STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF FOREST GLENN	1101 HARTWELL STREET GARNER, NC 27529

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F 000	INITIAL COMMENTS A Minimum Data Set (MDS) 3.0 Focused Survey was conducted June 20 and 21, 2017. The facility was not in compliance with applicable requirements of 42 C.F.R. Part 483, Health Standard Requirements for Long Term Care Facilities.	F 000		
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	F 278		7/13/17

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

Electronically Signed | 06/30/2017

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F 278	Continued From page 1 subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) to reflect the active diagnoses for 1 of 12 residents (Resident #11), and failed to accurately code the MDS to reflect a fall for 4 of 12 residents (Resident #3, #5, #2, and #10) reviewed for accuracy of the MDS. Findings included: 1. Resident #11 was admitted to the facility on 6/27/15 with diagnoses that included Pneumonia and Cerebral Vascular Accident. Review of resident #11's MDS dated 4/21/17, coded as a quarterly assessment, indicated resident #11 had received antipsychotic medication for 7 of 7 days of the look back period, and no active diagnosis was marked to support the use of the antipsychotic medication. A review of the resident's cumulative diagnoses had documentation of resident having a current diagnosis of Psychosis. During an interview with the MDS Coordinator on 6/21/17 at 11:25 am, the MDS Coordinator indicated the assessment was inaccurate. She further indicated psychotic disorder should have been marked under the Active Diagnosis section of the MDS dated 4/21/17. She stated the assessment would be modified and submitted before the end of the day. 2. Resident #3 was admitted to the facility on 8/11/1015 with diagnoses that included Muscle Weakness, Dysphasia, and Dementia.	F 278	The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged date of compliance is July 13, 2017. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F 278 483.20 Assessment Accuracy/Coordination/Certified Corrective Action On June 21, 2017, the MDS (Minimum Data Set) assessment for resident number 11 was corrected to reflect the active diagnosis, and for resident number□s #2, 3, 5 & 10 the MDS was corrected to reflect a fall. The MDS nurses has submitted the corrections on June 21, 2017. Corrective action for those who have the potential to be affected	

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F 278	Continued From page 2 Review of Resident #3's MDS dated 5/1/17, coded as an annual assessment, indicated the resident had one fall with no injury since admission or previous assessment. Review of the facility's Incident/Accident log for May 2017 had the resident's name listed as having fallen twice on 5/1/17. Once at 7:00am and again at 6:30pm. Review of a nursing note dated 5/1/17 had documentation that read in part: Resident fell from bed to floor. No injuries. The note was written at 10:00pm on 5/1/17. During an interview with the MDS Coordinator on 6/21/17 at 11:46am the MDS Coordinator stated the resident had fallen twice on 5/1/17. The MDS Coordinator indicated the assessment was inaccurate and should have been coded to include both falls on 5/1/17. She further stated the assessment would be modified and submitted before the end of the day. 3. Resident #5 was admitted to the facility on 4/21/16 with diagnoses that included Diabetes Mellitus and Dementia. A review of Resident #5's MDS dated 6/2/17, coded as a discharge assessment revealed the resident had 2 or more falls with no injury and 1 fall with major injury since admission or previous assessment. Review of the facility's Incident/Accident log for May 2017 had the resident's name listed as having fallen on 5/11/17 with no apparent injury and as having fallen on 5/16/17 resulting in a skin tear to her left finger. A review of an incident/accident report dated 5/16/17 had documentation that the resident had a witnessed fall in the bathroom and sustained a	F 278	After notification of errors detected during the survey, the DON (Director of Nurses) and the MDS nurse reviewed the last completed assessment for all current residents that were assessed in the past six months, reviewing for capturing any falls that may have occurred and capturing of all active diagnosis. Additional necessary corrections will be completed by the MDS nurses by July 10, 2017. Systemic changes The MDS nurses will be re-educated by our Corporate Clinical Resource Specialist for accuracy in coding the MDS. Re-education was completed on June 21, 2017. The MDS nurse will attend the daily clinical meeting to ensure that falls and new diagnosis are captured appropriately. Monitoring The Corporate Clinical Resource Specialist will visit the facility twice a month for the next two months and will review all comprehensive MDS□s. The Director of Nurses, using a QA auditing tool, will review all MDS□s for those residents that have had new diagnosis and falls for completeness and accuracy, weekly for the next 2 months, and then will review random MDS□s completed weekly for the next month to ensure that MDS□s are and continue to be accurate and completed. The results will be reported by the DON, to the monthly QAPI	

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F 278	Continued From page 3 skin tear. During a review of the facility's Incident/Accident log for June 2017 had the resident's name listed as having fallen on 6/1/17 with no apparent injury. A nursing note was written on 6/1/17 which stated the resident had a fall in the bathroom and no injuries were apparent at that time. Review of a nursing note dated 6/2/17 had documentation that the resident was sent to the hospital for a fracture sustained from her fall on 6/1/17. During an interview with the MDS Coordinator on 6/21/17 at 11:48am the MDS Coordinator indicated she was aware of the three falls, but did not notice the resident sustained a skin tear when she fell on 5/16/17. The MDS Coordinator indicated the assessment was inaccurate and should have been coded to include one fall with no injury, one fall with minor injury, and one fall with major injury. She further stated the assessment would be modified and submitted before the end of the day. 4. Resident #2 was admitted to the facility on 1/21/2017 with diagnoses that included End Stage Renal Disease, Diabetes Mellitus, and Hypertension. Review of Resident #2's MDS dated 5/24/17, coded as an admission assessment, indicated the resident had no falls since admission or previous assessment. Review of the facility's Incident/Accident log for May 2017 had the resident's name listed as having fallen on 5/23/17. Review of a nursing note dated 5/23/17 had documentation that read in part: Resident had a fall at 10am, no injuries noted.	F 278	(Quality Assurance and Performance Improvement) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.	

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F 278	Continued From page 4 During an interview with the MDS Coordinator on 6/21/17 at 12:58pm, the MDS Coordinator stated the resident had fallen on 5/23/17. The MDS Coordinator indicated the assessment was inaccurate and should have been coded to include the fall on 5/23/17. She further stated the assessment would be modified and submitted before the end of the day. 5. Resident #10 was admitted to the facility on 4/21/17 with diagnoses that included Atrial Fibrillation and History of falling. Review of Resident #5's MDS dated 5/19/17, coded as a 30 day PPS (Prospective Payment System) assessment, indicated the resident had not fallen since admission or previous assessment. Review of the facility's Incident/Accident log for May 2017 had the resident's name listed as having fallen on 5/13/17 resulting in a skin tear to his left lower leg. A nursing note was written on 5/13/17 that had documentation that read in part: Fell on the floor today at 7:45pm. Small skin tear to left shin. During an interview with the MDS Coordinator on 6/21/17 at 1:10pm the MDS Coordinator indicated the assessment was inaccurate and should have been coded to include one fall with minor injury. She further stated the assessment would be modified and submitted before the end of the day.	F 278		
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	F 520		7/13/17

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F 520	Continued From page 5 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 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 reviews and staff interviews the facility's Quality Assessment and Assurance	F 520	F 520 483.75 Administration	

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F 520	Continued From page 6 Committee failed to maintain implemented procedures and monitor the interventions that the committee put into effect January 2017. This was for one recited deficiency which was originally cited in December 2016 during a recertification survey and was recited again during a Minimum Data Set (MDS) 3.0 Focused Survey of June 20 and 21, 2017. The deficiency was in 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. The Findings Included: This tag is cross referred to: F 278: Accuracy of Assessment. Based on record reviews and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) to reflect the active diagnoses for 1 of 12 residents (Resident #11), and failed to accurately code the MDS to reflect a fall for 4 of 12 residents (Resident #3, #5, #2, and #10) reviewed for accuracy of the MDS. During the previous recertification of 12/09/2016, the facility was cited a deficiency at F278 for failure to accurately code the Minimum Data Set to reflect the resident's dental status for 1 of 3 residents reviewed for dental status (Resident #13). An interview with the Director of Nursing and the Administrator was conducted on 6/21/2017 at 1:45 PM. During this interview, the Administrator stated that MDS assessments monitoring for accuracy was ongoing.	F 520	Corrective Action On June 21, 2017, the MDS (Minimum Data Set) assessment for resident number 11 was corrected to reflect the active diagnosis, and for resident number□s #2, 3, 5 & 10 the MDS was corrected to reflect a fall. The MDS nurses has submitted the corrections on June 21, 2017. Corrective action for those who have the potential to be affected After notification of errors detected during the survey, the DON (Director of Nurses) and the MDS nurse reviewed the last completed assessment for all current residents that were assessed in the past six months, reviewing for capturing any falls that may have occurred and capturing of all active diagnosis. Additional necessary corrections will be completed by the MDS nurse by July 10, 2017. Systemic changes The QAPI committee will be in-serviced by the Administrator by June 30, 2017, on the procedure for developing and implementing appropriate plans of action to correct identified quality concerns. Education will include determining the root cause of the identified concern, identifying, implementing and monitoring the corrective action plan and recognizing when an action plan may need to be revised. The MDS/Care Plan Nurse and	

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F 520	Continued From page 7	F 520	administrative nurses will have been re-educated on June 21, 2017, by our Corporate Clinical Resource Specialist regarding coding accuracy of the MDS. The MDS nurses will attend the daily clinical meeting to ensure that falls and new diagnosis□s are captured appropriately. Monitoring The Corporate Clinical Resource Specialist will visit the facility twice a month for the next two months and will review all comprehensive MDS□s. The Director of Nurses, using a QA auditing tool, will review all MDS□s for those residents that have had new diagnosis, new antipsychotic medications, falls, and/or UTI□s, for completeness and accuracy, weekly for the next 2 months, and then will review random MDS□s completed weekly for the next month to ensure that MDS□s are and continue to be accurate and completed. The results will be reported by the DON, to the monthly QAPI (Quality Assurance and Performance Improvement) meeting for any further recommendations. The DON will be responsible to follow-up on any recommendation from the QA committee with additional training to be provided by the Clinical Resource Specialist, as indicated.	