STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHAB CTR	109 FOOTHILLS DRIVE MORGANTON, NC 28655

(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		11/16/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/06/2017

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 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 reviews and staff interviews, the facility failed to complete Care Area Assessments that addressed underlying causes and contributing factors for psychotropic drug use and urinary incontinence for 3 of 20 sampled residents (Resident #62, #49 and #94). The findings included: 1. Resident #62 was admitted to the facility on 12/15/10 with current diagnoses of depression and diabetes. Review of the significant change Minimum Data Set (MDS) dated 11/30/16 revealed Resident #62 was severely cognitively impaired and able to make her needs known. The MDS further revealed Resident #62 received antidepressant medication during the 7 day assessment period. Review of the Care Area Assessment (CAA) Summary for Psychotropic Medication Use dated 12/06/17 revealed it was completed by MDS Nurse #1. The CAA summary indicated Resident #62 had a diagnoses of depression and took an antidepressant medication per physician orders and medications were monitored for effectiveness and potential side effects. The CAA did not analyze how the psychotropic medications	F 272	1.MDS nurse that completed MDS for resident #62 is no longer employed. Current MDS Nurse #1 & MDS Nurse #2 did not understand that the required detail should be included in the CAA area and have received training since MDS was completed as followed; Attended MDS training by Mary Mass on 9/20/17 & 9/21/17 and attended MDS certification class sponsored by AANAC 10/11/17-10/13/17. A significant correction MDS will be completed by 11/8/17 by MDS Nurse #1 or MDS Nurse #2. The Director of Nursing or designee will complete an MDS audit for MDS accuracy, completion date and CAA summary on a random sample of 10 residents monthly for 3 months and then quarterly using the MDS Audit Form to verify compliance for 3 quarters. The Director of Nursing is the person responsible for implementing the acceptable plan of correction and shall ensure audit results and corrective actions taken are presented at monthly Quality Assurance Performance Improvement (QAPI) meetings. The QAPI team shall	

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F 272	Continued From page 2 actually affected her day to day function and activities. The CAA summary did not indicate if there had been any adverse reactions or attempted dose reductions. The CAA did not state if a referral was necessary or if Resident #62 had received psychiatric services. An interview conducted on 10/19/17 at 2:39 PM with MDS Nurse #1 revealed she has been doing MDS for six years. She stated she is MDS Certified and has also attended the State-offered MDS class. She reported when she wrote an MDS summary it was a recap of the MDS. She stated she was not aware the summary should include how the MDS Care Area Trigger affected the resident's day to day life and activities. 2. Resident # 49 was admitted to the facility on 12/21/12 with current diagnoses of non-Alzheimer's dementia, anxiety, and depression. Review of the annual Minimum Data Set (MDS) dated 07/31/17 revealed Resident #49 was moderately cognitively impaired but could make her needs known. The MDS further revealed Resident #49 received antipsychotic, antianxiety and antidepressant medications during the 7 day assessment period. Review of the Care Area Assessment (CAA) Summary for Psychotropic Medication Use dated 08/11/17 revealed it was completed by MDS Nurse #1. The CAA summary indicated Resident #49 had a diagnoses of depression; dementia with psychosis (schizophrenia) and anxiety. Takes psychotropic medications which are monitored for effectiveness and potential side effects. The CAA did not analyze how the psychotropic medications	F 272	ensure corrective actions are achieved and maintained. 2.For Resident #49, the MDS nurse #1 did not understand that the required detail should be included in the CAA area and have received training since MDS was completed as followed; Attended MDS training by Mary Mass on 9/20/17 & 9/21/17 and attended MDS certification class sponsored by AANAC 10/11/17-10/13/17. A significant correction MDS will be completed by 11/8/17 by MDS Nurse #1 or MDS Nurse #2. The Director of Nursing or designee will complete an MDS audit for MDS accuracy, completion date and CAA summary on a random sample of 10 residents monthly for 3 months and then quarterly using the MDS Audit Form to verify compliance for 3 quarters. The Director of Nursing is the person responsible for implementing the acceptable plan of correction and shall ensure audit results and corrective actions taken are presented at monthly Quality Assurance Performance Improvement (QAPI) meetings. The QAPI team shall ensure corrective actions are achieved and maintained. 3.For Resident #94, the MDS Nurse #1 did not understand that the required detail	

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F 272	Continued From page 3 actually affected her day to day function and activities. The CAA summary did not indicate if there had been any adverse reactions or attempted dose reductions. The CAA did not state if a referral was necessary or if Resident #49 had received psychiatric services. An interview conducted on 10/19/17 at 2:39 PM with MDS Nurse #1 revealed she has been doing MDS for six years. She stated she is MDS Certified and has also attended the State-offered MDS class. She reported when she wrote an MDS summary it was a recap of the MDS. She stated she was not aware the summary should include how the MDS Care Area Trigger affected the resident's day to day life and activities. 3. Resident #94 was admitted to the facility on 06/02/17 with diagnoses of non-Alzheimer's dementia, arthritis, and hemiplegia. Review of the admission Minimum Data Set (MDS) dated 06/09/17 revealed Resident #94 was cognitively intact. The MDS further revealed Resident #94 was occasionally incontinent of bladder. Review of the Care Area Assessment dated 06/15/17 for urinary incontinence was completed by MDS Nurse #1. The CAA Summary indicated Resident #94 was incontinent of bladder and bowel and was on a toileting program. Resident reported incontinence was a long time issue. The CAA did not analyze how the urinary incontinence actually affected her day to day function and activities. An interview conducted on 10/19/17 at 2:39 PM with MDS Nurse #1 revealed she has been doing	F 272	should be included in the CAA area and have received training since MDS was completed. Attended MDS training by Mary Mass on 9/20/17 & 9/21/17 and attended MDS certification class sponsored by AANAC 10/11/17-10/13/17. A significant correction MDS will be completed. The Director of Nursing or designee will complete an MDS audit for MDS accuracy, completion date and CAA summary on a random sample of 10 residents monthly for 3 months and then quarterly using the MDS Audit Form to verify compliance for 3 quarters. The Director of Nursing is the person responsible for implementing the acceptable plan of correction and shall ensure audit results and corrective actions taken are presented at monthly Quality Assurance Performance Improvement (QAPI) meetings. The QAPI team shall ensure corrective actions are achieved and maintained.	

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F 272	Continued From page 4 MDS for six years. She stated she is MDS Certified and has also attended the State-offered MDS class. She reported when she wrote an MDS summary it was a recap of the MDS. She stated she was not aware the summary should include how the MDS Trigger affected the resident's day to day life and activities.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an admission comprehensive assessment within the required 14 day time frame for 1 of 20 sampled residents reviewed for completion of the Minimum Data Set and Care Area Assessment (Resident #94). The findings included: Resident #189 was admitted to the facility on 09/25/17 with diagnoses of hypertension and	F 273	Resident #189 was a new admission that was listed on the MDS list for completion but not moved to the MDS/Care Plan list for other disciplines. An admission interim care plan was completed. The MDS Nurse #1 & MDS Nurse #2 was out of the facility for MDS training and found that the MDS had not been completed when they returned. All disciplines were notified that the MDS needed completion on 10/16/17. The MDS was completed and transmitted	11/16/17

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F 273	Continued From page 5 Alzheimer's disease. The admission Minimum Data Set (MDS) had an assessment reference date of 10/06/17. Review of the MDS revealed there were sections in red that had not been completed as of 10/19/17 at 2:40 PM. In addition the Care Area Assessments for the triggered areas were not complete. An interview conducted on 10/19/17 at 2:39 PM with MDS Nurse #1 revealed she had worked as an MDS Nurse for six years. She stated she was aware Resident #189's admission MDS had not been completed within 14 days after her admission. She stated she made a list that lets her know when MDS assessmwnts were due and she placed Resident #189 on the bottom of the list due to being admitted under a different payer source, overlooking her MDS due date. She stated she had sent a reminder today to all staff that had not completed their sections to please complete them today. An interview conducted with the Director of Nursing on 10/19/17 at 3:50 PM revealed it was her expectation for all MDS to be completed within the correct time frame.	F 273	on 10/20/17. No other residents were affected. The IDT including nursing, social services, activities, therapy, and dietary were in-serviced on 11/6/17 by MDS Nurse #1 regarding RAI guidelines stating admission MDS assessment completion is required 14 days from admission date. MDS Nurse #1 & MDS Nurse #2 completed online training on 11/2/17 to utilize MDS analyzing software for alerts on approaching completion dates. The Director of Nursing or designee will complete an MDS audit for MDS accuracy, completion date and CAA summary on a random sample of 10 residents monthly for 3 months and then quarterly using the MDS Audit Form to verify compliance for 3 quarters. The Director of Nursing is the person responsible for implementing the acceptable plan of correction and shall ensure audit results and corrective actions taken are presented at monthly Quality Assurance Performance Improvement (QAPI) meetings. The QAPI team shall ensure corrective actions are achieved and maintained.	
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	F 278		11/16/17

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F 278	Continued From page 6 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. (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 Minimum Data Set (MDS) for dental status (Resident #92) and bladder continence (Resident #94) for 2 of 20 residents reviewed for MDS accuracy. Findings included: 1. Resident #92 was admitted to the facility on	F 278	1. For resident #92, the MDS nurse was not aware that she could check all that apply in LO200 and only checked unable to examine due to resident refusing examination during the look back period. A dental consult note on 4/13/17 could have been used to confirm resident was edentulous.	

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F 278	Continued From page 7 09/16/14 with diagnoses that included dementia. Review of Resident #92's medical record revealed a dental note dated 04/13/17 which indicated she was edentulous (having no teeth). The annual MDS dated 04/27/17 coded Resident #92 with severe impairment in cognition. The oral/dental status section of the MDS was coded as "unable to examine." An interview conducted on 10/19/17 at 2:40 PM with MDS Nurse #1 revealed she coded Section L on the MDS by information gathered from talking to the resident or their family member and examining the resident's mouth. MDS Nurse #1 explained she did not always go by the information listed on the dental note because it might not indicate if the resident had other issues such as pain, trouble chewing or sores on the gum. MDS Nurse #1 confirmed Resident #92 was edentulous and acknowledged the MDS should have been coded to reflect she was edentulous. An interview was conducted on 10/19/17 at 3:50 PM with the Director of Nursing who revealed it was her expectation for the MDS to be accurately coded. 2. Resident #94 was admitted to the facility on 06/02/17 with diagnoses of non-Alzheimer's dementia, hemiplegia and depression. Review of the admission Minimum Data Set (MDS) dated 06/09/17 revealed Resident #94 was cognitively intact. The MDS further revealed Resident #94 was occasionally incontinent of bladder.	F 278	MDS nurse that completed MDS for resident #62 is no longer employed. Current MDS Nurse #1 & MDS Nurse #2 have received training since MDS was completed as followed; Attended MDS training by Mary Mass on 9/20/17 & 9/21/17 and attended MDS certification class sponsored by AANAC 10/11/17-10/13/17. A significant correction MDS will be completed by 11/8/17 by MDS Nurse #1 or MDS Nurse #2. The Director of Nursing or designee will complete an MDS audit for MDS accuracy, completion date and CAA summary on a random sample of 10 residents monthly for 3 months and then quarterly using the MDS Audit Form to verify compliance for 3 quarters. The Director of Nursing is the person responsible for implementing the acceptable plan of correction and shall ensure audit results and corrective actions taken are presented at monthly Quality Assurance Performance Improvement (QAPI) meetings. The QAPI team shall ensure corrective actions are achieved and maintained. 2.For Resident #94 a clerical error was made with the incorrect box marked. MDS Nurse #1 has been educated to review each section after completion before moving to the next section of the MDS.	

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F 278	Continued From page 8 Review of the bowel and bladder reports from 06/02/17 through 06/03/17 revealed Resident #94 was incontinent of bladder each time bladder continence was checked. An interview conducted on 10/19/17 at 2:39 PM with MDS Nurse #1 revealed she coded Section H on the MDS for bladder by reviewing the bowel and bladder reports. MDS Nurse #1 reviewed the bowel and bladder reports from 06/02/17 through 06/09/17 with the surveyor and agreed Resident #94 was incontinent of bladder on those days and stated she should have been coded as always incontinent of bladder. An interview conducted on 10/19/17 at 3:50 PM with the Director of Nursing revealed it was her expectation for the MDS to be coded correctly.	F 278	MDS Nurse #1 & MDS Nurse #2 have received training since MDS was completed as followed; Attended MDS training by Mary Mass on 9/20/17 & 9/21/17 and attended MDS certification class sponsored by AANAC 10/11/17-10/13/17. A significant correction MDS will be completed by 11/8/17 by MDS Nurse #1 or MDS Nurse #2. The DON or designee will complete MDS audit for MDS accuracy, completion date and CAA summary on a random sample of 10 residents monthly for 3 months and then quarterly using the MDS Audit Form to verify compliance. The QAPI committee will monitor this process for effectiveness quarterly. Preparation and/or execution of this plan of correction does not constitute admissions or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The Plan of Correction is prepared in/or executed solely because the provision of the Federal and State Law require it.	