STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING _____ B. WING _____	03/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209

(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 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and	F 272		4/11/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/17/2017

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 272	Continued From page 1 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to fully complete the Minimum Data Set (MDS) assessment in the areas of pain (Residents #4 and #9) and mental status and mood (Resident #60) for 3 of 18 sampled residents. The findings included: 1. Resident #4 was admitted to the facility on 11/20/15 with multiple diagnoses that included cancer. A significant change Minimum Data Set (MDS) assessment dated 3/12/17 indicated Resident #4 had moderate cognitive impairment and was on hospice services. Section J, the Health Conditions section, was not fully completed. Questions J0200 through J0600, the Resident Pain Assessment Interview, were not assessed. This section was indicated to have been completed by MDS Nurse #2. An interview was conducted with MDS Nurse #2 on 3/29/17 at 10:42 AM. She stated she was responsible for coding Section J of the 3/12/17 significant change MDS for Resident #4. The Resident Pain Assessment Interview, questions J0200 through J0600, which was not completed for Resident #4's 3/12/17 MDS was reviewed with MDS Nurse #2. She stated she was responsible	F 272	Steps Taken in Regards to those Residents found to be affected: - Resident #4□s pain assessment was modified on 4/10/2017 by the Minimum Data Set Coordinator. - Resident #9□s pain assessment was modified on 4/11/2017 by the MDS Coordinator. - Resident #60□s Brief Interview of Mental Status was completed for the 4/9/2017 assessment by the Social Service Director on 4/7/2017. Steps Taken in Regards to those Residents having the potential to be affected: - MDS Coordinators were re-educated to complete pain assessments timely and accurately by the Administrator on 3/29/17 - Social Service Director and MDS Coordinators were re-educated on the timely completion of resident BIMs by the Administrator on 3/29/17 - An audit was conducted on 4/7/2017 by the MDS Coordinators to determine if pain assessments were accurately coded. Three additional resident assessments	

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F 272	Continued From page 2 for conducting the Resident Pain Assessment Interview with Resident #4. She revealed that if the resident interview was not conducted prior to the Assessment Review Date (ARD) then the questions had to be left incomplete. She stated she was unsure why the resident interview was not conducted prior to the 3/12/17 ARD for Resident #4, but she indicated this was why Section J was incomplete. An interview was conducted with the Director of Nursing (DON) on 3/29/17 at 10:49 AM. She indicated she expected the MDS to be fully completed for all residents. 2. Resident #9 was admitted to the facility on 3/13/17 with diagnoses that included chronic pain syndrome. The admission MDS assessment dated 3/20/17 indicated Resident #9 was cognitively intact. Section J, the Health Conditions section, was not fully completed. Questions J0200 through J0600, the Resident Pain Assessment Interview, were not assessed. This section was indicated to have been completed by MDS Nurse #2. An interview was conducted with MDS Nurse #2 on 3/29/17 at 10:43 AM. She stated she was responsible for coding Section J of the 3/20/17 admission MDS for Resident #9. The Resident Pain Assessment Interview, questions J0200 through J0600, which was not completed for Resident #9's 3/20/17 MDS was reviewed with MDS Nurse #2. She stated she was responsible for conducting the Resident Pain Assessment Interview with Resident #9. She revealed that if the resident interview was not conducted prior to the ARD then the questions had to be left	F 272	were found to be miscoded. MDS Coordinator made modifications to all on 4/11/17. - An audit was conducted on 4/11/17 by the Social Service Director to determine if BIMs were not completed during the past 3 months. No other deficient practice was noted. Measures put in Place to ensure the deficient practice does not recur: - A Pain assessment audit will be completed by the Assistant Director of Nursing, Director of Nursing or Administrator one time per week for 12 weeks on 20% of assessments to be transmitted to CMS - A BIMs audit will be completed by the Assistant Director of Nursing, Director of Nursing, or Administrator one time per week for 12 weeks on 20% of assessments to be transmitted to CMS Monitoring effectiveness of corrective action: - The Pain assessment audits will be brought by the Administrator, DON, or ADON to the Quality Assurance committee 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan. - The BIMs audits will be brought by the Administrator, DON or ADON to the Quality Assurance committee 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further	

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F 272	Continued From page 3	F 272		

incomplete. She stated she was unsure why the resident interview was not conducted prior to the 3/20/17 ARD for Resident #9, but she indicated this was why Section J was incomplete.

An interview was conducted with the Director of Nursing (DON) on 3/29/17 at 10:49 AM. She indicated she expected the MDS to be fully completed for all residents.

3. Resident #60 was originally admitted to the facility on 9/7/16 and was most recently admitted on 10/3/16 with multiple diagnoses that included dementia and anxiety.

A review of the quarterly Minimum Data Set (MDS) assessment dated 1/10/17 revealed that a Brief Interview for Mental Status (BIMS) was not conducted.

An interview was conducted with the facility Social Worker (SW) on 3/29/17 at 11:11 AM. She stated she was responsible for completing and coding Section C of the 3/12/17 MDS for Resident #60. The SW acknowledged that the BIMS and mood assessments had not been attempted with the resident. The SW was unable to find a corresponding SW note for the assessment dated 1/10/17 that may have provided information as to why she had not completed the BIMS and mood assessments. She indicated that she had signed the MDS assessment on 1/12/17. Since the BIMS was not completed and she had not written a SW note in the resident's record, the SW concluded she must not have spoken to the resident regarding the assessment. The SW indicated the BIMS and mood assessments should have been completed on resident #60 for the quarterly assessment dated 1/10/17.

action plan.

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F 272	Continued From page 4 An interview was conducted with the Director of Nursing (DON) on 3/29/17 at 10:49 AM. She indicated she expected the MDS assessments to be fully completed and coded correctly for all residents.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278		4/11/17

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F 278	Continued From page 5 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of life expectancy for 1 of 1 residents (Resident #4) reviewed for hospice and in the area of medications for 1 of 5 residents (Resident #36) reviewed for unnecessary medications. The findings included: 1. Resident #4 was admitted to the facility on 11/20/15 with multiple diagnoses that included cancer. A review of the medical record indicated Resident #4 was admitted to hospice services on 3/6/17. A significant change Minimum Data Set (MDS) assessment dated 3/12/17 indicated Resident #4 had moderate cognitive impairment. She was indicated to have received hospice services during the last 14 days and while a resident at the facility. Section J, the Health Conditions section, had not indicated Resident #4 had a life expectancy of six months or less (Question J1400). An interview was conducted with the MDS Nurse #2 on 3/29/17 at 10:41 AM. She stated she was responsible for coding Section J of the 3/12/17 MDS for Resident #4. She indicated this significant change assessment was completed due to Resident #4's admission to hospice. Section J of the MDS dated 3/12/17 for Resident #4 that indicated there was no prognosis of 6	F 278	Steps Taken in Regards to those Residents found to be affected: - Modification of Resident #4 assessment was made on 3/29/17 by MDS Coordinator. - Modification of Resident #36 assessment was made of 3/29/17 by MDS Coordinator. Steps Taken in Regards to those Residents having the potential to be affected: - On 4/7/17, All Assessments for all residents who received hospice services during the past six months were audited to ensure that question J1400 was answered indicating that the resident□s life expectancy was six months or less. No other issues noted as a result of the audit. - On 4/7/17, MDS Coordinator conducted an audit of all assessments completed on all residents from the past 30 days to ensure that question N0401 was coded accurately. No other issues noted. - MDS nurses were re-educated on accurately coding life expectancy and medications on 3/29 by the Administrator. Measures put in Place to ensure the deficient practice does not recur:	

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F 278	Continued From page 6 months or less was reviewed with MDS Nurse #2. She revealed the MDS was inaccurate. She indicated this was an oversight and a modification was going to be completed that indicated Resident #4's life expectancy was 6 months or less. An interview was conducted with the Director of Nursing (DON) on 3/29/17 at 10:49 AM. She indicated she expected the MDS to be coded accurately. 2. Resident #36 was admitted to the facility on 4/13/16 with multiple diagnoses that included depression. The significant change MDS assessment dated 1/30/17 indicated Resident #36 had significant cognitive impairment. Section N, the Medications section, indicated Resident #36 received no antidepressant medication during the 7 day MDS look back period. A review of the Medication Administration Record (MAR) for the look back period of Resident #36's 1/30/17 MDS indicated she had been administered Zoloft (antidepressant medication) on 7 of 7 days during the MDS look back period (1/24/17 through 1/30/17). An interview was conducted with MDS Nurse #1 on 3/29/17 at 10:39 AM. She indicated she was responsible for completing Section N of the 1/30/17 MDS for Resident #36. This section that indicated Resident #36 had not received antidepressant medication during the 7 day MDS look back period was reviewed with MDS Nurse #1. Resident #36's MAR for the 1/30/17 MDS look back period was reviewed with MDS Nurse	F 278	- An audit of question N0401 will be completed one time a week for 12 weeks by the ADON, Director of Nursing, or Administrator on 20% of all assessments - An audit will be conducted by the ADON, Director of Nursing, or Administrator once a week for 12 weeks on every assessment completed on resident□s receiving hospice services. Monitoring effectiveness of corrective action: Audits on question N0401 will be brought by the Administrator, ADON,or DON to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan. Audits regarding question J1400 will be brought by the Administrator, DON, or ADON to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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F 278	Continued From page 7 #1. She revealed Resident #36's 1/30/17 MDS was inaccurately coded for antidepressants. She indicated the 1/30/17 MDS should have indicated Resident #36 was administered antidepressant medication on 7 of 7 days during the look back period. She stated that was an oversight. An interview was conducted with the DON on 3/29/17 at 10:48 AM. She indicated her expectation was for the MDS to be completed accurately.	F 278		
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after	F 285		4/11/17

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F 285	Continued From page 8 January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after	F 285		

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F 285	Continued From page 9	F 285		

being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or

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F 285	Continued From page 10 intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to make a referral for re-evaluation after a significant change in condition, for 1 of 1 sampled residents (Resident #4) reviewed for Preadmission Screening Resident Review Level II status. The findings included: Resident #4 was admitted to the facility on 11/20/15 with multiple diagnoses that included schizophrenia and other intellectual disabilities. Review of the medical record revealed Resident #4 was determined to have a Level II Preadmission Screening Resident Review (PASRR), dated 11/16/15. Further record review revealed Resident #4 was admitted to hospice services on 3/6/17 and a Significant Change in Status Minimum Data Set (MDS) assessment was completed on 3/12/17. An interview was conducted with the Admissions Director on 3/29/17 at 10:04 AM. She indicated she was responsible for making a referral to the PASRR Authority when a resident with Level II status had a significant change in condition. She stated that one of the MDS Nurses or the Social Worker informed her verbally if a resident with a Level II status had a significant change in condition. Resident #4's Level II PASRR status was confirmed with the Admissions Director. She reviewed her records and stated the most recent Level II PASRR determination notification she had on file for Resident #4 was dated 11/16/15 with no expiration date. She revealed she was not aware a Significant Change in Status assessment was	F 285	Steps Taken in Regards to those Residents found to be affected: Admissions coordinator submitted for a level II screening for resident #4 on 3/29/17 Steps Taken in Regards to those Residents having the potential to be affected: An audit was conducted by the administrator on 4/10 on all assessments completed over the past 6 months to identify any resident who has a level II Pre Admission Screening and Resident Review that had a significant change assessment. One resident was found to have had a significant change. A PASRR screening was completed on 4/11 by the admissions coordinator. Measures put in Place to ensure the deficient practice does not recur: - An in-service was conducted by the Administrator on 3/29/17 with the admissions coordinator, MDS coordinators, Director of Nursing and Social worker on submitting a PASRR screening within 7 days of a significant change. - An audit will be completed by the Social worker, admissions coordinator, DON or Administrator once a week for 12 weeks to identify any significant change	

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F 285	Continued From page 11 completed for Resident #4 on 3/12/17. She additionally revealed she had not made a referral for re-evaluation after this significant change in condition for Resident #4. She stated she would initiate this referral for re-evaluation for Resident #4 to the PASRR Authority today (3/29/17). An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 3/29/17 at 10:45 AM. They both indicated their awareness of the requirement for a referral for re-evaluation to the PASRR Authority for a resident with a Level II status following a significant change in condition. MDS Nurse #1 and MDS Nurse #2 stated that they were not responsible for completion of the referrals. The MDS Nurses indicated that all residents with significant changes in condition were reviewed in morning meetings and this was how the department heads were made aware of the information. An interview was conducted with the Director of Nursing (DON) on 3/29/17 at 10:49 AM. She stated it was her expectation that a referral be done when a resident with Level II PASRR had a significant change in status.	F 285	assessments that were completed. These residents will be reviewed to see if a PASRR screening is necessary. Monitoring effectiveness of corrective action: The MDS accuracy audit tool will be brought by the MDS Coordinators, Administrator or DON to the Quality Assurance committee for monthly review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based	F 315		4/14/17

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	345000	A. BUILDING _____ B. WING _____	03/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209

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F 315	Continued From page 12 on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to anchor the catheter tubing to prevent excessive tension for 1 of 2 sampled residents (Resident #40) with indwelling catheters. Findings included: Resident #40 was admitted on 1/27/17. The 5-day minimum data set dated 3/17/17 revealed the resident was severely cognitively impaired with no psychosis or behaviors. The resident	F 315	Steps Taken in Regards to those Residents found to be affected: Resident #40□s indwelling catheter was anchored on 3/29/17 by Nurse #1. Steps Taken in Regards to those Residents having the potential to be affected: - An indwelling catheter audit was	

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F 315	Continued From page 13 required extensive assist of 2 persons for activities of daily living. Resident was incontinent of urine. Diagnoses were diabetes mellitus type 2, debility, and recurrent UTI. A review of Resident #40 ' s care plan dated 1/27/17 for the urinary catheter interventions included daily care, placement below the bladder, drainage bag concealment, secure the tubing, and evaluate for signs and symptoms of urinary tract infection. The physician's order dated 3/16/17 was reviewed and revealed placement of a urinary catheter for wound healing of a stage 3 pressure ulcer, to keep the urinary drainage bag below the bladder, to keep the bag discreet, for daily catheter care, to anchor the catheter tubing, and to record the urine output each shift. On 3/29/17 at 10:50 am an observation was conducted of the urinary catheter care performed by Nurse #1. Nurse #1 performed catheter care according to the physician order. The catheter was not secured with a leg strap or tape when Nurse #1 removed the bed covers from the resident. Nurse #1 did not secure the catheter with a leg strap or tape when finished with catheter care. On 3/29/17 at 11:45 am an interview was conducted with Nurse #1. Nurse #1 stated that there was a physician's order to secure Resident #40's indwelling catheter, but it was not done today. Nurse #1 stated the expectation was that the resident have her catheter secured to prevent tension or dislodgement and that she would need to place a leg strap to secure the catheter. On 3/29/17 at 2:00 pm an interview was conducted with the Director of Nursing (DON).	F 315	completed by the Assistant Director of Nursing to confirm all resident□s with indwelling catheters were anchored on 3/30/17. All other catheters were anchored at this time. - Re-education was provided to Nurse #1 on 3/30/2017 by the DON on securing indwelling catheters appropriately. - Nursing staff will be provided re-education by the DON, ADON and Staff Development Coordinator on securing indwelling catheters to be completed by 4/17/2017. Measures put in Place to ensure the deficient practice does not recur: The DON, ADON, Staff Development Coordinator or Nursing Supervisor will conduct a weekly audit x 12 weeks to determine that all indwelling catheters are anchored appropriately. Monitoring effectiveness of corrective action: The catheter audits will be brought by the DON, ADON or Administrator to the Quality Assurance committee 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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F 315	Continued From page 14 The DON stated her expectation was that staff follow physician orders to secure the resident's catheter.	F 315		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of	F 520		4/11/17

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F 520	Continued From page 15 such committee with the requirements of this section. (i) Sanctions. 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 interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 4/7/16 recertification survey. This was for a recited deficiency in the area of assessment accuracy (F278). This deficiency was cited again on the current recertification survey of 3/29/17. 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 Assessment and Assurance program. The findings included: This tag is cross referenced to: F278 - Assessment Accuracy: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of life expectancy for 1 of 1 residents (Resident #4) reviewed for hospice and in the area of medications for 1 of 5 residents (Resident #36) reviewed for unnecessary medications. During the recertification survey of 4/7/16 the facility was cited F278 for failing to accurately code the MDS assessment in the areas of PASRR level II, medications, diagnosis, and	F 520	Steps Taken in Regards to those Residents found to be affected: - Resident #4□s assessment was modified for life expectancy on 3/29/17 by the MDS Coordinator. - Resident # 36□s assessment was modified for medications on 3/29/17 by the MDS Coordinator. Steps Taken in Regards to those Residents having the potential to be affected: - An audit was completed by the MDS Coordinators on 4/7/2017 to ensure all resident□s receiving Hospice services have assessments that are coded correctly. - An audit was completed by the MDs Coordinators on 4/7 to ensure all resident□s medications are coded correctly on assessments. - MDS nurses were re-educated on accurately coding life expectancy and medications on 3/29 by the Administrator. Measures put in Place to ensure the deficient practice does not recur: The MDS accuracy audit tool will be	

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F 520	Continued From page 16 dental. On the current recertification survey of 3/29/17 the facility failed to code the MDS accurately in the areas of life expectancy and medications. An interview was conducted with the Assistant Director of Nursing (ADON) on 3/29/17 at 2:45 PM. She stated she was the head of the facility's QAA Committee. She indicated the committee consisted of the Administrator, Director of Nursing (DON), MDS Nurse #1, MDS Nurse #2, Admissions Director, Dietary Manager, Social Worker, Medical Director, and Pharmacist. She stated the committee met monthly with the exception of the pharmacist who attended quarterly. The ADON indicated she was aware Assessment Accuracy was a repeat citation from the 4/7/16 recertification survey. She stated the previous plan of correction included audits of the MDS assessments for a period of about 3 months. She reported there was no current focus on MDS audits for accuracy.	F 520	completed by DON, ADON, Staff Development Coordinator or Administrator for one year. Monitoring effectiveness of corrective action: The MDS accuracy audit tool will be brought by the DON, ADON or Administrator to the Quality Assurance committee for monthly review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	