STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345483	A. BUILDING _____ B. WING _____	11/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAIRE NURSING CENTER	1450 SHAIRE CENTER DRIVE LENOIR, NC 28645

(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 278 SS=D	483.20(g) - (j) ASSESSMENT 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 assess and include the active diagnoses such as dementia and hypertension on the Minimum Data Set (MDS) for 1 of 14 residents (Resident #53) comprehensive assessments reviewed.	F 278	This Plan of Correction is submitted to address deficiencies cited under Tag #F278 This is to state that we do not concur with this recommendation as stated for	11/27/15

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

Electronically Signed | 11/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 1 Findings included: Resident #53 was admitted to the facility on 9/17/15. Accumulative diagnoses included dementia and hypertension. A record review of Resident #53 admission MDS dated 9/24/15 revealed dementia and hypertension were not coded in section I - Active diagnoses. Physician orders for resident #53 for the corresponding time frame included an order for Aricept for dementia and Norvasc for hypertension. On 11/3/15 at 1:42 PM, an interview with the MDS coordinator revealed dementia and hypertension should have been coded on the MDS. She stated that she would correct it on the next MDS. On 11/3/15 at 2:13 PM, an interview with the director of nursing (DON) revealed her expectation was for dementia and hypertension to be coded accurately on resident #53 ' s MDS. On 11/03/2015 at 2:15 PM, an interview with the administrator revealed his expectation would be for the MDS to be coded accurately.	F 278	deficient practice. Upon finding stated deficiencies. On November 3, 2015 the assessment date October 15, 2015 for Resident #53 was corrected with appropriate diagnosis codes added to Section I of the MDS. On November 10, 2105 the MDS Coordinator and Director of Nurses audited and reviewed current resident MDSs to ensure accuracy of diagnosis coded in Section I of the MDS. All MDSs were found to be coded accurately. The MDS Coordinator and Rehab Director will discuss and review resident diagnosis and the relevance of the diagnosis to resident care while in the facility on a weekly basis. Diagnosis to be coded will have a direct relationship to the resident□s current functional, cognitive, or mood or behavior status, medical treatments or nurse monitoring. All MDS Assessments will be completed accurately, timely and according to the RAI Manual. The Director of Nurses will conduct random reviews on a weekly basis. All findings will be reported to the Q.A. Committee monthly for a period of three months.	