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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		11/28/18

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

Electronically Signed | 11/16/2018

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 1 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 2 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and ombudsman interview, the facility failed to provide written notification to the resident, or resident's representative and the ombudsman when the residents were discharged to the hospital and/or home. This was evidence for 2 of 4 resident reviewed for discharged (Resident #25, and Resident #26). Findings included: 1. Resident #25 was admitted to the facility on June 10, 2018 with diagnoses to include age-related osteoporosis without current pathological fractural, difficulty in walking, and displaced fracture of lateral alleluias of left fibula, initial encounter for closed fracture. A review of the admission Minimum Data Set (MDS) dated June 13, 2018, the assessment assess Resident #25 to be cognitively intact.	F 623	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected. The ombudsman will be notified monthly of all discharges from the facility, unless	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 3 Record review of the departmental notes reviews resident was discharged home on July 31, 2018. No written notice of discharged was documented to have provided to the Ombudsman. During an interview with the Ombudsman by phone on October 26, 2018 at 9:00 am revealed that she had not received any written documentation from this facility when residents are discharged. During an interview with Social Worker on October 30, 2018 at 1:15pm review they did not complete written notification to the resident or resident's representation or the facility ombudsman when a resident was discharged to the hospital or home. During an interview with the Director of Nurses (DON) and the Administrator on October 31, 2018 at 4:30pm revealed DON indicated she would need to read more on this regulation, however their expectation that Social Workers would have complete written notification to the resident and the Ombudsman about this resident being discharge, per regulation. 2. Resident #26 was admitted to the facility on August 7, 2018 with diagnoses to include hypertension, urinary tract infection, hyperlipidemia, and osteoporosis and non-Alzheimer dementia. Review of her admission Minimum Data Set (MDS) dated August 15, 2018 revealed that she has some short and long term memory problems. A review of the departmental notes review dated	F 623	the reason for discharge warrants immediate notification. The facility will also develop written correspondence to be sent to the resident and/or representative prior to discharge or as soon as practicable given the circumstances surrounding the need for discharge, by 11/23/2018. 2. How the facility will identify other residents having the potential to be affected by the same practice and what corrective action will be taken. All residents discharged from the facility have the ability to be affected by the alleged deficient practice. 3. Measures to be put into place to ensure this practice does not recur. A 100% audit for all discharges from the facility in the month of October 2018 was completed. The ombudsman was sent notification of these discharges by the Administrator on 11/01/2018. The Administrator or designee will complete an audit of all facility discharges to home and/or the hospital weekly x 2 beginning on 11/12/2018, then biweekly x 2, then monthly x 3. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur Findings of these audits will be reported quarterly at facility's Quality Assurance	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 4 September 4, 2018 indicated that the Medical Doctor (MD) made a referral to an area hospice and the family toured the facility. The hospice is ready to accept her as early as tomorrow. A review of clinical note report dated September 5, 2018 Social Worker (SW) indicated resident continues to experience a functional decline. Per family request and MD assessment, MD made a referral to Hospice. Resident was accepted into Hospice. Resident was discharged on September 5, 2018. No written notice of discharged was documented to have provided to the Ombudsman. During an interview with the Ombudsman by phone on October 26, 2018 at 9:00 am revealed that she had not received any written documentation from this facility when residents are discharged. During an interview with Social Worker #2 on October 31, 2018 at 9:00 am, SW#2 indicated she had no knowledge of completed a written statement to the family and/or ombudsman. SW#2 indicated that the family were the one who requested to discharge the resident. SW #2 was unsure of this information. SW #2 indicated she need to talk to her boss about this. During an interview with the Director of Nurses (DON) and the Administrator on October 31, 2018 at 4:30pm revealed DON indicated she would need to read more on this regulation, however their expectation that Social Workers would have complete written notification to the resident's representative and the Ombudsman about this resident being discharge, per regulation.	F 623	Performance Improvement committee meetings, for determination if further performance improvement measures are necessary until completion of audits.	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for 3 out of 5 residents (Resident #15, Resident #20, and Resident #5) reviewed for unnecessary medications and 1 out of 3 residents (Resident #11) reviewed for nutritional status. Findings include: 1. Resident #15 was admitted to the facility on 9/6/17 with diagnoses that included Non-Alzheimer's dementia, depression, and Chronic Obstructive Pulmonary Disease. A review of Resident #15's medical record revealed a physician's order written on 6/14/18 for Trazodone 125mg at bedtime for insomnia. A review of Resident #15's most recent MDS dated 9/14/18 was coded as a quarterly assessment. Active diagnoses included Atrial fibrillation, Coronary Artery Disease, Heart failure, Non-Alzheimer's dementia, depression, and Chronic Obstructive Pulmonary Disease. Insomnia was not noted as an active diagnosis on the resident's MDS. An interview was conducted on 10/31/18 at 3:00pm with the MDS coordinator. She reported it is her responsibility to accurately code all	F 641	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective action will be accomplished for resident(s) affected. Lead Nursing Engagement Coach or designee will provide in-service education to facility MDS coordinator and Dietician staff on accurate coding on MDS assessments by 11/23/2018. Lead Nursing Engagement Coach or designee will complete an audit by 11/23/2018 of all MDS assessments with Assessment Reference Dates between 10/01/2018 and 11/12/2018 for accuracy of assessments in sections I,K,N,Q.	11/28/18

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6 MDS assessments. She reported because Trazodone was ordered for insomnia for Resident #15, she should have coded the diagnosis of insomnia on the MDS. An interview was conducted on 10/31/18 at 5:30pm with the DON (Director of Nursing) and the Administrator. They report the MDS coordinator was responsible for correctly coding the MDS assessments. The DON reported it was her expectation that all MDS assessments were coded accurately. 2. Resident #20 was admitted to the facility in March 2018 with a diagnosis of Chronic Obstructive Pulmonary Disease. A review of Resident #20's medical record revealed a physician's note dated 6/18/18 that stated the resident had a diagnosis of anxiety. A review of the pharmacist's consult regarding Resident #20's medications dated 9/13/18 revealed the resident was on Ativan 0.5mg three times a day for anxiety. A review of Resident #20's most current MDS dated 10/10/18 and coded a quarterly assessment revealed active diagnoses that included Peripheral Vascular Disease, Hypertension, Urinary Tract Infection, Depression, and Chronic Obstructive Pulmonary Disease. In the MDS Medication section, it was revealed Resident #20 had taken an antianxiety medication for 7 out of 7 days during the look back period. Anxiety was not noted as an active diagnosis on the resident's MDS.	F 641	2. How will facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken. The facility will review current medication list for all current residents as of 11/12/2018, in addition to reviewing all physician notes in the facility's electronic medical record for the previous 60 days for accurate coding of current ICD 10 coding on the MDS assessments for determination if other residents have been affected. All Corrections to MDS assessments are to be completed by 11/23/2018. 3. Measures to be put into place to ensure this practice does not recur. Lead Nursing Engagement Coach or designee will complete a 100% audit of all assessments for accuracy in the sections I,K,N,Q for 6 months. Followed by a random audit of 50% of all MDS assessments completed weekly for 3 months, than a random audit of 50% of MDS assessments completed monthly for 3 months. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur. Findings of these audits will be reported quarterly x 4 at facility's Quality Assurance Performance Improvement meetings, for determination if further performance improvement measures are necessary,	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7 An interview was conducted with the MDS coordinator on 10/31/18 at 3:00pm. She reported it was her responsibility to correctly code all MDS assessments. She reported Resident #20's quarterly MDS should have been coded with a diagnosis of anxiety as she was on an antianxiety medication and the physician noted a diagnosis of anxiety in his documentation. An interview was conducted with the DON (Director of Nursing) on 10/31/18 at 5:30pm. She reported it was the responsibility of the MDS coordinator to assure all MDS assessments were coded adequately. She reported it was her expectation that all MDS assessments were coded with the correct diagnoses. 3. Resident #5 was admitted to the facility 8/12/17 with diagnoses that included Diabetes Type I, depression, aftercare of hip fracture, and coronary artery disease. A review of Resident #5's most current MDS dated 8/12/18 was coded as an annual assessment. Active diagnoses included atrial fibrillation, coronary artery disease, congestive heart failure, diabetes, and depression. Under the medication section of Resident #5's MDS it was revealed the resident had taken a diuretic 7 out of 7 days. A review of Resident #5's MAR (Medication Administration Record) revealed for the MDS look back period dated 8/12/18, the resident took Lasix 20mg 4 out of 7 days - 8/11, 8/9, 8/7, and 8/5. The order for the Lasix read 20mg every other day for CHF (congestive heart failure). An interview with the MDS coordinator was	F 641	until completion of audits.	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 8	F 641		

conducted on 10/31/18 at 3:00pm. She reported it was her responsibility to accurately code all MDS assessments. She reported the Medication section of Resident #5's annual assessment should have been coded for diuretics 4 out of 7 days in the look back period.

An interview was conducted on 10/31/18 at 5:30pm with the DON (Director of Nursing) and the Administrator. They report the MDS coordinator was responsible for correctly coding the MDS assessments. The DON reported it was her expectation that all MDS assessments were coded accurately.

4. Resident #11 was admitted to the facility on 5/26/18 with diagnoses that included after care for hip fracture, depressive disorder, and dementia.

A review of Resident #11's monthly weight record revealed the resident weighed 119.7 lbs. (pounds) on 6/1/18; 112.4 lbs. on 6/25/18, 107.1 lbs. on 8/27/18, and 102.8 lbs. on 10/10/18. There was no recorded weight for July 2018.

A review of Resident #11's medical record revealed a dietician's note dated 8/27/18. The note documented Resident #11's weight on 8/27/18 as 107.1lbs.

A review of Resident #11's most recent MDS was coded as a quarterly assessment and was dated 9/1/18. Active diagnoses included atrial fibrillation, non-Alzheimer's dementia, and osteoarthritis. Under the Nutrition section of Resident #11's MDS, it was revealed the resident had no weight loss of 5% in past month or 10% in past 6 months. Resident #11's weight

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9 was coded as 118 lbs in past 30 days. An interview was conducted with the facility's registered dietician on10/31/18 at 11:53am. She reported it is the dietician's responsibility to complete the Nutrition section of the MDS assessments. She reported she does not know where the weight of 118 came from on Resident #11's quarterly MDS assessment dated 9/1/18. She reported the weight was entered incorrectly. An interview was conducted on 10/31/18 at 5:30pm with the DON. She reported it was the responsibility of the dietician to accurately complete the nutrition section of all MDS assessments. She reported it was her expectation that all MDS assessments were completed accurately.	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	F 656		11/28/18

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to develop a care plan for 2 of 4 residents reviewed for discharged (Resident #25 and Resident #26) and 1 of 5 residents reviewed for unnecessary medications (Resident #15). Finding included: 1. Resident #25 was admitted to the facility on June 10, 2018 with diagnoses to include age-related osteoporosis without current pathological fractural, difficulty in walking, and displaced fracture of lateral alleluias of left fibula,	F 656	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 11 initial encounter for closed fracture. A review of the admission Minimum Data Set (MDS) assessment assess Resident #25 to be cognitively intact. A review of Section Q of the MDS dated 6/13/2018 was reviewed and question Q0400 "discharge plan" was answered 0-No. A care plan dated "6/10/2018-Present" was reviewed and revealed no documentation for Resident #25 for discharge plan. A review of a Social Work Note dated Monday, July 30, 2018 indicated "Resident has been advanced to weight-bearing with walker by Medical Doctor (MD), she would like to d/c (discharge) home on Tuesday. Will need to discharge order. Do not anticipate other needs at this time. Resident has strong family and social support. She is extremely resourceful. Daughter will make sure there are groceries in the home. Resident will continues with outpt. PT". During an interview with Social Worker #1 (SW) on October 31, 2018 at 1:15pm revealed that she was the "SW for Resident #25, Resident #25 was placed here because of a fractural ankle and SW indicated that she would only be here from 4 to 6 week and would return back to the Carol Wood Community. SW #1 also indicated that she was unaware that she needed to have a care plan for discharge for Resident #25. SW indicated she only have discharge plan for Residents who had issues with discharge plans." During an interview with the Minimum Date Set (MDS) Nurse on October 31, 2018 at 4:00pm revealed a care plan for Resident #25 had not been completed, MDS Nurse indicated that the	F 656	Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected. A 100% audit of all Care Plans that were completed between 10/01/2018 and 11/12/2018 for discharge plans of care, and accurate care planning for any resident who has current orders for any Anti-anxiety, Hypnotics, Anti-depressant, Anti-psychotic, Anti-coagulant, Antibiotic, or Opioid medications. 2. How will facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken. An audit of all current residents will be completed to identify any medications that require Care Planning. Care Plans will be updated as needed. 3. What measures will be put into place to ensure this practice does not recur. A 100% audit of completed care plans will be performed for 6 months in the areas of medications, and discharge plans. This is to be followed by a random audit of 50% of completed care plans monthly for 3 months. 3. How corrective action(s) will be monitored to ensure the deficient practice will not recur	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12 Social Worker would be responsible for care planning this section. MDS Nurse stated that her expectation for discharge planning on the care plan would be done by the Social Worker. During an interview with the Director of Nurses (DON) and the Administrator on October 31, 2018 at 4:30pm revealed DON indicated she would need to read more on this regulation, however their expectation that Social Workers would have care plan discharge for each residents in the Nursing Home section per regulation. 2. Resident #26 was admitted to the facility on August 7, 2018 with diagnoses to include hypertension, urinary tract infection, hyperlipidemia, and osteoporosis and non-Alzheimer dementia. Review of her admission Minimum Data Set (MDS) dated August 15, 2018 revealed that she has some short and long term memory problems. A care plan dated "8/7/2018-Present" was reviewed and revealed no documentation for Resident #26 for discharge plan. A review of the departmental notes review dated September 4, 2018 indicated that the Medical Doctor (MD) made a referral to an area hospice and the family toured the facility. The hospice is ready to accept her as early as tomorrow. A review of clinical note report dated September 5, 2018 Social Worker (SW) indicated resident continues to experience a functional decline. Per family request and MD assessment, MD made a referral to Hospice. Resident was accepted into Hospice. Resident was discharged on September	F 656	Findings of these audits are to be reported to the Administrator and Lead Nursing Engagement Coach for review and reporting to the facility's Quality Assurance Performance Improvement Committee for review to identify any trends or needs for further investigation quarterly x 4.	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 13	F 656		

5, 2018.

During an interview with Social Worker #1 on October 31, 2018 at 11:00 am, SW#1 indicated she had no care plan discharge because we knew she was short term. SW#1 indicated that the family were the one who requested to discharge the resident on September 5, 2018. SW also indicated she did not care plan because she knew coming in that this Resident #26 would be short stay.

During an interview with the Minimum Date Set (MDS) Nurse on October 31, 2018 at 4:00 pm revealed a care plan for Resident #25 had not been completed, MDS Nurse indicated that the Social Worker would be responsible for care planning this section. MDS Nurse stated that her expectation for discharge planning on the care plan would be done by the social Worker.

During an interview with the Director of Nurses (DON) and the Administrator on October 31, 2018 at 4:30pm revealed DON indicated she would need to read more on this regulation, however their expectation that Social Workers would have care plan discharge for each residents in the Nursing Home section per regulation.

3. Resident #15 was admitted to the facility on 9/6/17 with diagnoses that included Non-Alzheimer's dementia, depression, and Chronic Obstructive Pulmonary Disease.

A review of Resident #15's medical record revealed a physician's order written on 6/14/18 for Trazodone 125mg at bedtime for insomnia.

A review of Resident #15's most recent care plan dated 8/12/18 revealed the resident was care

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 14	F 656		

planned for depression with only intervention was to monitor effectiveness of antidepressant medications, anticoagulant therapy, and diuretic therapy. There was no care plan for Resident #15's insomnia.

A review of Resident #15's most recent MDS (Minimum Data Set) dated 9/14/18 was coded as a quarterly assessment. Active diagnoses included Atrial fibrillation, Coronary Artery Disease, Heart failure, Non-Alzheimer's dementia, depression, and Chronic Obstructive Pulmonary Disease.

An interview was conducted with NA #1 on 10/30/18 at 12:30pm. She reported she got report from previous shift with what needs each resident had. She reported when Resident #15 seemed depressed, she went in the room and talked with her or offered to let her watch old movies on her phone. She reported these actions seemed to help the resident. She reported she wasn't sure what time the resident went to bed, but she liked to sleep until 11:00am.

An interview was conducted on 10/31/18 at 3:00pm with the MDS coordinator. She reported it was her responsibility to update and develop the residents' care plans. She reported because Trazodone was ordered for insomnia for Resident #15, she should have care planned insomnia. She also reported Resident #15's care plan for depression should have been individualized with non-pharmacological interventions.

An interview was conducted with the DON (Director of Nursing) on 10/31/18 at 3:30pm. She reported it was the MDS coordinator's responsibility for developing and updating care

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 15 plans. She reported it was her expectation that every care plan was individualized for each resident. She reported it was her expectation that any diagnosis should be care planned.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise a comprehensive care plan	F 657	This Plan of Correction constitutes the facilities allegation of compliance for the	11/28/18

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 16 on 1 out of 3 residents (Resident #11) reviewed for nutrition. Findings include: Resident #11 was admitted to the facility on 5/26/18 with diagnoses that included after care for hip fracture, depressive disorder, and dementia. A review of Resident #11's monthly weight record revealed the resident weighed 119.7 lbs. (pounds) on 6/1/18; 112.4 lbs. on 6/25/18, 107.1 lbs. on 8/27/18, and 102.8 lbs. on 10/10/18. There was no recorded weight for July 2018. A review of Resident #11's medical record revealed a dietician's note dated 8/27/18. The note documented Resident #11's weight on 8/27/18 as 107.1 lbs. (pounds). A review of Resident #11's most recent MDS was coded as a quarterly assessment and was dated 9/1/18. Active diagnoses included atrial fibrillation, non-Alzheimer's dementia, and osteoarthritis. Under the Nutrition section of Resident #11's MDS, it was revealed the resident had no weight loss of 5% in past month or 10% in past 6 months. Resident #11's weight was coded as 118 lbs. in past 30 days. A review of the most current care plan for Resident #11 dated 9/1/18 revealed no care plan for weight loss. An interview was conducted with the facility's registered dietician on10/31/18 at 11:53am. She reported it is the dietician's responsibility to complete the Nutrition section of the MDS	F 657	deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected. An audit of all MDS assessments was completed on 11/12/2018 to ensure that all residents had an accurate weight entered into the facility's electronic medical record system. Also an audit of all current residents Care Plans for any needs related to nutrition will be completed by 11/23/2018. 2. How the facility will identify other residents having the potential to be affected. All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place to ensure this practice does not recur. A 100% audit of completed MDS assessments and Care Plans will be done weekly for 3 months by the Dietician or	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 17 assessments. She reported she does not know where the weight of 118 came from on Resident #11's quarterly MDS assessment dated 9/1/18. She reported the weight was entered incorrectly. She reported the resident's care plan should have been revised to address the weight loss. An interview was conducted on 10/31/18 at 5:30pm with the DON. She reported it was the responsibility of the dietician to accurately complete the nutrition section of all MDS assessments and update care plans accordingly. She reported it was her expectation that all care plans were updated as each resident's condition changes and each care plan be individualized.	F 657	designee to ensure that weights entered in the MDS are accurate, and that all Care Plans have accurately identified the nutritional needs of the residents. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur. Findings of these audits will be reported weekly to the Administrator and will be reported at the facility's QAPI meetings to identify any trends or needs for further investigation quarterly x 4.	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of	F 660		11/28/18

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 18	F 660		

developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 19 data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to implement an effective discharge plan for 1 of 4 residents reviewed for discharge planning (Resident #25). Finding included: Resident #25 was admitted to the facility on June 10, 2018 with diagnoses to include age-related osteoporosis without current pathological fractural, difficulty in walking, and displaced fracture of lateral alleluias of left fibula, initial encounter for closed fracture. A review of the admission Minimum Data Set (MDS) assessment assess Resident #25 to be cognitively intact. A review of Section Q of the MDS dated 6/13/2018 was reviewed and question Q0400 "discharge plan" was answered 0-No. A care plan dated "6/10/2018-Present" was reviewed and revealed no documentation for Resident #25 for discharge plan.	F 660	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective actions will be accomplished for residents affected. Administrator provided in-service education to Social Work staff who participate in care planning process for facility on 11/16/2018 on requirements for discharge planning and the importance of	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 20 A review of a Social Work Note dated Monday, July 30, 2018 indicated "Resident has been advanced to weight-bearing with walker by Medical Doctor (MD), she would like to d/c (discharge) home on Tuesday. Will need to discharge order. Do not anticipate other needs at this time. Resident has strong family and social support. She is extremely resourceful. Daughter will make sure there are groceries in the home. Resident will continues with outpt. PT". During an interview with Social Worker #1 (SW) on October 31, 2018 at 1:15pm revealed that she was the "SW for Resident #25, Resident #25 was placed here because of a fractural ankle and SW indicated that she would only be here from 4 to 6 week and would return back to the Carol Wood Community. SW #1 also indicated that she was unaware that she needed to have a discharge plan for Resident #25. SW indicated she only have discharge plan for Residents who had issues with discharge plans." During an interview with the Director of Nurses (DON) and the Administrator on October 31, 2018 at 4:30pm revealed DON indicated she would need to read more on this regulation, however their expectation that Social Workers would have discharge plan for each residents in the Nursing Home section per regulation.	F 660	having a coordinated plan of care post discharge. 2. How the facility will identify other residents having the potential to be affected. The alleged deficient practice has the ability to affect all residents discharged from the facility. 3. What measures will be put into place to ensure this practice does not occur. An audit will be completed for all current residents by Lead Nursing Engagement Coach or designee to ensure that a discharge plan of care by 11/23/2018. Administrator or designee will complete a random audit of 5 residents monthly for 3 months to ensure that each resident has a discharge plan of care in the resident's record. 4. How corrective action(s)will be monitored to ensure the deficient practice will not recur. Findings of these audits will be reported to the facility's Quality Assurance Performance Improvement measures quarterly until completion of audits.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program.	F 865		11/28/18

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 21 §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. 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 observation, record review 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 November 2017. This was for a recited deficiency, which was originally cited in November 2017 on a recertification survey. This 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 Assessment and Assurance (QAA) Program. Findings included: This tag is cross referenced to: F 641 Based on observations, record review, and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for 3 out of 5	F 865	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected. All identified MDS assessment inaccuracies will be corrected no later	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 22 residents (Resident #15, Resident #20, and Resident #5) reviewed for unnecessary medications and 1 out of 3 residents (Resident #11) reviewed for nutritional status. This tag was originally cited in November 2017 during the recertification survey when the facility failed to accurately code the Minimum Data Set (MDS) to include the active diagnoses for 1 of 5 residents (Resident #9) reviewed for unnecessary medication. The facility also failed to accurately code a resident's behavior of wandering and refusal of care on 2 different MDS for 1 of 3 resident's reviewed for accidents (Resident # 26). Interview with Director of Nurses and Administrator on 10/31/2018 at 5:00 pm indicated their expectation for addressing repeat tags that with the "new season staff" (MDS Nurse) and other season staff who are aware of the regulation, once the process and monitor of this problem begin we will ensure sustainable improvement will come.	F 865	than 11/23/2018. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place to ensure this practice does not recur. To ensure that the practice does not recur there will be audits of the MDS assessments in section I,K,Q,N for 6 months. Followed by a 50% audit of all MDS assessments completed weekly x 3 months, followed by a 50% audit of all MDS assessments completed monthly. Findings of these audits are to reported at the facility's Quality Assurance Performance Improvement committee quarterly until completion of the audit. The QAPI committee will assess findings of the audits to identify any trends or need for further investigation. 4.How corrective action(s) will be monitored to ensure the deficient practice will not recur. Findings from facility's Quality Assurance Performance Improvement committee will be reported to the facility's Executive Leadership Team of the organization quarterly x 4 for oversight and recommendations for further investigation or auditing.	

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 _____	10/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE