STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345199	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROL WOODS	**750 WEAVER DAIRY ROAD CHAPEL HILL, NC 27514**

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F 000	INITIAL COMMENTS There were no deficiencies cited for the complaint investigation. Event ID: PQRC11.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the	F 278	This Plan of Correction constitutes the	10/7/16

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

Electronically Signed | 10/07/2016

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F 278	Continued From page 1 facility inaccurately assessed a surgical wound as a pressure ulcer. This was evident in 1 of 2 sampled residents reviewed for pressure ulcers. (Resident #21) The findings included: Resident #21 was admitted to the facility on 07/31/2016 with numerous diagnoses which included status post septic shock and urinary tract infection. Review of the Nurse Practitioner ' s progress note dated 08/02/16 revealed Resident #21 had a right groin and buttock surgical incision following a resection of the necrotizing fasciitis. Necrotizing fasciitis is an infection caused by bacteria which can destroy skin, fat, and the tissue covering the muscles. Review of the Admission Minimum Data Set (MDS) dated 08/13/16 revealed Resident #21 was coded as having a Stage 1 or higher pressure ulcers. Interview on 09/15/2016 at 11:16 AM with the MDS coordinator revealed the incorrect coding was an error on his part. The MDS coordinator indicated Resident #21 developed an abscess which rapidly spread at the thigh, groin up to the sacral area. Further interview with the MDS coordinator revealed Resident #21 MDS assessment should have been coded as a surgery wound and not a pressure ulcer. Interview on 09/15/2016 at 12:45 PM with the administrator revealed his expectation was to have an accurate assessment which affects the development of care plan.	F 278	facility□s written allegation of compliance for the deficiencies cited in the CMS -2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or conclusion set forth in the Statement of Deficiencies. F278 1. Actions taken for the residents affected by the alleged deficient practice: It is the expectation of the facility to code the Minimum Data Set (MDS) accurately to the best of the coder□s knowledge. Resident #21 was readmitted to facility from the hospital on 7/31/2016. On readmission resident # 21 had a surgical wound secondary to necrotizing fasciitis. The Minimum Data Set (MDS) dated 8/13/2016 was coded to indicate a pressure ulcer instead of surgical wound. Once the inaccuracy was found, a modification to the MDS was completed on 9/13/2016 to make the surgical wound correction. 2. Identification of others who may be affected by the alleged deficient practice: Because all residents are potentially affected by the cited deficiency, the Lead Nursing Engagement Coach (DON) or designated nurse completed a 100% audit	

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F 278	Continued From page 2	F 278	of latest Minimum Data Set (MDS) for all active residents to review for accurate wound coding by 10/7/2016. 3. Systems and measures to ensure that all alleged deficient practice does not occur: To enhance the accuracy of the Minimum Data Set (MDS) coding the Clinical Support-Specialist/MDS -coordinator has been in-serviced on 10/7/2016 by the Lead Nursing Engagement Coach (DON) on the following: -Chart and assessment data must be reviewed and collected for the appropriate assessment reference period (ARD) and data must be coded accurately. 4. Monitoring compliance of the alleged deficient practice: A quality assurance program has been implemented under the supervision of the Lead Nursing Engagement coach (DON) to monitor for potential and actual inaccuracies to MDS assessment. The DON or designated nurse will perform quality assurance monitoring to include weekly monitoring of 10% of random Minimum Data Set (MDS) assessments to ensure ongoing compliance. Inaccuracies found will be corrected. Any findings or trends will be submitted to the Quality Assurance Committee. A plan of action will be developed and implemented as needed to ensure continued coding accuracy.	

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F 278	Continued From page 3	F 278	Completion Date: 10/28/2017	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, interviews and observation the resident did not have care plans in place for 1 of 3 residents reviewed for accidents and 1 of 1 resident reviewed for Activities of Daily Living (Resident #33). Findings included: Resident #33 was admitted to the facility on 6/28/16 with the current diagnoses of atrial fibrillation, chronic kidney disease and a fracture. The resident ' s admission Minimum Data Set	F 279	F279 1. Action taken for residents affected by the alleged deficient practice: Resident #33 had a Minimum Data Set (MDS) assessment dated 7/6/2016 with care area assessments (CAA) indicating that a care plan would be initiated for all triggered areas including activities of daily	10/7/16

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F 279	Continued From page 4 (MDS) dated 7/6/16 revealed the resident ' s cognition was moderately impaired. The resident required extensive assistance with bed mobility, transfers, personal hygiene, dressing and toilet use and limited assistance with walking in the room, corridor and locomotion on the unit. The resident required total dependence with locomotion off the unit. The resident was not steady with moving from seated to standing position, walking, turning, transfers or moving off and on the toilet. The resident was frequently incontinent and had impairment on 1 side of his lower extremity and used a wheelchair. The MDS also revealed the resident had a fall in the last month prior to admission and had a fracture related to the fall in the last six months. The Care Area Assessment (CAA) for the MDS dated 7/6/16 revealed the resident ' s should have a care plan in place for ADL ' s functional/rehabilitation potential and for falls. In the comments section of the MDS for ADL ' s and falls, it stated the resident was admitted to the facility status post a fall. He would benefit from skilled PT/OT for ADL training, therapeutic exercise, therapeutic activities, gait training and self-care home management to regain functional mobility and return to his independent living situation. An incident report dated 7/16/16 revealed the resident had a fall at the facility. Resident #33 did not have a care plan in place for falls or ADL ' s. The Physical Therapist #1 was interviewed on 9/15/16 at 9:36 AM. She stated the resident required stand by assistance to minimal assistance with a walker. The resident was not cleared to walk by himself. The resident came in with a fractured hip from a previous fall. The Director of Nursing (DON) was interviewed	F 279	living and falls. Upon review, the care plans for all triggered areas except for the above two areas were completed. Because resident #33 was discharged on 7/16/2016 and is no longer an active resident, there is no current active care plan to update at this time. 2. Identification of others who may be affected by the alleged deficient practice: Because all residents are potentially affected by the cited deficiency, the Lead Nursing Engagement Coach (DON) or designated nurse completed a 100% audit of the latest comprehensive assessments for all active residents to ensure all triggered care areas on the Minimum Data Set (MDS) assessment have appropriate care plans on 10/07/2016. 3. Systems and measures to ensure that all alleged deficient practice does not occur: To enhance compliance regarding care plans for care assessment areas on comprehensive Minimum data set (MDS) assessments, the Clinical Support-Specialist/MDS coordinator, Social Workers, dietician, and Physical Therapist have been in-serviced by the Lead Nursing Engagement Coach (DON) on 10/7/2016 regarding the following: -all triggered areas on care area assessments should have care a plan that has measurable objectives and time tables if CAA indicates progression to the care plan.	

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F 279	Continued From page 5 on 9/15/16 at 10:30 AM. She stated the resident was at risk for falls and had a fall at the facility. The MDS Nurse was interviewed on 9/15/16 at 10:34 AM. He stated the resident was at risk for the following areas and should have been care planned for ADL ' s and falls. He stated based on the resident ' s risk factors identified by the MDS assessment was how the care plans are completed. The MDS Nurse confirmed the resident did not have care plans in place for falls or ADL's. The MDS Nurse was interviewed again on 9/15/16 at 12:19 PM. He stated he would review the CAA and the areas the resident was at risk for on the MDS. Then he would go under each section in the CAA and would create a care plan for areas that were at risk for the resident. He stated he would create goals and interventions for each care plan. He just missed making those missing care plans for the resident. The DON was interviewed on 9/15/16 at 2:19 PM. She stated that her expectation was if a care area showed the resident was at risk on the CAA then a care plan should be created for the area.	F 279	4. Monitoring compliance of the alleged deficient practice: A Quality Assurance Program has been implemented under the supervision of the Lead Nursing Engagement coach (DON) to ensure that care plans are created for all triggered Care Area Assessments (CAAs) that indicate progression to care plan. The Lead Nursing Engagement coach (DON) or designated nurse or Health Information Specialist will perform quality assurance monitoring including a random audit of 10%of active comprehensive assessments weekly to ensure compliance. Concerns will be addressed and corrected when identified. Any problems or trends identified are documented and submitted to Quality Assurance Committee. A plan of action will be developed and implemented as needed. Completion Date: 10/28/2016	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520		10/7/16

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F 520	Continued From page 6 issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility ' s Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place in December, 2015. This was for a recited deficiency, which was originally cited in December, 2015 on a recertification survey and on the current recertification survey. The deficiency was in the area of Minimum Data Set (MDS) accuracy. The continued failure of the facility during two federal surveys of record showed a pattern of the facility ' s inability to sustain an effective Quality Assurance (QA) Program. Finding Included: This tag is cross referenced to F278: Based on record reviews and staff interviews the facility inaccurately assessed a surgical wound as a pressure ulcer. This was evident in 1 of 2 sampled residents reviewed for pressure ulcers. (Resident #21)	F 520	F520 1. Action taken for residents affected by the alleged deficient practice: The Quality Assurance committee consisting of Lead Nursing Engagement Coach (DON), physician, and at least 3 representatives from other departments convene quarterly to identify issues with respect to quality assessment, assurance and safety. The team develops and implements plans to identify and correct quality deficiencies. A quality improvement program will be created to address the perceived quality assurance deficiency. 2. Identification of others who may be affected by the alleged deficient practice:	

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F 520	Continued From page 7 This was originally cited in December, 2015 during the recertification survey when the facility failed to code the Minimum Data Set for active diagnosis for two of fourteen residents and again on the current survey, the facility continued to miscode a surgical wound as a pressure ulcer for one of two sampled residents. The Director of Nursing/Quality Assurance Nurse (DON/QA) was interviewed on 9/15/16 at 2:17 PM. She stated the previous DON completed audits for the MDS from last year after it was cited during the recertification survey. She stated her expectation for QA was to identify issues, create a plan to resolve the area of concern and look at goals to see if they accomplish what they set out to do.	F 520	Because other quality areas are potentially affected, the quality assurance team completed a QAPI self- assessment by 10/7/2016 and will meet on 10/17/2016 to discuss current quality assurance programs and identify any other areas of concern for quality assessment, assurance, and safety. 3. Systems and measures to ensure that all alleged deficient practice does not occur: To enhance the quality assurance process, the quality assurance team joined the Southern Partners Action Collaborative for Excellence (SPACE) through Alliant Quality, the Medicare Quality improvement organization (QIO) for North Carolina. The Quality Advisor educated the Administrator Lead Nursing Engagement Coach (DON) about their service on 9/21/16. The Administrator will provide further education to the QAPI committee on the responsibility and requirements to identify and resolve systemic problems on 10/17/2016. This will include review of pertinent clinical/operational systems necessary to provide quality care to the residents residing in the Health Center. Identified trends will be prioritized and placed on an action plan. The action plan will be reviewed as needed in an Ad Hoc QAPI committee meeting or monthly as applicable and revised as needed until concern has been accurately resolved. 4. Monitoring compliance of the alleged	

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F 520	Continued From page 8	F 520	deficient practice: The quality improvement program has been implemented under the supervision of the administrator. The Administrator or designee will perform quality assurance monitoring by holding monthly quality assurance committee meetings to review current quality assurance programs and identify any new quality concerns. Completion Date: 11/14/2016	