting habits. An interview with MDS nurse #1 on 9/3/2015 at 12:00 noon was conducted. The nurse indicated Resident #73's medical record indicated both continent and incontinent urinary episodes and the use of anticoagulant and diuretic medications during the assessment look back period (5/05/2015-5/11/2015). The nurse indicated the medical record review for MDS assessments should include the whole record and discrepancies in the documentation should be investigated. The nurse also indicated the medications had been miscoded. An interview with the Director of Nurses (DON) on 9/03/2015 at 12:20 PM was conducted. The DON stated she would expect all assessments to include a thorough review of the medical record and documentation and they should be as accurate as possible. 2. Resident #22 had been admitted to the facility on 5/07/2015. Diagnoses included: chronic ulcer of the leg, lower extremity ulceration, bilateral below the knee amputations, chronic kidney disease, glaucoma, cellulitis, chronic obstructive pulmonary disease, hypertension, diabetes and coronary atherosclerosis. The Nurse Aide (NA) documentation dated 5/08/2015 to 5/14/2015 indicated Resident #22 had been continent of urine. The nurse's notes dated 5/12/2015 and	F 278	N/Medications, Section H/Incontinence, Section I/Diagnosis and Section E/Behaviors. The RCMD will utilize an audit tool to review fifty percent of completed assessments for accuracy with special focus on vision, incontinence, diagnosis, medications and behaviors times thirty days then twenty-five percent of completed assessments times thirty days. Any identified coding errors will be modified prior to being submitted with re-education provided to the nurse completing the identified assessment. The audits will be reviewed monthly times three at the Quality Assurance Performance Committee meeting, consisting of the Administrator, Director of Nursing, Social Worker, Activity Director and Medical Director. The Quality Assurance Performance Committee will review and analyze for patterns and trends. The Committee will review and evaluate the results and implement additional interventions as needed.	

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F 278	Continued From page 12 5/13/2015 indicated Resident #22 had urinary incontinence episodes. Resident #22's Admission Minimum Data Set (MDS) dated 5/14/2015 indicated the resident had been continent of urine. The urinary incontinence Care Area Assessment (CAA) dated 5/14/2015 indicated Resident #22 had functional incontinence related to the inability to get to the toilet in time due to physical disability, external obstacles and problems thinking or communicating. Resident #22's care plan dated 5/20/2015 indicated Resident #22 required assistance related to incontinence. The care plan goal indicated Resident #22 would have incontinence episodes managed without signs and symptoms of potential complications, and would have dignity maintained with incontinence care. An interview with MDS nurse #1 on 9/3/2015 at 12:00 noon was conducted. The nurse indicated Resident #22's medical record indicated both continent and incontinent urinary episodes during the assessment look back period. The nurse indicated the medical record review for MDS assessments should include the whole record and discrepancies in the documentation should be investigated. An interview with the Director of Nurses (DON) on 9/03/2015 at 12:20 PM was conducted. The DON stated she would expect all assessments to include a thorough review of the medical record and documentation and they should be as accurate as possible.	F 278		

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F 278	Continued From page 13 #3. Resident #45 was admitted to the facility on 8/12/2010 with diagnoses to include hypertension, chronic obstructive pulmonary disease (COPD), and glaucoma. The Physician orders dated July 2015 included the medications Labetalol 100mg twice daily for hypertension, Symbicort inhaler twice daily for COPD, and Xalatan eye drops daily for glaucoma. Her most recent Minimum Data Set (MDS) assessment dated 7/26/2015 revealed her cognition was intact. No diagnoses were noted on the MDS. On 9/3/2015 at 9:02 AM an interview was conducted with MDS nurse #1, who stated it was true, there were no diagnosis on the MDS. She indicated she must have missed that section. An interview was conducted with the Director of Nursing (DON) on 9/3/2015 at 10:53 AM. The DON stated she expected the MDS to be accurate, and for the nurse to find the answers that were appropriate for each section of the MDS. #4. Resident #14 was admitted to the facility on 4/22/2005 with diagnoses to include hypertension and diabetes. Her most recent Minimum Data Set (MDS) assessment dated 7/27/2015 indicated the resident had moderate cognitive impairment. Her vision was assessed as impaired, with no corrective lenses. An interview was conducted with the resident on 9/2/2015 at 8:14 AM who stated she had glasses. She was not wearing the glasses during the interview. On 9/2/2015 at 2:40 PM an interview was conducted with the nursing assistant (NA #1) who stated the resident had glasses and wore them sometimes. On 9/2/2015 at 3:06 PM NA #2 stated the	F 278		

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F 278	Continued From page 14	F 278		

resident had glasses and took them out of the top drawer of her bedside table.
An interview was conducted with the MDS nurse #1 on 9/2/2015 at 3:13 PM. The MDS nurse stated that she did not know the resident had glasses. She indicated she always asked the resident to put their glasses on, but if they didn't she just coded that section as resident with no corrective lenses. She did not document whether the resident had glasses but did not wear them because it did not occur to her.
An interview was conducted with the Director of Nursing (DON) on 9/3/2015 at 10:53 AM. The DON stated she expected the MDS to be accurate, and for the nurse to find the answers that were appropriate for each section of the MDS.
5. Resident #69 was admitted on 2/4/14 with hypertension, depression and anxiety.

A Quarterly Minimum Data Set (MDS), with a 7/31/15 assessment reference date, indicated Resident #69 had short and long term memory impairment. There were no behaviors or rejection of care documented. The MDS revealed the resident had received an anti-anxiety medication for 3 days during the 7 day assessment period.

Review of the July 2015 physician's orders indicated the resident was ordered to receive Lorazepam (a medication given for anxiety) every 8 hours as needed for agitation.

Review of the July 2015 Medication Administration Record (MAR) revealed Resident #69 received Ativan on 8 occasions, with 1 of those during the assessment reference period.
Review of the Behavior Intervention Outcome

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F 278	Continued From page 15	F 278		

sheet for July 2015, behaviors had been documented during the assessment reference period.

The Corporate Area MDS Coordinator was interviewed on 9/2/15 at 2:15 PM. The MDS nurse acknowledged she had signed the behavior section of the MDS for Resident #69 as being accurate and complete; and added the Social Worker (SW) was responsible for documenting in the behavior section of the MDS. She added when verifying the accuracy of the MDS she typically used nursing documentation, care tracker documentation, behavior flow sheets, physician's consult, the MAR to see if the resident received as needed medications. The MDS nurse reviewed the MDS and acknowledged there were no behaviors coded. She then reviewed the behavior sheet for the assessment period and stated there were behaviors coded as occurring during the assessment period. The MDS nurse added based on the evidence she had seen, the MDS would be inaccurate. She stated she was not perfect and although she had checked the MAR and the behavior sheet she had missed the documentation of behaviors.

The SW was interviewed on 9/3/15 at 8:43 AM. The SW stated she was responsible for coding the behavior section on the MDS. She stated when coding the MDS, she used information she received in morning meetings, observations of residents and she asked the nurses about resident behaviors. She stated Resident #69 had a behavior of wandering and she was sure she had coded that area. The SW reviewed the behavior section and verified she had not coded the resident as wandering. The SW stated she had not looked at the Behavior Form prior to

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F 278	Continued From page 16 coding the MDS because she had no knowledge the Behavior Form existed. She added she had not reviewed the MAR and had no idea what each medication was used for and had not asked what the medications were used for. She stated based on the information she had reviewed, the MDS was inaccurate.	F 278		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		10/1/15

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F 329	Continued From page 17 Based on observations, staff interviews and record review, the facility failed to care plan and use non-pharmacological interventions prior to the administration of an as needed anti-anxiety medication (Ativan) for 1 of 5 sampled residents whose medications were reviewed (Resident #69). The facility also failed to consistently document the reason for Ativan administration and the effectiveness of the medication. Resident #69 was admitted on 2/4/14 with diagnoses that included episodic mood disorder, anxiety and psychosis. July and August 2015 physician's orders included Ativan 2 milligrams (mgs) every 8 hours as needed for anxiety or Ativan 1 mg topically every 6 hours as needed for severe anxiety. Review of the July 2015 Medication Administration Record (MAR) revealed Resident #69 received Ativan on 8 occasions. There was only one entry on the back of the MAR for 7/20/15 at 1:30 PM that indicated the medication was given for pacing or hollering. Review of the Behavior Intervention Outcome sheet for July 2015, failed to review any behaviors documented. Review of nurse's notes for July 2015 indicated no documentation related to behaviors/anxiety or any non-pharmacological interventions attempted prior to the administration of medication. Resident #69's care plan, last reviewed on 7/16/15, identified the resident as requiring administration of an antianxiety agent due to bipolar disorder. The goal of receiving medications at the smallest dosage that was effective was to be attained by periodic reviews of medications, observe for potential side effects	F 329	Resident #69 has exhibited no socially inappropriate behaviors since 9/1/15, therefore, has received no antianxiety medication. On 9/14/15, resident #69's physician reviewed the resident's Medication Administration Record (MAR) to ensure the antianxiety medication type and dose were appropriate and met the needs of the resident. No new orders or changes were made by the physician. All facility resident's Medication Administration Records receiving prn (as needed) antipsychotic medications were audited on 9/15/15 by the Director of Nursing and the Assistant Director of Nursing to ensure that residents receiving prn antipsychotic medication exhibited a need for the medication and the dose was appropriate. This audit was reviewed by the Medical Director with new orders written as indicated. The Director of Nursing and/or Assistant Director of Nursing audited the documentation of licensed nurses (Licensed Practical Nurses and Registered Nurses) on 9/25/15 using an audit form to ensure that appropriate documentation was completed to include need for the prn antipsychotic medication, non-pharmacological interventions were attempted and the effectiveness of the medication was documented. The Director of Nursing and/or Assistant Director of Nursing will review fifty percent of residents receiving prn antipsychotic medications Medication Administration Records weekly times four weeks then	

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F 329	Continued From page 18 and observed for medication effectiveness, and psychiatric services as ordered. Non-pharmacological interventions prior to the administration of the antianxiety medication was not listed. A quarterly Minimum Data Set (MDS), dated 8/5/15, indicated Resident #69 had short and long term memory impairment. There were no behaviors coded. The MDS coded the resident as receiving an antianxiety medication 3 times during the 7 day assessment period. The Director of Nursing (DON) was interviewed on 9/2/15 at 1:46 PM. The DON stated prior to giving an as needed (PRN) psychotropic medications nurses were expected to assess the resident and document the reason for medication administration. She stated non-pharmacological interventions should also be attempted prior to administering medication. The DON added behaviors requiring the medication should be documented on the back of the MAR, the behavior sheet or in nurse's notes. The DON reviewed the MAR, the nurse's notes and the behavior sheets for Resident #69 and acknowledged there was no documentation to support the use of the Ativan at times and no documentation of non-pharmacological interventions attempted prior to administration of the Ativan Nurse #3 was interviewed on 9/2/15 at 2:11 PM. Nurse #3 stated she had been instructed to document why a PRN medication was being given on the back of the MAR, the behavior sheet or the nurse's notes. The nurse stated she typically documented on the behavior sheet and the MAR. She added Resident #69 used profane	F 329	bi-monthly times two months using an audit form to ensure accurate documentation by the licensed nurses whenever administering prn antipsychotic medications to include reason for administering of antipsychotic medications, non-pharmacological interventions attempted and effectiveness of the medication. Facility licensed staff were provided re-education on 9/2/15 by the Director of Nursing regarding the proper documentation of antipsychotic medication administration including the non-pharmacological interventions to be attempted prior to administration of antipsychotic medication, behaviors observed with appropriate documentation and the effectiveness of the medication. Licensed nurses that did not receive the re-education on 9/2/15, received the re-education before working their next shift. Newly hired licensed nurses will receive this education during orientation. The Director of Nursing will report findings of the audits to the Quality Assurance Performance Committee (consisting of the Administrator, Director of Nursing, Social Worker, Activity Director and Medical Director) monthly times two months. The Quality Assurance Committee will review and analyze for patterns and trends. The Committee will review and evaluate the results and implement additional interventions as needed.	

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F 329	Continued From page 19 language and would pace back and forth. The nurse stated prior to giving the medication, she would try to sit the resident down. The nurse acknowledged she had signed out Ativan 2 mg on 8/14/15 at 11:00 AM. Nurse #3 reviewed the MAR and acknowledged she had not identified any behaviors on the back of the MAR, the behavior sheets or in the nurse's notes. Nurse #3 added she had given Resident #69 the Ativan for pacing, but acknowledged she had not documented the effectiveness of the medication. The nurse stated she had not been taught to try non-pharmacological interventions and document those interventions and effectiveness of the interventions prior to the administration of the Ativan.	F 329		
F 520 SS=E	. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		10/1/15

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F 520	Continued From page 20 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assurance (QA) Committee failed to maintain implemented procedures and effective monitoring practices to address residents' choices and to accurately code the Minimum Data Set (MDS) to ensure compliance as sustained. The facility had a pattern of two re-cited deficiencies which were originally cited in September 2014 on a recertification survey and on the current survey for resident choices and MDS coding. 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 was cross referenced to: 1. F242 - Based on observations, record review and staff and resident interviews the facility failed to honor residents' preferences for showers for 2 of 3 residents (Resident #45 and #53) reviewed for choices. During the recertification survey of September 2014 the facility was cited for failing to honor the choice to take a whirlpool bath. 2. F278- Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 5 of 15 residents who had their MDS reviewed.	F 520	F 520 For residents affected by this alleged deficiency, F 242, the Social Worker, Director of Nursing and Assistant Director of Nursing were re-educated by the Administrator on 9/28/15 on policy and procedure related to resident's right of choice in reference to bathing preference to include type of bath, time of bath and frequency of bathing. For F 242, there were two residents affected by the alleged deficient practice. A plan of correction is in place to correct and prevent future deficient practice. For residents affected by this alleged deficiency, F 278, the Resident Care Management Director (RCMD) and MDS licensed staff were re-educated by the Administrator on 9/28/15 on policy and procedure using the RAI Manual to include the interview process with the resident, family member or care givers to accurately code the MDS and how to accurately code the MDS 3.0. For F 278, five residents were affected by the alleged deficient practice. A plan of correction is	

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F 520	Continued From page 21 During the recertification survey of September 2014 the facility was cited for failing to accurately code visual function for 1 of 3 sampled residents. During an interview with the Administrator on 9/3/15 at 2:00 PM she stated the Quality Assurance Performance Improvement Committee met monthly and used a form to guide the meeting to ensure all items were discussed and none were missed. She stated all newly admitted residents were visited within 72 hours of admission to discuss preferences which included bathing preferences. She stated the bathing preference was on each resident's Kardex. She also stated that the facility was conducting chart audits to ensure the residents' preferences were present. She stated the audit results were discussed each month for the results of the previous month.	F 520	in place to correct and prevent future deficient practice. Since all residents have the potential to be affected by the same alleged deficient practice, the Quality Assurance auditing team, Divisional Director of Clinical Service and/or Divisional Director of Operations, revised our Quality Assurance process. All members of the Quality Assurance Committee, Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Activity Director and Medical Director received re-education on the Quality Assurance process and the need to monitor areas of concern to ensure compliance. The Quality Assurance Committee will monitor and review the following audits to prevent the alleged deficient practices from re-occurring: For F 242, using an interview form, the Director of Nursing or Administrator will complete two resident or family interviews weekly times four weeks then two resident or family interviews monthly throughout the year to ensure bathing preferences are being honored. These interview forms will be reviewed at the Quality Assurance meeting for changes as indicated. For F 278, the RCMD will utilize an audit tool to review fifty percent of completed assessments for accuracy with special focus on vision, incontinence, diagnosis, medications and behaviors times thirty days then twenty five percent of completed assessments times thirty days, then ten percent throughout the year. Any	

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F 520	Continued From page 22	F 520	identified coding errors will be modified prior to being submitted with re-education provided to the Interdisciplinary Team (MDS Nurse, Social Worker, Activity Director, Dietary Manager, and Rehab Manager). The audit tools will be reviewed at the Quality Assurance Committee meeting for changes as indicated. The Divisional Director of Clinical Service will be assigned to review the F 242 interview forms and the F 278 audit tools weekly for four weeks then monthly thereafter. The Divisional Director of Clinical Service will bring the interview forms and the MDS 3.0 audit tools to the monthly Quality Assurance Committee meeting where the Quality Assurance Committee along with the Divisional Director of Clinical Service will examine results and make recommendations. All audits and resident/family interview forms will be conducted monthly and will continue throughout the year. Any new audit tools that are added to the Quality Assurance process will be conducted monthly and continue throughout the year. Results of the audits will be reviewed by the Quality Assurance Committee monthly for recommendations and follow up an any recommended changes. If auditing tools and process are not producing results desired, the Quality Assurance Committee will modify the process for more effective results.	