STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	495272	A. BUILDING: _____ B. WING _____	6/8/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON COURT REHABILITATION & HEALTH CARE	1776 CAMBRIDGE DRIVE RICHMOND, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	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 accuracy of that portion of the assessment.

(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review it was determined that facility staff failed to maintain an accurate MDS (Minimum data set) assessment for one of 28 residents in the survey sample, Resident #4.

The facility staff failed to accurately code Section J (Falls) on Resident #4's 2/11/17 quarterly MDS assessment. Section J was not completed and the clinical record documented Resident #4 had sustained falls on 2/7/17 and 2/10/17.

The findings include:

Resident #4 was admitted to the facility on 11/28/11 and readmitted on 1/14/17 with diagnoses that included but were not limited to: abnormal posture, glaucoma, high blood pressure, Parkinson's Disease, anemia, depressive disorder, and BPH (Benign prostatic hyperplasia) with recurrent UTIs (Urinary Tract Infection). Resident #4's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 5/11/17. Resident #4 was coded as being moderately impaired of cognition in the ability to make daily decisions scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status)

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exam. Resident #4 was coded as requiring extensive assistance from one staff member with transfers, locomotion on the unit and dressing; and totally dependent on staff with eating, and bathing.

Review of Resident #4's quarterly MDS assessment dated 2/11/17, documented in part, the following in section J1800.: "Has the resident had any falls since admission /entry or reentry or the prior assessment (OBRA or scheduled PPS), whichever is more recent?" A "0" (zero) was coded indicating that Resident #4 had not had any falls since his last scheduled assessment. Resident #4's last scheduled assessment prior to 2/11/17 was a 14 day assessment with an ARD (assessment reference date) of 1/28/17.

Review of Resident #4's clinical record revealed that Resident #4 had two falls between 1/28/17 and 2/11/17. Resident #4 had falls on the following dates: 2/7/17 and 2/10/17.

Section J1900. "Number of falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent?" on Resident #4's quarterly MDS dated 2/11/17, was not assessed or documented.

On 6/8/17 at 8:57 a.m., an interview was conducted with RN (registered nurse) #4, the MDS nurse who completed section J of Resident #4's quarterly MDS dated 2/11/17. When asked about the process followed for completing section J of the MDS assessment, RN #4 stated, "I go back to the last MDS assessment and look for falls from that ARD (assessment reference date) and the next ARD." When asked if Resident #4 had falls between the 1/28/17 and 2/11/17 ARD, RN #4 stated, "I have to go check."

On 6/8/17 at 9:12 a.m., an interview was conducted with RN #2, the MDS director. RN #2 stated, "I am not sure what happened because we have it documented in our notes that he (Resident #4) has had falls but we didn't code it accurately on the MDS. It was an entry error but we corrected the MDS." RN #2 stated that she uses the RAI (Resident Assessment Instrument) manual as a reference when completing Section J.

On 6/8/17 at 12:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

The RAI 3.0 manual documents the following steps for assessment and coding instructions for Section J1800. and J1900.:

"Steps for Assessment
1. If this is the first assessment (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
2. If this is not the first assessment (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.
3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any

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health care setting since last assessment.
4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes).
5. Ask the resident and family about falls during the look-back period. Resident and family reports of falls should be captured here whether or not these incidents are documented in the medical record.

Coding Instructions
· Code 0, no: if the resident has not had any fall since the last assessment. Skip to Swallowing Disorder item (K0100).
· Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls Since Admission or Prior Assessment (OBRA or PPS) item (J1900), whichever is more recent.

Coding Instructions for J1900
Determine the number of falls that occurred since admission or prior assessment and code the level of fall-related injury for each. Code each fall only once.
· If the resident has multiple injuries in a single fall, code the fall for the highest level of injury.

Coding Instructions for J1900A, No Injury
· Code 0, none: if the resident had no injurious fall since the admission or prior assessment.
· Code 1, one: if the resident had one injurious fall since admission or prior assessment.
· Code 2, two or more: if the resident had two or more injurious falls since admission or prior assessment.

Coding Instructions for J1900B, Injury (Except Major)
· Code 0, none: if the resident had no injurious fall (except major) since admission or prior assessment.
· Code 1, one: if the resident had one injurious fall (except major) since admission or prior assessment.
· Code 2, two or more: if the resident had two or more injurious falls (except major) since admission or prior assessment.

Coding Instructions for J1900C, Major Injury
· Code 0, none: if the resident had no major injurious fall since admission or prior assessment.
· Code 1, one: if the resident had one major injurious fall since admission or prior assessment.
· Code 2, two or more: if the resident had two or more major injurious falls since admission or prior assessment."