STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING ______ B. WING ______	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted 12/16/19 through 12/19/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3JNI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted 12/16/19 through 12/19/19. There were 3 allegations investigated and they were all unsubstantiated. Event ID #3JNI11.	F 000		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by	F 640		1/14/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 01/15/2020

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 640	Continued From page 1 CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and/or transmit discharge MDS (Minimum Data Set) assessments within the required time frame for 3 of 3 residents reviewed for resident assessments and discharge (Residents #1, #2 and #10). Findings included: 1. Resident #1 was admitted to the facility on 08/4/19 and discharged from the facility on 08/14/19.	F 640	Disclaimer: The component elements of the following plan of correction are those specifically required by Section 7304 of the CMS State Operations manual. This filing does not constitute an admission that the deficiencies alleged did in fact exist. This POC is filed as evidence of the facility's desire to comply with the requirements and to provide high quality resident care. This POC constitutes written allegation of substantial compliance with written Medicare and	

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Review of Resident #1's electronic medical record revealed the last transmitted MDS assessment was coded as a 5-day Medicare PPS (Prospective Payment System) assessment dated 08/10/19. Further review revealed there was a discharge MDS assessment dated 08/14/19 that had not been completed or transmitted to CMS (Centers for Medicare and Medicaid Services) as of 12/18/19.

During an interview on 12/18/19 at 10:46 AM, the MDS Coordinator confirmed Resident #1's discharge MDS assessment dated 08/14/19 was not completed or transmitted within the regulatory time frame. She explained the information for Section GG, Functional Abilities and Goals, never pulled over from the rehab department and therefore, the MDS assessment was never completed, signed or transmitted. The MDS Coordinator stated it was an oversight on her part and she would complete and transmit the MDS assessment.

During an interview on 12/18/19 at 2:20 PM, the Director of Nursing stated she expected MDS assessments to be accurately coded, completed and transmitted within the regulatory time frame.

During an interview on 12/18/19 at 2:44 PM, the Administrator shared he was aware of the identified concerns and would expect for MDS assessments to be completed and transmitted within the regulatory time frame.

2. Resident #2 was admitted to the facility on 08/06/19 and discharged from the facility on 08/16/19.

Medicaid requirements.

During the Survey, the surveyor noted that residents 1,2, and 10 did not have a Discharge MDS assessment completed and/or transmitted to CMS within the required time. The MDS Coordinator immediately submitted the MDS for each discharged resident to CMS and the assessments were verified to be accepted. The assessments were submitted to CMS on 12/18/19. On 12/19/19 the MDS Coordinator was provided coaching by DON and Administrator on how to address transmittal rejections moving forward.

In order to ensure no other residents were affected in a similar manner, the MDS Coordinator and the Director of Nursing audited 15 discharged residents to ensure successful transmittal of Discharge MDs assessments. This audit was completed by 1/14/20. No further issues were found. In order to prevent reoccurrence of this type of error in the future, On December 19th Administrator and DON met with MDS Coordinator and had detailed discussions regarding the root causes of the non-transmittals, This meeting provided the MDS coordinator instruction of the expectations going forward and outlined the plans of correction to ensure the expectations were met. On Dec. 19th the facility's Nursing Consultant was contacted to schedule further training. Further, to provide additional support and knowledge for our MDS coders, the MDS Coordinator and assistant have been

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F 640	Continued From page 3 Review of Resident #2's electronic medical record revealed the last transmitted MDS assessment was coded as a 5-day Medicare PPS (Prospective Payment System) assessment dated 08/13/19. Further review revealed there was a discharge MDS assessment dated 08/16/19 that had not been transmitted to CMS (Centers for Medicare and Medicaid Services) as of 12/18/19. During an interview on 12/18/19 at 10:46 AM, the MDS Coordinator shared when MDS assessments were submitted to CMS, she received a submission report that indicated if the assessments were accepted or rejected. She added she reviewed the report the day it was received and when a MDS assessment was rejected, she made the necessary corrections and immediately resubmitted the assessment. She explained Resident #2's MDS assessment dated 08/16/19 was transmitted to CMS on 08/27/19 but when she originally reviewed the submission report, she had overlooked the assessment was rejected. She confirmed Resident #2's discharge MDS assessment dated 08/16/19 needed to be resubmitted to CMS and would be considered a late transmission. During an interview on 12/18/19 at 2:20 PM, the Director of Nursing stated she expected MDS assessments to be accurately coded, completed and transmitted within the regulatory time frame. During an interview on 12/18/19 at 2:44 PM, the Administrator shared he was aware of the identified concerns and would expect for MDS assessments to be completed and transmitted within the regulatory time frame.	F 640	scheduled and will attend the DHSR MDS 3.0 training seminar in Black Mountain in March 2020. Additional training and coaching will occur as indicated going forward. Further, the DON or designee will verify that each resident discharged has had a successful DC MDS transmitted to CMS until March 31, 2020 or until the DON feels that consistent compliance has been achieved and then randomly thereafter. Ongoing compliance for MDS accuracy will be monitored as noted in a Performance Improvement Plan (PIP) that was initiated 1/8/19. This PIP addresses MDS Accuracy and Timeliness and directs the DON to report her Audits of MDS accuracy to the QAPI Committee for ongoing monitoring and oversight until March 31, 2020 or until the QAPI Committee determines that ongoing, consistent compliance has been achieved The completion date is 1/14/20.	

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F 640	Continued From page 4 3. Resident #10 was admitted to the facility on 09/20/19 and discharged from the facility on 11/23/19. Review of Resident #10's electronic medical record revealed the last transmitted MDS assessment was coded as an admission assessment dated 10/01/19. There were no other MDS assessments completed or transmitted after 10/01/19. During an interview on 12/18/19 at 10:46 AM, the MDS Coordinator confirmed Resident #10 discharged from the facility on 11/23/19. She explained a discharge MDS assessment should have been completed within 14 days of Resident #10's discharge and verified it was never completed or transmitted. She stated it was an oversight on her part and a discharge MDS assessment for Resident #10 would be completed and transmitted to CMS (Centers for Medicare and Medicaid Services). During an interview on 12/18/19 at 2:20 PM, the Director of Nursing stated she expected MDS assessments to be accurately coded, completed and transmitted within the regulatory time frame. During an interview on 12/18/19 at 2:44 PM, the Administrator shared he was aware of the identified concerns and would expect for MDS assessments to be completed and transmitted within the regulatory time frame.	F 640		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		1/14/20

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resident's status.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) in the areas of urinary catheter (Resident #30), active diagnoses (Resident #23, Resident #15, and Resident #67) and discharge status (Resident #72) for 5 of 9 sampled residents.

Findings included:

1. Resident #30 was admitted to the facility on 02/20/16 with diagnoses of dementia.

A physician's order dated 03/07/19 indicated Resident #30 had an indwelling urinary catheter due to neurogenic (lack control) bladder and urinary retention.

A care plan with start date 03/11/19 indicated Resident #30 had indwelling urinary catheter for urinary retention.

The annual MDS assessment dated 10/15/19 indicated under Section H0300 Urinary Incontinence that Resident #30 was occasionally incontinent of urine.

On 12/17/19 at 2:21 PM an interview was conducted with the MDS Coordinator who stated she coded Section H0300 Urinary Incontinence on Resident #30's annual MDS assessment dated 10/15/19. The MDS Coordinator stated Resident #30 should have been coded under Section H0300 to indicate use of an indwelling urinary catheter. The MDS Coordinator stated she knew Resident #30 had an indwelling

During the Survey, the surveyor noted a typographical error in the MDS coding for section H0100 regarding the presence of a catheter for resident #30. The Care Area Assessment noted the presence of a catheter and the care plan addressed proper interventions for catheter care. The surveyor brought the issue to the attention of the MDS coordinator. The MDS Coordinator immediately modified the MDS portion of the assessment to indicate the presence of a catheter. The CAA portion of the assessment noted the presence of the catheter and therefore did not require modification. The entire assessment, including the MDS and CAA, was then re-submitted to CMS on 12/17/19.

Also during the Survey, the surveyor noted an error in the MDS coding for Section “I” regarding the Active Diagnoses for residents #23,15,67. The MDS Coordinator immediately modified the MDS for each to indicate the accurate diagnosis. The assessments were then re-submitted to CMS on 12/18/19 and 12/19/19.
In addition, during the Survey, the surveyor noted an error in the MDS coding for discharge destination, MDS section A-2100, for resident #72. The MDS coordinator immediately modified the MDS and re-submitted it to CMS on 12/18/19.

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F 641	Continued From page 6 catheter and missed checking the box to indicate use of indwelling catheter. The MDS Coordinator stated she would have to submit a modification to the annual MDS assessment dated 10/15/19 to accurately reflect Resident #30 had an indwelling urinary catheter. On 12/17/19 at 2:55 PM an interview was conducted with the Director of Nursing (DON) who indicated her expectation was that the annual MDS assessment dated 10/15/19 would have been accurately coded to reflect Resident #30 had an indwelling urinary catheter. The DON shared the MDS Coordinator missed checking the correct box on the MDS that indicated indwelling catheter. The DON stated it was her expectation that the MDS Coordinator would submit a modification to the annual MDS assessment dated 10/15/19 to indicate Resident #30 had an indwelling urinary catheter. On 12/17/19 at 3:45 PM an interview was conducted with the Administrator who indicated his expectation was that the annual MDS assessment dated 10/15/19 would have been accurately coded to reflect Resident #30 had an indwelling catheter. The Administrator shared that the MDS Coordinator missed checking the correct box on the MDS that indicated indwelling catheter. The Administrator stated it was his expectation that the MDS Coordinator would submit a modification to the annual MDS assessment dated 10/15/19 to indicate Resident #30 had an indwelling urinary catheter. 2. Resident #23 was admitted to the facility on 07/05/19 with diagnoses of dementia and benign prostatic hypertrophy (enlarged prostate) with urinary obstruction.	F 641	In order to ensure no other residents were affected in a similar manner, the MDS Coordinator and the Director of Nursing checked the Section H0100 of the most recent MDS assessment of all residents with indwelling catheters. In the additional cases, the MDS coding was found to be accurate. This audit was complete as of 12/18/19. In addition, the MDS Coordinator and the Director of Nursing also audited the Active Diagnoses, Section “I” of the MDS, for proper coding for 10 randomly selected MDS assessments. In the additional cases, the MDS coding was found to be accurate. Also, the MDS Coordinator and the Director of Nursing audited all discharge assessments from July 1, 2019 to Dec. 31, 2019 for coding accuracy on Section A-2100 of the MDS. In the additional cases, three were noted to have errors. These D/C MDS’s were immediately corrected and submitted to CMS on 1/14/19. In order to prevent reoccurrence of this type of error in the future, the DON or designee will audit every MDS assessment of residents with indwelling catheters for accurate catheter coding of section H0100. Likewise, the DON or designee will audit every MDS Discharge assessment for accurate coding of Section A2100. Further, the DON or designee will audit one MDS assessment per week for accurate diagnosis coding of section I of the MDS. These audits will continue until March 31, 2020 or until the DON feels that consistent compliance has	

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A review of hospital discharge summary dated 07/05/19 indicated Resident #23 was diagnosed with benign prostatic hypertrophy (BPH) with urinary obstruction and had an indwelling urinary catheter.

A review of admission history and physical dated 07/08/19 indicated Resident #23 had diagnoses which included BPH and bladder outlet obstruction and had an indwelling urinary catheter.

The admission MDS assessment dated 07/12/19 indicated under Section I Active Diagnoses that Resident #23 was not coded as having a diagnosis of BPH and obstructive uropathy.

On 12/18/19 at 10:36 AM an interview was conducted with the MDS Coordinator who stated she coded Section I Active Diagnoses on Resident #23's admission MDS assessment dated 07/05/19. The MDS Coordinator verified by reviewing the hospital discharge summary dated 07/05/19 and the admission history and physical dated 07/08/19 that Resident #23 had diagnoses of BPH and urinary obstruction. The MDS Coordinator stated she missed coding active diagnoses because she believed the hospital discharge summary and admission history and physical were not available for her to review when she coded the admission assessment dated 07/12/19 for Resident #23. The MDS Coordinator stated she would have to submit a modification to the admission MDS assessment dated 07/12/19 to accurately reflect Resident #23 had active diagnoses of BPH and obstructive uropathy.

On 12/18/19 at 11:04 AM an interview was

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been achieved and then randomly thereafter. On December 19th Administrator and DON met with MDS Coordinator and had detailed discussions regarding the root causes of the inaccuracies, This meeting provided the MDS coordinator instruction of the expectations going forward and outlined the plans of correction to ensure the expectations were met. On Dec. 19th the facility's Nursing Consultant was contacted to schedule further training. Further, to provide additional support and knowledge for our MDS coders, the MDS Coordinator and assistant have been scheduled and will attend the DHSR MDS 3.0 training seminar in Black Mountain in March 2020. In addition, an apparent computer issue that contributed to this error has been forwarded to the software vendor for correction . Additional training and coaching will occur as indicated going forward. Furthermore, the evaluation of the need for additional MDS support was already in progress before the survey. Operational changes have been made to provide additional licensed nursing on an ongoing basis to aid in completion and accuracy verification of the MDS assessments.
Ongoing compliance for MDS accuracy will be monitored as noted in a Performance Improvement Plan (PIP) that was initiated 1/8/19. This PIP addresses MDS Accuracy and directs the DON to report her Audits of MDS accuracy to the QAPI Committee for ongoing monitoring and oversight until March 31, 2020 or until the QAPI Committee determines that

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conducted with the Director of Nursing (DON) who indicated her expectation was that the admission MDS assessment dated 07/05/19 would have been accurately coded to reflect active diagnoses for Resident #23. The DON stated the reason why active diagnoses may not have been coded was because Resident #23's hospital discharge summary and admission history and physical were not available in the medical record at the time the assessment was coded by the MDS Coordinator. The DON stated it was her expectation that the MDS Coordinator would submit a modification to the admission MDS assessment dated 07/05/19 to indicate active diagnoses for Resident #23.

On 12/18/19 at 11:15 AM an interview was conducted with the Administrator who indicated his expectation was that the admission MDS assessment dated 07/05/19 would have been accurately coded to reflect active diagnoses for Resident #23. The Administrator stated the reason why active diagnoses may not have been coded was because Resident #23's hospital discharge summary and admission history and physical were not available in the medical record at the time the assessment was coded by the MDS Coordinator. The Administrator stated it was his expectation that the MDS Coordinator would submit a modification to the admission MDS assessment dated 07/05/19 to indicate active diagnoses for Resident #23.

3. Resident #15 was admitted to the facility on 08/03/18 with diagnoses of depression and non-Alzheimer's dementia.

A physician's order for Resident #15 dated 09/06/19 indicated decrease Venlafaxine

F 641

ongoing, consistent compliance has been achieved. Further, to provide additional support and knowledge for our MDS coders, the MDS Coordinator and assistant have been scheduled and will attend the DHSR MDS 3.0 training seminar in Black Mountain in March 2020. The completion date is 1/14/20.

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(antidepressant medication) to 37.5 milligram (mg) one tablet by mouth daily.

A review of the September 2019 monthly medication administration record (MAR) indicated per staff documentation on the MAR that Resident #15 received Venlafaxine daily for depression per physician's order.

A psychiatric practitioner evaluation dated 09/23/19 indicated Resident #15 had a diagnosis of depression.

The quarterly Minimum Data Set (MDS) assessment dated 10/01/19 indicated under Section N Medications that Resident #15 received antidepressant medication during the last 7 days and was not coded under Section I Active Diagnoses as having a diagnosis of depression.

On 12/19/19 at 10:19 AM an interview was conducted with the MDS Coordinator who stated she was responsible for coding Section I Active Diagnoses on the quarterly MDS assessment dated 10/01/19. The MDS Coordinator verified Resident #15 had received antidepressant medication during the 7 day look back period and verified the psychiatric practitioner evaluation dated 09/23/19 indicated Resident #15 had diagnoses of depression. The MDS Coordinator shared that she missed checking the box under Active Diagnoses to indicate Resident #15 had diagnoses of depression. The MDS Coordinator stated she would have to submit a modification to the quarterly MDS Assessment dated 10/01/19 to accurately reflect Resident #15 had an active diagnosis of depression.

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On 12/19/19 11:04 AM an interview was conducted with Director of Nursing (DON) who indicated her expectation was the quarterly MDS assessment dated 10/01/19 would have been accurately coded to reflect Resident #15 had diagnoses of dementia. The DON shared that she believed the MDS Coordinator had missed checking the box on Resident #15's quarterly MDS assessment to indicate active diagnoses of depression. The DON stated her expectation was that the MDS Coordinator would submit a modification to Resident#15's quarterly MDS assessment dated 10/01/19 to indicate active diagnoses of depression.

On 12/19/19 at 11:27 AM an interview was conducted with the Administrator who indicated his expectation was the quarterly MDS assessment dated 10/01/19 would have been accurately coded to reflect Resident #15 had diagnoses of dementia. The Administrator shared that he believed the MDS Coordinator had missed checking the box on Resident #15's quarterly MDS assessment to indicate diagnoses of depression. The Administrator stated his expectation was that the MDS Coordinator would submit a modification to Resident #15's quarterly MDS assessment dated 10/01/19 to indicate active diagnoses of depression.

4. Resident #67 was admitted to the facility on 06/21/19 with multiple diagnoses that included dementia without behavioral disturbance and and anemia.

Review of Resident #67's signed physician order summary for the month of November 2019 revealed the following orders:
Buspirone (medication used to treat anxiety) 15

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milligrams (mg) - take one half tablet (7.5 mg) twice daily for depression.
Escitalopram (medication used to treat depression) 5 mg - take one and one half mg (7.5 mg) every morning for depression/anxiety.
Ferrous Sulfate (medication used to treat anemia caused by iron deficiency) 325 mg daily for anemia.

Review of Resident #67's Medication Administration Record (MAR) for the month of November 2019 revealed Buspirone, Escitalopram and Ferrous Sulfate were administered per physician's orders.

A psychiatric progress note dated 11/06/19 for Resident #67 listed multiple diagnoses that included anxiety and mood disorder.

The quarterly Minimum Data Set (MDS) dated 11/19/19 assessed Resident #67 with severe cognitive impairment. The MDS indicated she received antianxiety and antidepressant medications daily during the MDS assessment period. The diagnoses of anemia, depression or anxiety were not marked under Section I of the MDS as active diagnoses.

During an interview on 12/19/19 at 10:10 AM the MDS Coordinator acknowledged she was responsible for coding Section N Medications on the MDS assessments. The MDS Coordinator explained she reviewed medical record documentation such as physician progress notes, physician orders and psychiatric progress notes, when determining the active diagnoses to code on the MDS assessment. She confirmed Resident #67 received Buspirone, Escitalopram and Ferrous Sulfate daily during the MDS

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assessment period and stated it was an oversight the relevant diagnoses were not coded on the MDS assessment dated 11/19/19. The MDS Coordinator verified a modification of Resident #67's MDS assessment dated 11/19/19 would need to be submitted to accurately reflect the active diagnoses of anemia, depression and anxiety.

During an interview on 12/19/19 at 11:04 AM, the Director of Nursing (DON) stated she expected the MDS assessments to be accurately coded. The DON added she felt the missed coding of active diagnoses for Resident #67 was due to human error.

During an interview on 12/19/19 at 11:04 AM, the Administrator stated he would expect for MDS assessments to be accurately coded which included the active diagnoses to support the medications received to treat the medical conditions.

7. Resident #72 was admitted to the facility on 09/16/19 with multiple diagnoses that included fractures and other multiple trauma, heart failure and left hip hemarthrosis (bleeding into the joints).

The discharge Minimum Data Set (MDS) assessment dated 10/09/19 revealed Resident #72 discharged on 10/09/19 to an acute hospital.

Review of Resident #72's electronic medical record revealed a nurse note dated 10/09/19 which indicated Resident #72 discharged to the community with home health services.

During an interview on 12/18/19 at 5:25 PM the

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F 641	Continued From page 13 MDS Coordinator confirmed Resident #72 discharged home on 10/09/19. She verified the discharge MDS assessment dated 10/09/19 incorrectly indicated Resident #72 discharged to an acute hospital. The MDS Coordinator stated it was a coding error and a modification would be submitted to accurately reflect Resident #72 discharged to the community. During an interview on 12/18/19 at 2:20 PM, the Director of Nursing stated it was her expectation MDS assessments would be accurately coded, completed and transmitted within the regulatory time frame. During an interview on 12/18/19 at 2:44 PM, the Administrator stated he would expect for all MDS assessments to be accurately coded.	F 641		
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 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	F 656		1/14/20

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F 656	Continued From page 14 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: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for a resident, who required assistance with all activities of daily living (ADL) that included how much staff assistance was needed to care for the resident (Resident #14) and failed to develop a comprehensive, individualized care plan for antipsychotic medication use (Resident #57) for 2 of 7 residents reviewed for ADL and unnecessary medications. Findings included: 1. Resident #14 admitted to the facility on	F 656	Disclaimer: The component elements of the following plan of correction are those specifically required by Section 7304 of the CMS State Operations manual. This filing does not constitute an admission that the deficiencies alleged did in fact exist. This POC is filed as evidence of the facility's desire to comply with the requirements and to provide high quality resident care. This POC constitutes written allegation of substantial compliance with written Medicare and Medicaid requirements.	

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F 656	Continued From page 15 05/19/18 with multiple diagnoses that included Alzheimer's disease, cerebral infarction (stroke), and vascular dementia. The quarterly Minimum Data Set (MDS) dated 10/01/19 assessed Resident #14 with moderate impairment in cognition. The MDS indicated Resident #14 had impairment on one side of the upper extremity and required extensive staff assistance with all ADL. Review of an undated, resident care guide (document used by staff that specified the individualized care needs of the residents) noted Resident #14 required: total staff assistance for ADL, the use of a mechanical lift for transfers and a Geri chair (reclining chair) for mobility. Review of Resident #14's care plans, last reviewed on 10/15/19, revealed no care plan for ADL. During an interview on 12/19/19 at 10:10 AM the MDS Coordinator explained ADL care plans were standard and typically developed for every resident. She confirmed Resident #14 required total staff assistance with all ADL and upon review of her medical record, was unable to locate an ADL care plan. The MDS Coordinator stated the lack of an ADL care plan was an oversight that was missed during the quarterly review and verified a care plan should have been developed to address Resident #14's ADL care needs. During a joint interview on 12/19/19 at 11:04 AM the Director of Nursing and Administrator both stated a comprehensive care plan should have been developed that addressed the specific ADL	F 656	During the survey, the survey team noted that while the CNA Daily Care plan indicated the ADL care needs and interventions for resident #14, there was not a specific ADL Care Plan developed. A specific ADL Care Plan was developed Resident # 14 during the survey. This Care plan was uploaded on 12/19/19. During the survey, the survey team noted that Res #57 was receiving Antipsychotic medications for dx. of delusions per Dr. order. However, there was not a specific Care for antipsychotic medication use. A specific plan of care for antipsychotic use was developed and uploaded on 12/19/19 In order to ensure no other residents were affected in a similar manner, the MDS Coordinator and the Director of Nursing performed an audit of all other current residents who required staff assistance for all ADLS to ensure an ADL Care plan was developed. Each of these residents had an ADL care plan in place. These audits were complete as of 1/14/19, and all other residents were found to have ADL care plans in place. In addition, the MDS Coordinator and Director of Nursing audited all other residents receiving Antipsychotic medications to ensure a specific Antipsychotic Care Plan was developed. Each of these were found to have an Antipsychotic Care plan to be in place. These audits and updated care plans were complete as of 1/14/19. In order to prevent reoccurrence of this type of error in the future, the DON or	

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F 656	Continued From page 16 care needs of Resident #14. 2. Resident #57 was admitted to the facility 06/28/19 with diagnoses including non-Alzheimer's dementia and diabetes. A review of Physician's orders revealed an order dated 10/04/19 for quetiapine (an antipsychotic medication) 25 milligrams (mg) to be taken daily at bedtime for delusions. Review of Resident #57's Medication Administration Records revealed she received quetiapine daily at bedtime from 10/04/19 through 12/18/19. Review of the quarterly Minimum Data Set (MDS) dated 11/26/19 revealed Resident #57 was cognitively intact and received antipsychotic medication on a routine basis. Review of Resident #57's care plan last updated 12/04/19 revealed no care plan to address antipsychotic medication use. An interview with the MDS Coordinator on 12/19/19 at 10:03 AM revealed Resident #57 should have had a care plan for antipsychotic use. The MDS Coordinator stated she coded the quarterly MDS correctly but failed to add the antipsychotic medication use to Resident #57's care plan. She stated she should have put the antipsychotic medication care plan in place when she did the quarterly MDS for Resident #57 and did not do it. An interview with the Director of Nursing (DON) on 12/19/19 at 11:04 AM revealed she expected Resident #57 to have a care plan for	F 656	designee will audit every MDS assessment to ensure that any resident requiring staff assistance for all ADLs will have a specific ADL care plan in place. Further, the audits will verify that any resident noted to have antipsychotic medications will have a specific antipsychotic care plan in place. These audits will continue until March 31, 2020 or until the DON feels that consistent compliance has been achieved and then randomly thereafter. On December 19th , the Administrator and DON met with MDS Coordinator and had detailed discussions regarding the need for consistent care-planning of ADLs and Antipsychotic use. This meeting provided the MDS coordinator instruction of the expectations going forward and outlined the plans of correction to ensure the expectations were met. Additional training and coaching will occur as indicated going forward. On Dec. 19th the facility's Nursing Consultant was contacted to schedule further training. Further, to provide additional support and knowledge for our MDS team, the MDS Coordinator and assistant have been scheduled and will attend the DHSR MDS 3.0 training seminar in Black Mountain in March 2020. Additional training and coaching will occur as indicated going forward. Furthermore, the evaluation of need for additional MDS support was already in progress before the survey. Operational changes have been made to provide additional, on-going licensed nursing support for the review for accuracy of care plans and to review the care plans with the resident and resident	

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F 656	Continued From page 17 antipsychotic medication use and she was not sure what the breakdown was that led to Resident #57 not having the antipsychotic medication use care plan. An interview with the Administrator on 12/19/19 at 11:04 AM revealed Resident #57 should have had a care plan for antipsychotic medication use and the MDS Coordinator missed developing the care plan. He stated the antipsychotic medication care plan should have been developed when the quarterly MDS dated 11/26/19 was completed.	F 656	representative. Ongoing compliance will be monitored as noted in a Performance Improvement Plan (PIP) that was initiated 1/8/19. This PIP addresses Comprehensive Care planning and directs the DON to report her Audits of ADL and Antipsychotic Care Plans to the QAPI Committee for ongoing monitoring and oversight until March 31, 2020 or until the QAPI Committee determines that ongoing, consistent compliance has been achieved. Further, to provide additional support and knowledge for our MDS coders, the MDS Coordinator and assistant have been scheduled and will attend the DHSR MDS 3.0 training seminar in Black Mountain in March 2020. The completion date is 1/14/20.	