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	355082	A. BUILDING _____ B. WING _____	06/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

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F 000	INITIAL COMMENTS For the MDS 3.0 Focused Survey started on 06/13/17 and completed on 06/14/17, the sample included 12 residents for focused review. The sample included 9 additional residents to verify specific concerns during the survey.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 1 sampled resident (Resident #9) reviewed who experienced a significant decline. Failure to determine the need for and complete a SCSA in response to the resident's decline limited the facility's ability to accurately assess the resident's status and identify and implement appropriate interventions. Findings include:	F 274	1. A significant change assessment was completed for Resident #9 on 6/15/17. 2. Any resident that experiences a decline or improvement in status has the potential to be affected. 3. The interdisciplinary team will discuss any changes in resident status at regular huddle meetings on the four neighborhoods. Findings will be reviewed at QAPI meetings. All MDS coordinators were educated on 6/27/17, on SCSA, RAI Manual Chapter 2, page 2-22 through 2-26. 4. A QA tool has been developed and all	7/14/17

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

Electronically Signed | 06/30/2017

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F 274	Continued From page 1 The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2016, page 2-22 stated, ". . . A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." Page 2-25 and 2-26 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . Decline in two or more of the following: Resident's decision-making changes; Presence of a resident mood item not previously reported by the resident or staff . . . Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment; Resident's incontinence pattern changes . . . Overall deterioration of resident's condition. . . ." - Review of Resident #9's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 01/30/17, identified no behaviors or mood issues, independent or supervision with most ADLs, and occasional bladder incontinence. The annual MDS, dated 04/30/17, identified decrease in cognition from a score of 7 to a score of 4 (0-7 severely impaired), fluctuating inattention, a new depression score for feeling tired or having little energy 7-11 days of the 14 day look-back period, an increase to extensive assist for five ADLs (bed mobility, transfer, walk in room, locomotion on unit, locomotion off unit) with walking in the corridor not occurring during the 7 day look-back	F 274	MDSs will be audited for one month, and thereafter we will randomly audit ten MDS assessments per month. This will be completed by the QAPI manager, nurse manager, or designee. Specifically we will be looking at documentation to determine whether a significant change MDS is indicated by an improvement or decline in resident status. QA monitoring will begin 7/1/17. Any issues will be reported to the QAPI committee for review and potential further action.	

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F 274	Continued From page 2 period, and an increase to frequently incontinent of bladder. Review of Resident #9's care conference progress note, dated 04/25/17, stated, ". . . Review: The team met to review her care plans today. She has shown increased confusion as related to her dementia symptoms. As per staff report she was looking for her parents last week. . . . family has reported . . . [Resident's] memory has declined quite a bit. . . . uses the wheelchair when going to places outside of her room. Activity staff report that she does less for activities more recently. . . . has physically declined, must have more staff assistance, seems more tired and takes more naps . . ." During an interview on the afternoon of 06/14/17, a nurse manager (#2) agreed the progress note showed the 04/30/17 MDS should have been a significant change.	F 274		
F 278 SS=E	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	F 278		7/14/17

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F 278	Continued From page 3 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: ATTESTATION STATEMENT 1. Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), the facility failed to use the entire required days of observation when completing Minimum Data Set (MDS) items on 5 of 12 sampled residents (Resident #4, #5, #6, #7, and #9). Failure to include all the days of the look back period when completing the MDS has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include:	F 278	ATTESTATION STATEMENT: 1. There can be no corrective action for Residents #4,#5,#6,#7,& #9, as MDSs have been submitted and the signature date cannot be corrected. 2. All residents of the facility have the potential to be affected. 3. The dietitian was educated on 6/27/17 regarding using the entire lookback period prior to completing and signing the MDS, and on the requirements for signing assessments in a timely manner, as per the RAI manual. 4. A QA tool has been developed and, beginning 7/1/17, a random audit of ten charts will be completed by the QAPI	

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F 278	Continued From page 4 The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, page A-31 stated, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, the MDS item with a 7-day look-back period ending on and including the ARD which is the 7th day of this look-back period . . ." Therefore, the earliest you can code items with a look-back period and attest to the accuracy in Z0400 would be the day after the ARD. Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . " Page Z-7 stated, ". . . All staff who completed any part of the MDS must enter their signatures, titles, sections, or portion(s) of section(s) they completed, and the date completed. . . ." Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. - Review of Resident #4's medical record occurred on all days of survey. An admission MDS, dated 03/21/17, identified Section K (Swallowing/Nutritional Status) completed with a Z0400 date of 03/21/17. - Review of Resident #5's medical record occurred on all days of survey. An admission MDS, dated 04/30/17, identified Section K (Swallowing/Nutritional Status) completed with a	F 278	manager, nurse manager, or designee, weekly for ten weeks, then monthly thereafter. Specifically we will be auditing to ensure that the dietitian is using the entire lookback period prior to completing and signing the MDS. Any issues identified will be reported to the QAPI committee for review and potential further action. MEDICARE PPS DISCHARGE ASSESSMENTS: 1. Medicare PPS discharge assessments were completed for sampled Resident #21, plus three other residents who were not included in the sample. Nothing could be changed with the remainder of the missing assessments because the opportunity to do so is past. 2. Any resident being discharged from Medicare Part A has the potential to be affected. 3. All MDS coordinators were educated on appropriate and timely completion of Medicare PPS discharge assessments via phone conference with Joan Coleman at the Division of Health Facilities on 6/14/17. 4. A QA tool has been developed and, beginning 7/1/17, a random audit of ten residents being discharged from Medicare Part A will be completed by the QAPI manager, nurse manager or designee, weekly for ten weeks, then monthly thereafter. Specifically, we will be auditing to ensure that PPS discharge assessments are completed as required	

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F 278	Continued From page 5 Z0400 date of 04/28/17. - Review of Resident #6's medical record occurred on all days of survey. A significant change MDS, dated 05/15/17, identified Section K (Swallowing/Nutritional Status) completed with a Z0400 date of 05/15/17. - Review of Resident #7's medical record occurred on all days of survey. An annual MDS, dated 05/13/17, identified Section K (Swallowing/Nutritional Status) completed with a Z0400 date of 05/12/17. - Review of Resident #9's medical record occurred on all days of survey. An annual MDS, dated 04/30/17, identified Section K (Swallowing/Nutrition Status) completed with a Z0400 date of 04/28/17. A quarterly MDS, dated 01/30/17, identified Section K completed with a Z0400 date of 01/30/17. MEDICARE PART A PPS DISCHARGE ASSESSMENTS 2. Based on record review, review of the federal data base for long-term care, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to complete Medicare Part A Prospective Payment System (PPS) Discharge Assessments for 2 of 2 sampled residents (Resident #4 and #8) and 9 supplemental residents (Resident #13, #14, #15, #16, #17, #18, #19, #20, and #21) whose Medicare Part A stay ended during the following time frame March 15 - June 3, 2017. Failure to complete Medicare Part A PPS Discharge	F 278	and submitted to CMS. Any issues identified will be reported to the QAPI committee for review and potential further action. SECTION E (Behaviors): 1. The 3/22/17 significant change MDS assessment for Resident #11 was modified on 6/27/17 to reflect that the resident had experienced physical behaviors. The 5/15/17 significant change MDS assessment for Resident #6 was modified on 6/27/17 to reflect an improvement in resident behaviors. 2. All residents have the potential to be affected by a data entry error. 3. Social services staff were educated on 6/27/17 to ensure coding accuracy by interviewing staff regarding behavior charting, to review the responses provided on the current MDS and compare with the prior MDS, and then to make a global assessment of the change in behavior from the most recent to current, coding accordingly. 4. A QA tool has been developed and, beginning 7/1/17, an audit of all MDS assessments which have been completed in the past seven days will be performed by QAPI manager, nurse manager, or designee, weekly for ten weeks, then monthly thereafter. Specifically, we will audit to ensure that changes in behavior will be accurately reflected in the MDS. Any issues identified will be reported to the QAPI committee for review and potential further action.	

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F 278	Continued From page 6 Assessments resulted in no accurate assessment of these residents' status and their needs at the time when their Medicare Part A stay ended. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, page 2-45 stated, ". . . Part A PPS Discharge Assessment (A0310H = 1): Must be completed when the resident's Medicare Part A stay ends, but the resident remains in the facility (i.e., is not physically discharged from the facility). . . . If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required. If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined . . ." The Long-Term Care Facility RAI User's Manual, revised October 2016, page A-32 - A-33 stated, ". . . End Date of Most Recent Medicare Stay . . . The end of Medicare date is coded as follows, whichever occurs first: Date SNF benefit exhausts (i.e., the 100th day of the benefit); or Date of last day covered as recorded on the effective date from the Notice of Medicare Non-Coverage (NOMNC); or The last paid day of Medicare A when payer source changes to another payer (regardless if	F 278	SECTION J (HEALTH CONDITIONS): 1. The MDS assessments have been modified to correct the data entry error for Residents #4, #5, #11, and #6. Specifically, for Resident #4, her 3/21/17 admission MDS was modified 7/4/17 and her 3/28/17 14 day MDS was modified 6/28/17, both to accurately reflect that the resident had received scheduled pain meds. For Resident #5, the admission MDS dated 4/30/17 was modified on 6/28/17 to accurately reflect that the resident did not receive non-medication intervention for pain. Further, her 3/20/17 MDS was modified on 6/28/17 to accurately reflect that the resident did not receive any PRN medication for pain during the lookback period. For Resident #11, the 1/1/17 MDS was modified on 6/27/17 to reflect that the resident did in fact receive scheduled pain medication. For Resident #6, the 5/15/17 MDS was modified on 6/27/17 to accurately reflect that the resident had no falls since the prior MDS assessment. 2. All residents have the potential to be affected. 3. In regard to the issue with Resident #4, all MDS coordinators were re-educated on 6/27/17 regarding proper assessment and coding. Regarding Resident #5, all MDS coordinators were re-educated on 6/27/17 that pain interventions can only be coded if there is proper and timely documentation regarding effectiveness. Regarding	

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F 278	Continued From page 7 the resident was moved to another bed or not); or Date the resident was discharged from the facility (see Item A2000, Discharge Date) . . ." Upon request, the facility provided a list of residents whose Medicare Part A stay ended in the last 90 days, while the residents remained in the facility. Review of the federal data base on 06/13/17 for these residents, showed the facility failed to complete the required Medicare Part A PPS Discharge Assessments for the following eleven residents: * Resident #4 - Medicare Part A ended on 04/08/17 * Resident #8 - Medicare Part A ended on 05/18/17 * Resident #13 - Medicare Part A ended on 03/23/17 * Resident #14 - Medicare Part A ended on 03/18/17 * Resident #15 - Medicare Part A ended on 03/15/17 * Resident #16 - Medicare Part A ended on 04/14/17 and 05/08/17 * Resident #17 - Medicare Part A ended on 04/22/17 * Resident #18 - Medicare Part A ended on 05/13/17 * Resident #19 - Medicare Part A ended on 05/03/17 * Resident #20 - Medicare Part A ended on 05/23/17 * Resident #21 - Medicare Part A ended on 06/02/17 During a conference call on 06/14/17 at 9:15	F 278	Resident #11, all MDS coordinators were educated on 6/27/17 to check the eMAR for any scheduled pain medication during the lookback period. Regarding Resident #6, all MDS coordinators were re-educated on 6/27/17 to use the appropriate lookback period regarding falls when completing the MDS. 4. Due to the volume of MDS assessments conducted (133 alone in June, 2017), a random audit of 50 MDS assessments and supporting documentation will be conducted for coding accuracy. Thereafter, a minimum of 25 assessments per month will be randomly reviewed ongoing. This will be done by QAPI coordinator, nurse manager, or designee, beginning 7/1/17. Any issues identified will be reported to the QAPI committee for review and potential further action. SECTION K (SWALLOWING/NUTRITIONAL STATUS): 1. Resident #12's 5/24/17 MDS was modified on 6/28/17 to accurately reflect that the resident was not on a therapeutic diet. 2. All residents receiving nutritional supplements have the potential to be affected. 3. The licensed registered dietitian was educated on 6/27/17 regarding coding nutritional approaches in accordance with the RAI manual. 4. A QA tool has been developed, and an	

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F 278	Continued From page 8 a.m., four nurse managers (#1, #2, #4, and #5) verified Medicare Part A PPS Discharge Assessments had not been completed, as required, for the above-stated residents. CODING ACCURACY 3. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 1.14), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 7 of 12 sampled residents (Resident #4, #5, #6, #8, #10, #11, and #12). Failure to accurately complete Section E (behaviors), Section J (health conditions), Section K (swallowing/nutritional status), Section M (skin conditions), and Section N (medications) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION E: BEHAVIOR The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, pages E-4 and E-5, stated, ". . . E0200: Behavioral Symptom-Presence & Frequency . . . A. Physical behavioral symptoms directed toward others (e.g. [example given], hitting, kicking, pushing, scratching, grabbing, abusing others sexually) . . . Coding Instructions . . . Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur	F 278	audit of all MDS assessments completed in the past seven days will be done by QAPI manager, nurse manager, or designee, weekly for ten weeks, then monthly thereafter. Any issues identified will be reported to the QAPI committee for review and potential further action. SECTION M (SKIN CONDITIONS): 1. For Residents #4,#10,& #12, the MDSs have been modified to correct the data entry errors. Specifically, for Resident #4, the 3/28/17 MDS was modified to accurately reflect that the resident has been identified as being at risk to develop pressure ulcers. For Resident #10, the 4/21/17 MDS was modified on 6/28/17 to reflect that the resident did have a surgical wound. For Resident #12, the 5/24/17 MDS was modified to reflect that the resident did not have a skin tear or a turning/repositioning program in place. 2. All residents at risk for skin breakdown have the potential to be affected. 3. Regarding Resident #4, MDS coordinators were re-educated on 6/27/17 regarding using the appropriate tool for determining pressure ulcer risk and code accordingly. Regarding Residents #10 & #12, all MDS coordinators were educated on 6/27/17 regarding completing the appropriate skin assessments and code accordingly. 4. A QA tool has been developed, and an audit of all MDS assessments that have been completed in the past seven days	

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F 278	Continued From page 9 on any one of those days. . . ." Page E-21, stated, "E1100: Change in Behavioral or Other Symptoms . . . Steps for Assessment 1. Review responses provided to items E0100-E1000 on the current MDS assessment. 2. Compare with responses provided on prior MDS assessment. 3. Taking all of these MDS items into consideration, make a global assessment of the change in behavior from the most recent to the current MDS. . . . Coding Instructions: Code 0, same: if overall behavior is the same (unchanged). Code 1, improved: if overall behavior is improved. . . ." - Review of Resident #6's medical record occurred on all days of survey. The admission MDS, dated 03/30/17, identified rejection of cares and wandering occurred one to three days during the look-back period. A significant change MDS, dated 05/15/17, identified no behaviors occurred during the look-back period and no changes in behavior since the last MDS. Review of the medical record showed no behaviors during the MDS look-back period. The significant change MDS, dated 05/15/17, failed to identify an improvement in behaviors. - Review of Resident #11's medical record occurred on all days of survey. A significant change MDS, dated 03/22/17, identified no physical behaviors occurred during the look-back period. However, review of the behavior documentation showed Resident #11 experienced physical behaviors on 03/19/17 and 03/21/17. During an interview on 06/13/17 at 5:05 p.m., a	F 278	will be done by QAPI manager, nurse manager or designee weekly for ten weeks, then monthly thereafter. Any issues identified will be reported to the QAPI committee for review and potential further action. SECTION N (MEDICATIONS): 1. The MDS assessments for Residents #5 & #8 have been modified. Specifically, for Resident #5, the 3/20/17 MDS was modified on 6/28/17 to accurately reflect that the resident did receive diuretic medication during the lookback period. For Resident #8, the 4/20/17 MDS was modified on 6/28/17 to accurately reflect the correct number of days that the resident received anti-anxiety medication and that the resident actually received no antidepressant medications during the lookback period. 2. Any residents receiving specific classes of medications as outlined in the RAI manual. 3. Regarding Residents #5 & #8, all MDS coordinators were educated on 6/27/17 on reviewing the eMAR for accuracy of coding medications during the lookback period. 4. A QA tool has been developed and an audit of all MDS assessments completed in the last seven days will be done by the QAPI manager, nurse manager, or designee, weekly for ten weeks, then monthly thereafter. Any issues identified will be reported to the QAPI committee for review and potential further action.	

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AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

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social worker (#3) confirmed Resident #11's MDS, dated 03/22/17, identified no physical behaviors.

SECTION J: HEATH CONDITIONS

The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, pages J-2 and J-3 stated, ". . . Coding Instructions for J0100A-C Determine all interventions for pain provided to the resident during the 5-day look-back period. . . . Coding Instructions for J0100A, Been on a Scheduled Pain Medication Regimen . . . Code 1, yes: if the medical record contains documentation that a scheduled pain medication was received. Coding Instructions for J0100B, Received PRN Pain Medication *Code 0, no: if the medical record does not contain documentation that a PRN medication was received or offered. . . . Coding Instructions for J0100C, Received Non-medication Intervention for Pain *Code 0, no: if the medical record does not contain documentation that a non-medication pain intervention was received. *Code 1, yes: if the medical record contains documentation that a non-medication pain intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy. . . ." Page J-30 stated, "J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment . . . whichever is more recent . . . Steps for Assessment . . . 2. If this is not the first assessment/entry or reentry . . . the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment. . . . Coding Instructions *Code 0, no: if the resident has not had any fall since the last assessment. Skip to Swallowing

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F 278	Continued From page 11 Disorder item (K0100). . . ." - Review of Resident #4's medical record occurred on all days of survey. A 14-day Medicare MDS, dated 03/28/17, and an admission MDS, dated 03/21/17, identified J0100A coded for no scheduled pain medications. Review of the March 2017 electronic medication administration record (eMAR) identified gabapentin 300 milligrams (mg) twice daily (bid) for Meralgia paraesthetica (numbness or pain in the outer thigh nerve) initiated on 03/14/17. During an interview on the afternoon of 06/14/17, a nurse manager (#2) stated Resident #4 should have been coded for a scheduled pain medication on the admission and 14-day Medicare MDS. - Review of Resident #5's medical record occurred on all days of survey. A discharge return not anticipated MDS, dated 03/20/17, identified the resident received an as needed (PRN) pain medication during the look-back period. The March 2017 medication administration record (MAR) identified no PRN pain medications administered during the look-back period. An admission MDS, dated 04/30/17, identified Resident #5 received non-medication intervention for pain management during the look-back period. Record review showed Resident #5 received hot packs on 04/28/17. The documentation lacked evidence the intervention was assessed for efficacy as per the RAI manual.	F 278		

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During an interview on 06/14/17 at 3:08 p.m., a nurse manager (#4) confirmed Resident #5's MDS, dated 03/20/17, should not have been coded for PRN pain medication.

- Review of Resident #11's medical record occurred on all days of survey. An admission MDS, dated 01/01/17, identified Resident #11 did not receive a scheduled pain medication during the look-back period. The December 2016 MAR showed Resident #11 received scheduled Tylenol three times a day.

During an interview on 06/13/17 at 5:15 p.m., a nurse manager (#5) confirmed Resident #11's MDS, dated 01/01/17, should have been coded for scheduled pain medication.

- Review of Resident #6's medical record occurred on all days of survey. A significant change MDS, dated 05/15/17, identified Resident #6 had two or more falls with no injury since the last MDS assessment. Record review showed no falls since the prior MDS assessment.

During an interview on 06/14/17 at 3:08 p.m., a nurse manager (#4) confirmed Resident #6 experienced no falls since the prior MDS assessment.

SECTION K: SWALLOWING/NUTRITIONAL STATUS

The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, page K-11 and K-12 stated, "K0510: Nutritional Approaches . . . K0510D, therapeutic diet (e.g., low salt, diabetic, low cholesterol) . . . Coding Tips . . . A nutritional

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supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be part of a therapeutic diet. Therefore, supplements . . . are only coded in K0510D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition). . . ."

- Review of Resident #12's medical record occurred on all days of survey. A significant change MDS, dated 05/24/17, identified a therapeutic diet. The physician orders, dated 04/10/17, identified a liberal geriatric diet and chocolate ensure twice a day per family's request.

During an interview on 06/14/17 at 9:40 a.m., a dietician (#6) stated she coded a therapeutic diet related to Resident #12's daily supplements. Resident #12's medical record lacked evidence of a therapeutic diet.

SECTION M: SKIN CONDITIONS

The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, page M-3 stated, ". . . M0150: Risk of Pressure Ulcers . . . Coding Instructions . . . Code 1, yes: if the resident is at risk for developing pressure ulcers based on a review of information gathered for M0100." Page M-33 and M-34 stated, "M1040: Other Ulcers, Wounds and Skin Problems . . . Coding Instructions Check all that apply in the last 7 days. . . . M1040E, Surgical wound(s) . . . M1040G, Skin tear(s) . . ." Pages M-37 and M-38

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F 278	Continued From page 14 stated, "M1200: Skin and Ulcer Treatments . . . M1200D, Nutrition or hydration intervention to manage skin problems . . . The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours). . . ." - Review of Resident #4's medical record occurred on all days of survey. A 14-day Medicare MDS, dated 03/28/17, identified M0150 (At Risk for Pressure Ulcers) coded "no risk." The previous 5-day Medicare MDS, dated 03/21/17, identified M0150 coded "at risk." During an interview on the afternoon of 06/14/17, a nurse manager (#2) stated Resident #4 should have been coded as "at risk" for pressure ulcers on the 14-day Medicare MDS. - Review of Resident #10's medical record occurred on all days of survey. A 30-day Medicare MDS, dated 04/21/17, identified M1040Z (Other Ulcers, Wounds & Skin Problems: None of the above) coded. Review of Residents #10's progress notes identified the following: * 04/15/17 - surgical wound with staples due to an above the left knee amputation * 04/21/17 - staples removed During an interview on the afternoon of 06/14/17, a nurse manager (#3) stated M1040E should have been coded for a surgical wound.	F 278		

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F 278	Continued From page 15 - Review of Resident #12's medical record occurred on all days of survey. A significant change MDS, dated 05/24/17, identified a skin tear and a turning/repositioning program. The medical record during the 7-day look-back period lacked evidence of a skin tear and of a turning/repositioning program. The current care plan stated, "Focus: Potential for alteration in skin integrity r/t [related to] bedrest status. . . . Interventions . . . Reposition and toilet per AMV [Ave Maria Village] standards of care . . ." During interviews on 06/14/17 at 12:55 p.m. and 2:20 p.m., a nurse manager (#4) confirmed the inaccurate coding for Resident #12's turning/repositioning program and skin tear. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, pages N-5 and N-6 stated, "N0410: Medications Received . . . Coding Instructions . . . N0410B, Antianxiety: Record the number of days an anxiolytic medication was received by the resident at any time during the 7-day look-back period . . . N0410C, Antidepressant: Record the number of days an antidepressant medication was received by the resident at any time during the 7-day look-back period . . . N0410G, Diuretic: Record the number of days a diuretic medication was received by the resident at any time during the 7-day look-back period . . ." - Review of Resident #5's medical record occurred on all days of survey. A discharge return not anticipated MDS, dated 03/20/17, identified no diuretic medication received during	F 278		

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F 278	Continued From page 16 the 7-day look-back period. The March MAR showed Resident #5 received Torsemide (diuretic) seven days during the 7-day look-back period. During an interview on 06/14/17 at 3:08 p.m., a nurse manager (#4) confirmed diuretic medication should have been coded for seven days. - Review of Resident #8's medical record occurred on all days of survey. A 30-day Medicare MDS, dated 04/20/17, identified Section N0410 coded for an antianxiety medication and an antidepressant medication administered for 7 days during the 7 day look-back period. Review of Resident #8's April 2017 eMAR identified Ativan (antianxiety) administered on 5 days of the 7 day look-back period, and no antidepressant medication ordered or administered during the 7 day look-back period. During an interview on the afternoon of 06/14/17, a nurse manager (#3) stated Section N0410 had been coded incorrectly.	F 278		
F 287 SS=D	483.20(f)(1)-(4) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (f) Automated Data Processing Requirement (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.	F 287		7/14/17

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F 287	Continued From page 17 (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. (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 CMS and the State. (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 a resident that does not have an admission assessment. (4) Data Format. The facility must transmit data	F 287		

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F 287	Continued From page 18 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, review of the federal database for long-term care, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 1.14), the facility incorrectly submitted an End of Therapy (EOT) OMRA (Other Medicare-required Assessment) to the Centers for Medicare and Medicaid Services (CMS) Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system for 1 of 1 sampled resident (Resident #4). Transmitting assessments that are completed for purposes other than Omnibus Budget Reconciliation Act (OBRA) and Skilled Nursing Facility (SNF) Prospective Payment System (PPS) reasons, allows erroneous and/or unnecessary data into the CMS QIES ASAP system. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, page 2-51 stated, ". . . End of Therapy (EOT) OMRA. Required when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days. . ." The Long-Term Care Facility RAI User's Manual, revised October 2016, page 5-1, stated, ". . .	F 287	1. No correction can be made to Resident #4's MDS because the time frame for doing so has passed. 2. All residents with end of therapy (EOT) assessments have the potential to be submitted incorrectly. 3. MDS coordinators were re-educated on 6/27/17 to follow the standards for submission of MDS to appropriate receiving agencies. 4. A review of each MDS assessment that is export ready will be conducted by QAPI coordinator, nurse manager, or designee, prior to submission to CMS to assure that no EOT assessments are included. This review will be conducted beginning 7/1/17 and will be ongoing. Any issues found will be reported to the QAPI committee for review and possible further action.	

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F 287	Continued From page 19 Transmitting MDS [Minimum Data Set] Data . . . Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g. [example given], private insurance, including but not limited to Medicare Advantage Plans. . . ." Review of Resident #4's Minimum Data Sets in the federal database occurred on 06/13/17 and identified the following: * The EOT assessment with ARD of 01/15/17 showed Medicare Part A ended on 01/13/17 and Occupational Therapy ended on 01/13/17. An EOT for CMS purposes was not required. * The EOT assessment with ARD of 04/09/17 showed Medicare Part A ended on 04/07/17 and Occupational Therapy ended on 04/07/17. An EOT for CMS purposes was not required. Due to the Medicare Part A and therapies ending on the same date, an EOT assessment should not have been submitted to the CMS QIES ASAP system.	F 287		