STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345568	A. BUILDING _____ B. WING _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG	83 CAVALIER DRIVE WILMINGTON, NC 28405

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E 000	Initial Comments An unannounced Recertification investigation survey was conducted on 06/03/19 through 06/06/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M76411.	E 000		
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 observations, record review and staff interviews, the facility failed to accurately complete the comprehensive assessment for 1 of 5 residents reviewed for unnecessary medications. Resident #8 demonstrated behaviors of refusal of care. The comprehensive assessment revealed there were no behaviors coded as it related to refusal of care. Findings included: Resident # 8 was admitted to the facility on 03/25/19. Resident #8 was cognitively aware. The Minimum Data Set (MDS) completed on 04/01/19 revealed no behaviors were documented under section E (behaviors). A review of the care plans revealed on 04/04/19 a plan of care for resisting care was in place. All interventions were appropriate and goals were measurable. A review of a nursing note written on 03/25/19 at 11:06 PM revealed, in part, Resident #8 refused a laxative (a medication to help with bowel	F 641	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F641 Accuracy of Assessments Immediate Action: On 6/26/2019, the MDS assessment for resident #8 ARD 04/01/2019, was modified and transmitted by MDS #1, to reflect displaying behaviors on the look back period per RAI guidelines in Section E of the MDS.	6/27/19

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

Electronically Signed | 06/28/2019

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F 641	Continued From page 1 movements). A review of a nursing note written on 03/26/19 at 12:32 AM revealed, in part, Resident #8 refused night time Haldol (a medication to relax the resident). A review of a nursing note written on 03/26/19 at 12:40 PM revealed, in part, Resident #8 refused scheduled Tylenol (a medication to alleviate pain). A review of a nursing note written on 03/27/19, at 10:51 AM revealed, in part, Resident #8 refused his morning medications. A review of a nursing note written on 03/27/19 at 5:30 PM (recorded as late entry on 03/29/18 at 5:31 PM) revealed, in part, per therapy, Resident #8 refused evaluations again today. A review of a nursing note written on 04/01/19 at 6:52 AM revealed, in part, Resident #8 refused to allow staff to obtain a blood draw for lab work to check for hypokalemia (low potassium in the blood). An interview was conducted with Resident #8 on 06/03/19 12:10 PM. Resident #8 was alert and oriented. The resident refused to conduct an interview and refused to have a pressure ulcer observation conducted. An interview was conducted with Nurse #1 on 06/03/19 at 1:00 PM. Nurse #1 stated she was familiar with Resident #8 and he was known to refuse care such as incontinent care, taking medications and getting blood draws. Nurse #1 stated if a resident refused care, the process was to encourage and educate the resident regarding	F 641	Identification of Others: On 6/19/2019, a 100% audit for current residents most recent MDS assessment was completed by the Administrator to determine if any other residents displayed physical behaviors in the look back period and it was coded correctly based on RAI guidelines of Section E in the MDS. The results of the audit indicated no other residents were coded inaccurately per RAI guidelines in Section E. Findings of this audit is documented on Section E Coding Audit located in the facility compliance binder. Systematic Changes: Effective 6/26/2019, residents who display refusal of care behaviors will be coded accordingly in the MDS 3.0 per RAI guidelines. On 6/25/2019, the Administrator conducted a re-education to the MDS nurse #1 and the case manager on accurately coding Section E of the MDS 3.0 per the RAI guidelines. This education will also be provided annually for MDS nurses, and case managers. Monitoring Process: Effective 6/26/2019, prior to submission MDS nurse #1 will review Section E of the MDS 3.0 to ensure that documented displayed refusal of care behaviors are coded accurately per RAI guidelines. These reviews will take place Monday-Friday, prior to submission for 2 weeks, then 25% of all completed MDS assessments monthly for 3 months or until a pattern of compliance is achieved.	

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F 641	Continued From page 2 the care, document the refusal of care and notify the physician of the refusal. An interview was conducted with Nursing Assistant (NA) #1 on 06/05/19 at 11:20 AM. NA #1 reported Resident #8 had been known to refuse care and refused incontinent care on 06/05/19. NA #1 stated she notified the nurse of the refusal of care. An interview was conducted with the MDS nurse on 06/06/19 at 12:45 PM. The MDS nurse revealed when she completed the comprehensive assessments she would obtain her information regarding the resident by assessing the resident, reviewing the hospital records and admission orders, reading the physician orders, reviewing the progress notes, therapy notes, and the physician notes. The MDS nurse reviewed the progress notes for Resident #8 from 03/25/19 through 04/01/19 and confirmed there was documentation to support the resident had been refusing care. The MDS nurse stated the behavior of this type occurred 4-6 days but less than daily and should have been recorded under E0800 rejection of care. An interview was conducted with the acting Director of Nursing (DON) on 06/06/19 at 1:00 PM. The DON revealed her expectation would have been for the MDS nurse to accurately code the assessment.	F 641	Any inaccurate coding identified will be noted and corrected before submission. Findings of this monitoring process will be documented on the MDS monitoring tool located in the facility compliance binder. Effective 6/25/2019, the Administrator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months, or until a pattern of compliance is achieved. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: Effective 6/26/2019, the Administrator and MDS nurse #1 will be responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 06/27/2019	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		6/27/19

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F 656	Continued From page 3	F 656		

care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 4 Based on record review and staff interviews, the facility failed to create a care plan based on the Care Area Assessments (CAA) that triggered for cognition/dementia for 1 of 5 residents (Resident #4) reviewed for unnecessary medications. Findings included: Resident #4 was admitted to the facility on 03/10/19. Diagnoses included, in part, Alzheimer's disease. The Minimum Data Set (MDS) admission (to long term care) assessment on 03/17/19 revealed the resident was cognitively impaired. A review of the CAA dated 03/17/19 admission assessment indicated the following areas should have a care plan: cognitive loss/dementia, activities of daily living (ADLs), urinary incontinence/indwelling catheter, falls, pressure ulcers and psychotropic drug use. A review of the care plans revealed the resident had a plan of care in place with measurable goals and appropriate interventions for falls, pressure ulcers, psychotropic drug use, ADLs, nutrition, and discharge to long term care. There was no care plan for cognition loss/dementia. An interview was conducted with the MDS Nurse on 06/06/19 at 12:45 PM. The MDS Nurse stated the care area assessments were done upon admission and annually. The CAA ' s would trigger which areas should be care planned based on the information that was entered from the MDS Nurse. The MDS Nurse reported she obtained her information regarding Resident #4 by reviewing hospital records, admitting orders,	F 656	F656 Develop/Implement Comprehensive Care Plan Immediate Action: On 6/25/2019, MDS nurse #1 and the Social Worker updated Resident #4's care plan to reflect the CAA from 3/17/2019 and its recommendation to have a care plan associated with cognitive loss/dementia. Identification of Others: On 6/25/2019, MDS nurse #1 and the Social Worker completed a 100% audit of current residents most recent MDS assessment and CAA's to ensure that all other resident CAA's were reflected on their care plan. The results of the audit indicated all other residents had active CAA's reflected in their care plans. Findings of this audit are documented on the Comprehensive Care Plan/CAA Audit tool, located in the facility compliance binder. Systematic Changes: On 6/26/2019, the Administrator educated MDS nurse #1 and the Social Worker on Chapter 4 of the RAI manual regarding Care Area Assessments Process and Care Planning. Effective 6/26/2019, MDS nurse #1 and the Social Worker will accurately update every resident care plan according the RAI manuals guidelines pertaining to CAA's and Care Planning. When a CAA is triggered from the MDS 3.0, the care plan will be updated to reflect the triggered areas from the CAA.	

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F 656	Continued From page 5 nursing notes, physician notes, ADL notes and therapy notes. The MDS Nurse stated the Social Worker was responsible for completing the assessment for cognition on each resident. The MDS Nurse stated she would have expected a care plan to be created since cognitive loss/dementia triggered on the CAAs. The Social Worker was unavailable for an interview after multiple attempts to reach her by phone on 06/06/19. The acting Director of Nursing (DON) reported she was on vacation. An interview was conducted with the DON on 06/06/19 at 1:00 PM. The DON stated her expectation of the MDS Nurse would have been to ensure each care area that was triggered in the Care Area Assessment was carried over to create a care plan.	F 656	Monitoring Process: Effective 6/25/2019, MDS nurse #1, Social worker, and Administrator will utilize the CAA/Care Plan Tool for 100% of MDS 3.0 assessment for two weeks (Monday-Friday), then 50% of MDS 3.0 assessments for three weeks (Monday-Friday) or until a pattern of compliance is achieved. Effective 6/25/2019, the Administrator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months, or until a pattern of compliance is achieved. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: Effective 6/26/2019, the Administrator and MDS nurse #1 will be responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 06/27/2019	