STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 02/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 falls for 2 of 2 residents reviewed for falls with injury (Residents #1 and #2). The findings included: 1. Resident #2 was admitted to the facility on 1/26/18 with multiple diagnoses that included right sided hemiparesis (weakness of the entire side of the body and aphasia (language disorder caused by damage in a specific area of the brain that controls language expression and comprehension) following cerebral infarction. An incident report dated 1/26/18 indicated Resident #2 had a fall with no injury. An incident report dated 1/28/18 indicated Resident #2 had a fall that resulted in a hematoma to her right eyebrow/eyelid area. The admission Minimum Data Set (MDS) assessment dated 2/2/18 indicated Resident #2 had severe cognitive impairment. Section J, the Health Conditions Section, indicated Resident #2 had two or more falls without injury and zero falls with injury (minor or major) since her admission to the facility. (Minor injuries were defined as skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that caused the resident to complain of pain).	F 641	This Plan of Correction is prepared as a Necessary requirement for continued Participation in the Medicare and Medicaid program. It does not in any Manner constitute an admission to The validity of the alleged deficient Practice. F641 Resident number 2 had their Minimum Data Set (MDS) modified to accurately reflect falls by the Minimum Data Set(MDS) Nurse on 2/21/2018. Resident number 1 had their MDS modified to accurately reflect falls by the MDS nurse on 2/21/2018. The MDS Nurses, the Director of Nursing(DON), the Assistant Director of Nursing (ADON), and the Registered Nurse (RN) Clinical Supervisor completed a 100 % audit of all MDS□s completed within the current quarter to review for accuracy of coding. The current quarter of MDS were audited by the DON, ADON, MDS Nurses monitored each other, and the RN Clinical Supervisor on	2/28/18

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

Electronically Signed | 02/28/2018

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F 641	Continued From page 1 An interview was conducted with the MDS Coordinator on 2/20/18 at 11:09 AM. Section J of the MDS dated 2/2/18 for Resident #2 that indicated she had 2 or more falls with no injury and zero falls with injury since admission to the facility was reviewed with the MDS Coordinator. The incident reports dated 1/26/18 and 1/28/18 for Resident #2 that indicated she had 1 fall with no injury and 1 fall with minor injury (hematoma on 1/28/18) was reviewed with the MDS Coordinator. The MDS Coordinator revealed she had coded the 2/2/18 MDS incorrectly for Resident #2. She indicated she should have coded the 2/2/18 MDS for Resident #2 as 1 fall with no injury and 1 fall with minor injury. An interview was conducted with the Administrator on 2/21/18 at 9:29 AM. She indicated she expected the MDS to be coded accurately. An interview was conducted with the Director of Nursing on 2/21/18 at 10:08 AM. She indicated she expected the MDS to be coded accurately. 2. Resident # 1 was admitted to the facility on 1/12/18 with multiple diagnoses including Hypertension. The admission Minimum Data Set (MDS) assessment dated 1/19/18 indicated that Resident #1's cognition was intact and she a fall with no injury. Review of the incident reports and the nurse's notes revealed that Resident #1 had a fall on 1/17/18. The notes further indicated that the resident complained of right side pain and x-ray was done with the result of "non displaced fracture of the right sixth and seventh ribs". On 2/20/18 at 11:09 AM, the MDS Nurse was	F 641	02/28/2018. For the quarter there were 51 MDS's that required correction. All MDS's were modified as they were identified by the MDS Nurses and the ADON. The Minimum Data Set(MDS) Nurses and the ADON (Assistant Director of Nursing) was in-serviced on MDS accuracy by the Administrator on 2/20/2018. The MDS Nurses are registered to attend the state training on MDS on 4/3/18. The QAA (Quality Assessment and Assurance) Executive Committee assigned an MDS Assessment Committee(to include the Director of Nursing, Registered Nurse Clinical Supervisor, Wound Nurse, and Assistant Director of Nursing, and Charge Nurses as assigned) to monitor and review the accuracy of the each MDS completed at clinical meeting to ensure that it reflects the Residents condition weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The MDS Nurses and the ADON will maintain a working file for each MDS completed for a quarter. The working file will contain copies of the back up paperwork for the MDS coding. This file will be maintained for one quarter	

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F 641	Continued From page 2 interviewed. She stated that she reviewed the nurse's notes and the incident reports when completing the "fall section" of the MDS assessment. The MDS Nurse stated that she coded the admission MDS assessment dated 1/19/18 incorrectly, it should have been coded fall with "major injury" due to the fracture ribs. On 2/21/18 at 10:08 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessment to be coded accurately. The DON verified that Resident #1 had a fall with major injury on 1/17/18.	F 641	or until the next MDS is completed for the resident. An Audit tool will be used to compare the back up paperwork with the MDS to ensure appropriate coding of the MDS by the MDS Assessment Committee weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The RN Clinical Supervisor will turn the weekly QI Tool into the Administrator / DON weekly. The Administrator / DON will bring the weekly QI audit tool to the weekly QI meeting for the review of the MDS being coded correctly weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The Monthly QI meeting will review the minutes of the weekly QI Meeting for the continued need and frequency of monitoring for 4 months.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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.	F 865		2/28/18

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F 865	Continued From page 3 §483.75(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 staff interviews and record review, 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 12/3/15, 11/3/16, and 11/16/17 recertification surveys. This was for a recited deficiency in the area of Assessment Accuracy (483.20). This deficiency was cited again on the current complaint investigation survey of 2/21/18. The continued failure of the facility during four 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: 483.20 Accuracy of Assessments: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of falls for 2 of 2 residents reviewed for falls with injury (Residents #1 and #2). The findings included: During the recertification survey of 12/3/15 the facility was cited at 483.20 Assessment Accuracy for failing to code the MDS accurately in the areas of radiation, chemotherapy, range of motion, splinting, and medications. During the recertification survey of 11/3/16 the facility was cited for failing to code the MDS accurately in the areas of urinary catheters, weight, height, range	F 865	This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program. It does not in any manner constitute an admission to the validity of the alleged deficient practice. F5865 The Facility□s Quality Assurance Committee failed to maintain implemented procedures and to monitor the interventions that the Committee put into place following the 02/21/2018 complaint investigation survey and following the 12/3/2015, 11/3/2016, and the 11/16/2017 recertification survey in order to sustain compliance. All residents residing in the facility have the potential to be affected. On 02/23/2018 the Vice President (V.P.)of Operations in- serviced the department managers related to the appropriate functioning of the Monthly Quality assessment and	

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F 865	Continued From page 4 of motion, ambulation, and medications. During the recertification survey of 11/16/17 the facility was cited for failing to code the MDS accurately in the areas of medications, hospice, prognosis, and skin conditions. On the current complaint investigation survey of 2/21/18 the facility was cited for failure to code the MDS accurately for falls. An interview was conducted with the Administrator on 2/21/18 at 9:29 AM. She indicated she was the head of the facility ' s QAA Committee. She stated she was aware that Assessment Accuracy was a repeat citation from the previous recertification survey. She indicated the plan of correction included the MDS Coordinator attending daily morning meetings and documenting any changes in resident conditions, including falls and the types of injuries sustained. She stated she was informed on 2/20/18 by the MDS Coordinator of the identified inaccuracies of the MDS assessments in the areas of falls. The Administrator indicated she believed this was a repeat citation because the MDS Coordinator had failed to review all documentation relating to falls when she coded the MDS. She stated the MDS Coordinator was expected to review incident reports, nursing notes, rehabilitation notes, and radiology reports. She indicated the MDS Coordinator was re-educated on 2/20/18 on the need to review all documentation and to double check her work.	F 865	assurance Committee (Administrator,Director of Nursing, Assistant Director of Nursing, Minimum Data Set (MDS) Nurses, Maintenance Director, Dietary Manager, Social Worker, Medical Records, Housekeeping Supervisor, Admissions Coordinator, Staff Nurse, RN(Registered Nurse) Clinical Supervisor) and the purpose of the committee to include identifying issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for the identified facility concerns. During the weekly Quality Assurance Meeting the accuracy of the MDS (Minimum Data Set) was reviewed with deficiencies noted. The plan of correction was updated on 02/20/2018 to include verifying paperwork before coding something on the MDS. The MDS Nurses and the Assistant Director of Nursing(ADON) were in-serviced on verifying paperwork before coding on 2/20/2018 by the Administrator. Both MDS Nurses were registered to attend the next MDS training provided by the state on 4/3/2018. The Quality Assessment and Assurance (QAA)Executive Committee assigned an MDS Assessment Committee (to include the Director of Nursing (DON), Registered Nurse (RN) Clinical Supervisor,	

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F 865	Continued From page 5	F 865	Wound Nurse, Assistant Director of Nursing (ADON), and any assigned Charge Nurses) to monitor each MDS completed using the working file for each section at the daily clinical meeting recording the results on the QI (Quality Improvement) tool that monitors completed MDS assessments to review the accuracy of the MDS to ensure that it reflects the Residents condition weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. Findings and the results of the QI tools will be reviewed by the weekly QA (Quality Assurance) Committee for 4 weeks, bi-weekly for 4 weeks, and monthly for 4 months to determine the facility□s progress in correction of deficient practices or identified concerns to include medication orders, MDS Assessments, revise and review care plans, follow care plan intervention, nutrition, and pharmacy services. The Quarterly Quality Assurance Committee will continue to review one or more of the identified areas to determine continued compliance and the need to revise or update any issues as a part of their quarterly meeting going forward. The results of the audits and progress will be documented in the minutes of the meeting. The Administrator will be	

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F 865	Continued From page 6	F 865	responsible for ensuring that the QA Committee concerns and recommendations are addressed through further training or other interventions. The QA Committee will be advised of the results of the training or other interventions at the next scheduled QA meeting by the Administrator or the Director of Nursing.	