

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/31/2016
NAME OF PROVIDER OR SUPPLIER LEXINGTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELIA DRIVE LEXINGTON, NC 27292		
(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 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record and interviews with staff, resident room on 1 of 1 hall (100 hall) had a bathroom vent with a gray substance and missing slats (Room 103). There was paint scraped off of the wall (Room 103). The walls were painted a different color (Rooms 123 and 214). There was a cracked light fixture (Room 123). There was an accumulation of black colored substance in the bathroom (Rooms 200, 202, 204, 205 and 206). The cove molding by bathroom door was partially detached (Room 205). There were stains on the white privacy curtains (Rooms 122 and 203). Findings included: 1a. An observation on 3/29/16 at 8:52 AM of room 103 revealed the vent in the bathroom ceiling had a gray substance inside and was missing several slats. On 3/30/16 at 2:06 PM, the bathroom vent remained unchanged and there was still a gray substance inside and it was missing several slats. b. An observation on 3/29/16 at 8:52 AM of room 103 revealed the paint behind bed A was scraped off the wall. On 3/30/16 at 2:07 PM, the wall remained unchanged and the paint was still scraped off of the wall. c. An observation on 3/29/16 at 1:22 PM of room 202 revealed the perimeter of the bathroom floor had an accumulation of black colored substance.</p>	F 253	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.</p> <p>F253 1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice.</p> <p>During the week of April 11-15, Housekeeping and Maintenance corrected all items. Completed April 15, 2016.</p> <p>2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:</p>	4/28/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/14/2016

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 253	<p>Continued From page 1</p> <p>This bathroom was shared by room 200.</p> <p>On 3/30/16 at 1:33 PM, the perimeter of the bathroom floor had an accumulation of black colored substance. This bathroom was shared by room 200.</p> <p>d. An observation on 3/30/16 at 1:54 PM of room 206 revealed bathroom had an accumulation of black colored substance behind the toilet. This bathroom was shared with room 204.</p> <p>e. An observation on 3/29/16 of room 205 at 1:29 PM revealed there was an accumulation of brown colored particles and a white colored substance behind the door. The spaces between the closet at the wall near the bathroom and window had an accumulation of dark brown colored substance. The cove molding by the bathroom door was partially detached.</p> <p>On 3/30/16 at 1:39 pm revealed there was no change. There was still an accumulation of brown colored particles and a white colored substance behind the door. The spaces between the closet at the wall near the bathroom and window had an accumulation of dark brown colored substance. The cove molding by the bathroom door was partially detached.</p> <p>f. An observation on 3/29/16 at 9:08 AM of room 123 revealed above the resident 's bed the wall does not match the color of the rest of the wall. The resident stated that the wall had been patched and was repainted a different color than the rest of the wall.</p> <p>On 3/30/16 at 1:26 PM, the wall remained unchanged and was painted a different color than</p>	F 253	<p>From April 11-15 the Housekeeping Supervisor and Administrator inspected all the rooms in the facility. A list of corrections was generated and all items were corrected by Housekeeping or Maintenance. Completed April 15, 2016.</p> <p>3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: The Housekeeping Supervisor and Maintenance Director will jointly inspect five rooms every weekday. Rooms will be inspected in numerical order, i.e. 101-105. They will jointly submit a list of corrections to the administrator weekly until all room inspections are completed. Once all rooms have been inspected, the Housekeeping Supervisor and Maintenance Director will inspect 5 randomly chosen rooms 1X monthly for 3 months and submit a report to the Administrator each month noting what problems have been found and corrected. The Regional Coordinator of Physical Plant Management & Environmental Services will inspect the quality of the housekeeping and maintenance services and generate a report to the administrator every quarter using the Quarterly Management Evaluation tool. A score of 90 or greater will be considered acceptable. Areas to improve and plans to improve with timeframes will be a part of the evaluation.</p> <p>4. How facility will monitor corrective</p>		

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F 253	<p>Continued From page 2</p> <p>the rest of the wall.</p> <p>g. An observation on 3/30/16 at 2:02 PM of room 214 revealed the wall by window was painted different colors.</p> <p>h. An observation on 3/29/16 at 9:08 AM of room 123 revealed the light fixture above bed A was cracked.</p> <p>On 3/30/16 at 1:26 PM, the light fixture remained unchanged and was still cracked.</p> <p>i. An observation on 3/29/16 at 8:15 AM of room 122 revealed the white privacy curtain had five orange vertical stains on it.</p> <p>On 3/30/16 at 1:29 PM, the privacy curtain remained unchanged and had five orange vertical stains on it.</p> <p>j. An observation on 3/30/16 at 1:58 PM of room 203 revealed the white privacy curtain had stains on it.</p> <p>On 03/30/2016 at 2:30 PM, an interview and walk through with the housekeeping supervisor revealed her staff was responsible for cleaning the floors.</p> <p>On 03/30/2016 2:30 PM, an interview and walk through with maintenance supervisor revealed his staff was responsible for painting, the light fixture that was cracked, the detached cove molding, and the bathroom vent that was broken.</p> <p>Review of work order list revealed there was one work order for the repair of the bathroom vent for</p>	F 253	<p>action(s) to ensure deficient practice will not re-occur: The results of all inspections, reports and corrections will be discussed at Quarterly Quality Assurance meetings for four consecutive quarters for further problem resolution if needed. Completed by April 28, 2016.</p>		

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F 253	<p>Continued From page 3 room 103.</p> <p>On 03/30/2016 at 3:20 PM, a subsequent interview with the housekeeping supervisor revealed she let her floor technician go of ten years because the floors were not up to her standard. They were not clean enough. Right now she has an ad out for that position. She currently has someone filling in to sweep and mop but she does not have anyone to do the stripping and waxing of the floors. She stated she had been in contact with a floor contractor about pulling up and replacing the worse floors.</p> <p>On 03/30/2016 at 3:25 PM, a subsequent interview with the maintenance supervisor revealed he was the only maintenance person for the facility and he has been going around putting cushions on the beds to prevent them from tearing up the walls further. He also stated that he was slowly going through the facility painting rooms all the same color and will eventually have all the rooms painted.</p> <p>On 03/31/2016 at 7:37 AM, an interview with housekeeper #1 revealed she was in charge of the cleanliness of all rooms. This included dusting, wiping all the surfaces, cleaning the bathrooms and if beds were stripped wipe them down and wipe underneath all the rails. She stated during deep cleans every thirty days or when the room empties she would check curtains. She was also in charge of cleaning the nourishment rooms and pulling trash from the front offices and all the side offices. She would clean the break room on unit B. She also stated that hallways needed to be dusted and she dusted above the door frames. She always cleaned the nursing assistant computers by</p>	F 253			

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F 253	Continued From page 4 dusting them out every day. Also when there was no floor technician she had to take out the trash. On 03/31/2016 at 7:53 AM, an interview with housekeeper #2 revealed her duties included cleaning rooms, sweeping, dusting, mopping, and cleaning the bathrooms. She also changes the privacy curtains if they are soiled. When interviewed about the black substance behind the toilet in room 202 the housekeeper stated that some stains are embedded in the floor and will not come up. On 03/31/2016 at 8:54 AM, an interview with the administrator revealed his expectations was that he expects a clean, orderly and homelike environment. He also stated that cleaning by housekeeping and updating by maintenance are being done on a daily basis.	F 253			
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	F 278		4/28/16	

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F 278	<p>Continued From page 5</p> <p>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 record review, observations and staff interviews the facility failed to accurately code the Minimum Data Set Assessment (MDS) to reflect the resident ' s pressure ulcer for one of two residents (Resident #128) and failed to accurately code on the Minimum Data Set (MDS) assessment to reflect PASRR (Preadmission Screening and Resident Review) level 2 (two) for 1 of 1 resident in the sample reviewed for PASRR (Resident #148).</p> <p>Findings Included:</p> <p>1. Resident #128 was admitted 12/1/15 with the diagnoses of anxiety, depression and diabetes.</p> <p>The resident had a care plan dated 12/16/15 for pressure ulcers. The goal included " the pressure ulcer will show signs of healing and remain free from infection. "</p> <p>Physician ' s wound care orders dated 2/11/16 for Sacral/buttock wound revealed to cleanse the area with Normal Saline, apply Aquaseal to the</p>	F 278	<p>F278 Correction: On March 31, 2016, the MDSC resident <input type="checkbox"/>s # 128 2/26/16 Quarterly MDS was modified to accurately code the documented unstageable pressure ulcer to sacrum. On March 31, 2016, the MDSC modified revised resident <input type="checkbox"/>s # 148 Significant Change MDSs with an ARD of 2/26/16 and 3/15/16 and Admission MDS with an ARD of 9/16/15 on 3/31/16 to code the Level II PASRR correctly.</p> <p>2. Potential: All current residents most recent MDS with an ARD of March 31 or after with a documented pressure ulcer will be reviewed to ensure the pressure ulcer was accurately coded in Section M of the MDS. Any issues identified as being coded incorrectly, will be modified by the MDSC for any coding errors identified in the audit. Completion date 04/28/2016 All current residents current most recent</p>		

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F 278	<p>Continued From page 6</p> <p>wound bed, and cover with a foam dressing. Change every two days.</p> <p>The Quarterly MDS dated 2/26/16 revealed the resident was at risk for pressure ulcers but had no unhealed pressure ulcers at a stage 1 or higher. Resident # 128 had no pressure ulcers present on the prior assessment, had one Venous and Arterial ulcers present and had a diabetic foot ulcer.</p> <p>The weekly skin assessment dated 2/16/16 revealed that the resident had a sacral ulcer which measured 4.0 centimeters (cm) x 4.0 cm x 0.5 cm.</p> <p>The weekly skin assessment dated 2/23/16 revealed the resident had a sacral pressure ulcer which measured 4.0 cm x 4.0 cm x 0.5 cm.</p> <p>The weekly skin assessment dated 3/8/16 revealed the resident had a sacral pressure ulcer which measured 2.5 cm x 3.0 cm x 0.5 cm and a unstageable vascular wound to the inner left foot which measured 0.8 cm x 1.0 cm.</p> <p>The MDS nurse was interviewed on 3/30/16 at 10:04 AM. He stated to code the Quarterly MDS he would start by looking at the nursing assessments. He looked at the weekly skin assessment dated 2/23/16. He stated the resident did have a pressures ulcer. He also stated he was the only MDS coordinator and he would complete a modification to correct that there were no pressure ulcer present on the MDS. He stated the initial assessment on 12/22/16 the resident was admitted with an unstageable pressure ulcer. He may have overlooked the sacral wound because the</p>	F 278	<p>comprehensive MDS with an ARD of March 31 or after with a documented Level II PASRR will be reviewed to ensure Section A was accurately coded on the MDS. Any issues identified as being coded incorrectly, will be modified by the MDSC for any coding errors identified in the audit. Completion date 04/28/2016</p> <p>3. Measures: The MDSC Consultant reviewed with the MDSC and the DC Planner the requirements from the RAI Manual for coding ALL sections of the MDS accurately, including pressure ulcers from supporting documentation from resident's medical records and documentation during the look back period of the ARD of the MDS and any resident with a documented Level II PASRR must be coded accurately in Section A of their Comprehensive MDS.</p> <p>On 4/13/16, the MDSC Consultant</p> <p>4. Monitoring: The MDS Consultant will audit 5 residents with a comprehensive MDS for accuracy in coding ALL sections of the MDS 1X weekly for 4 weeks, 2X monthly for 1 month, and monthly for 8 months. Any coding issue identified on the audits will be corrected. Results of Audits will be reviewed at the Quarterly Quality Assurance Meeting for further problem resolution if needed X 4. Completed by 4/28/16</p>		

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F 278	<p>Continued From page 7</p> <p>resident had two other wounds which were healed at that time.</p> <p>A modification of the Quarterly MDS dated 2/26/16 was completed on 3/31/16 by the MDS nurse. It included the resident had one unstageable pressure ulcer that was present on admission. The wound measured 4.0 cm x 4.0 cm x 0.5 cm and had granulation tissue present. The pressure ulcer was present on the prior assessment.</p> <p>The Administrator was interviewed on 3/31/16 at 1:07 PM. He stated his expectation was for the MDS to be completed timely and accurate to the resident's condition.</p> <p>2. Resident #148 was admitted 9/9/15 with the following diagnoses of insomnia, anxiety, depression and psychosis.</p> <p>Resident #148 had an admission Preadmission Screening and Resident Review (PASRR) level II dated 9/24/15, which expired on 10/8/15. The resident had a second PASRR level II completed on 10/6/15, which expired on 1/4/16. Resident #148 had a third PASRR level II determination on 12/30/15, which expired 2/28/16. The resident had a current PASRR Level II determination on 3/1/16, which expired 5/30/16.</p> <p>Resident ' s #148 significant change Minimum Data Set (MDS) dated 2/26/16 revealed Section A of the MDS was not coded to reflect PASRR level II determination. The resident ' s significant change MDS dated 3/15/16 also revealed Section A of the MDS was not coded to reflect PASRR</p>	F 278			

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F 278	<p>Continued From page 8 level II determination.</p> <p>The Social Worker was interviewed on 3/31/16 at 8:49 AM. She stated the resident had a current PASRR. The resident came in with an anxiety and depression disorder. They had been reviewing the PASRR every 30, 60, and 90 days. The resident had been a PASRR level II since she was admitted to the facility. The resident was followed by the Behavior Health Group. The MDS nurse was responsible for coding the PASRR section on the MDS.</p> <p>The MDS nurse was interviewed on 3/31/16 at 9:07 AM. He stated that typically the social worker would fill out the PASSR information on the MDS. He stated the process was, the social worker would put the level 2 PASRR information on the MDS. There had never been a time in which the Social Worker told him to code the resident for PASRR on the MDS.</p> <p>The Social Worker was interviewed again on 3/31/16 at 9:12 AM. She stated she had never told the MDS nurse individually that the resident was a level II PASRR. She stated she had never coded the PASRR section on the MDS. If a section was coded by her, her name would show up by the questions that she answered on the MDS.</p> <p>The Administrator was interviewed on 3/31/16 at 1:07 PM. He stated his expectation was for the MDS to be completed timely and accurate to the resident's condition.</p> <p>The Administrator was interviewed again on 3/31/16 at 1:32 PM. He stated it was the social workers responsibility to code the PASRR section</p>	F 278			

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F 278	Continued From page 9 of the MDS.	F 278			
F 356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff</p>	F 356	F356 Nurse Staffing Posting	4/28/16	

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F 356	<p>Continued From page 10</p> <p>interviews, the facility failed to post the daily facility nursing staffing in an area that could easily be seen or located by the residents, staff and visitors for three days of the recertification survey 3/28/16, 3/29/16 and 3/30/16.</p> <p>Findings Included:</p> <p>On 3/28/16 at 11:20 AM, the facility nursing staffing was posted on the front of the Director of Nursing's (DON) door and could not easily be seen or located by residents, staff and visitors. The DON ' s office was located on the main hallway of the facility.</p> <p>On 3/29/16 at 8:00 AM, the DON office door was open and the staffing was not easily seen or located by residents, staff and visitors.</p> <p>On 3/30/16 at 8:00 AM, the DON office door was open and the staffing was not easily seen or located by residents, staff and visitors.</p> <p>On 03/30/2016 at 8:48 AM, an interview with the DON) revealed she was responsible for updating and posting the facility nursing staffing. She stated that she used to post it on the outside by her door but confused resident ' s would come by and take it down.</p> <p>On 03/30/2016 at 9:09:AM, an interview with the administrator revealed they used to post the facility nursing staffing on the outside of the DON ' s door but confused resident's would pull it down so they started posting it on the front of the DON ' s door.</p>	F 356	<ol style="list-style-type: none"> How corrective action will be accomplished for each resident found to have been affected by the deficient practice Daily staffing posted in a new location on the glass window beside the Director of nursing door facing the main hallway accessible to all visitors and residents 3/29/16. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: DON and designees will be educated by regional nurse consultant on Daily staffing posted in a new location on the glass window beside the Director of nursing door facing the main hallway accessible to all visitors and residents Completion date: April 18, 2016 Measures to be put in place or systemic changes made to ensure practice will not re-occur: Administrator and/or DON will conduct audits for Daily staffing posted in a new location on the glass window beside the Director of nursing door facing the main hallway accessible to all visitors and residents weekly x 4 weeks; biweekly x 1 month and then monthly x 1. Completion date: April 18, 2016. How facility will monitor corrective action(s) to ensure deficient practice will 		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/31/2016
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F 356	Continued From page 11	F 356	not re-occur: Results of audits will be reviewed in weekly Quality Assurance Risk Meeting weekly X 1 month, biweekly X 1 month and Quality Assurance meeting x 1 for further resolution as needed .Completion date: April 18, 2016		
F 520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 520		4/28/16	

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F 520	<p>Continued From page 12</p> <p>Based on record reviews and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into effect August 2015. This was for one recited deficiency which was originally cited in July of 2015 during a recertification survey and was recited again on a recertification survey. The 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 (QA).</p> <p>Findings included:</p> <p>This tag is cross referred to:</p> <p>F278: Accuracy of Assessments: Based on record review, observations and staff interviews the facility failed to accurately code the Minimum Data Set Assessment (MDS) to reflect the resident ' s pressure ulcer for one of two residents (Resident #128) and failed to accurately code on the Minimum Data Set (MDS) assessment to reflect PASRR (Preadmission Screening and Resident Review) level 2 (two) for 1 of 1 resident in the sample reviewed for PASRR (Resident #148).</p> <p>During the previous recertification of 7/16/2015, the facility was cited a deficiency at F278 for failure to code the Minimum Data Set (MDS) for the use of psychotropic medications for 2 residents (Resident #216 and Resident #83).</p> <p>An interview with the administrator on 3/31/16 at 12:53 PM revealed for last year ' s F278 they had</p>	F 520	<p>F520</p> <p>Correction: On March 31, 2016, the MDSC resident <input type="checkbox"/>s # 128 2/26/16 Quarterly MDS was modified to accurately code the documented unstageable pressure ulcer to sacrum.</p> <p>On March 31, 2016, the MDSC modified revised resident <input type="checkbox"/>s # 148 Significant Change MDSs with an ARD of 2/26/16 and 3/15/16 and Admission MDS with an ARD of 9/16/15 on 3/31/16 to code the Level II PASRR correctly.</p> <p>2. Potential: All current residents most recent MDS with an ARD of March 31 or after with a documented pressure ulcer will be reviewed to ensure the pressure ulcer was accurately coded in Section M of the MDS. Any issues identified as being coded incorrectly, will be modified by the MDSC for any coding errors identified in the audit. Completion date 04/28/2016</p> <p>All current residents current most recent comprehensive MDS with an ARD of March 31 or after with a documented Level II PASRR will be reviewed to ensure Section A was accurately coded on the MDS. Any issues identified as being coded incorrectly, will be modified by the MDSC for any coding errors identified in the audit. Completion date 04/28/2016</p> <p>3. Measures: The MDSC Consultant reviewed with the MDSC and the DC Planner the requirements from the RAI Manual for coding all sections of the MDS accurately, including pressure ulcers from supporting</p>		

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F 520	Continued From page 13 an internal consultant monitor antipsychotic medication use for residents with similar conditions. The monitoring began in August 2015 and ran for three months with 100% compliance. The monitoring consisted of monitoring that the resident had the appropriate diagnosis for drug use. The administrator provided documentation of the monitoring tool used to show 100% compliance with F278. He stated that QA was not currently monitoring F278.	F 520	documentation from resident's medical records and documentation during the look back period of the ARD of the MDS and any resident with a documented Level II PASRR must be coded accurately in Section A of their Comprehensive MDS. On 4/13/16, the MDSC Consultant 4. Monitoring: The MDS Consultant will audit 5 residents with a comprehensive MDS for coding all sections of the MDS accurately, including pressure ulcers from supporting documentation from resident's medical records and documentation during the look back period of the ARD of the MDS, and any resident with a documented Level II PASRR must be coded accurately in Section A of their Comprehensive MDS. The audit periods will include 1X weekly for 4 weeks, 2X monthly for 1 month, and monthly for 8 months. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC or DC Planner. Results of Audits will be reviewed at the Quarterly Quality Assurance Meeting for further problem resolution if needed X 4. Completed by 4/28/16		