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 ______	11/16/2017

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 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14)	F 157		12/31/17

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/11/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to notify the physician of the resident leaving the nursing home building for 1 of 3 resident's reviewed for accidents. (Resident #26). Findings included: Resident #26 was admitted to the facility on 3/13/17 with the current diagnoses of dementia, syncope and depressed mood. The resident's admission Minimum Data Set (MDS) dated 3/26/17 revealed that the resident was rarely understood. The resident had short term memory impairment and had moderate impairment of decision making. No medications were coded on the resident's MDS. The resident did not have any behaviors or moods. The resident was independent with all Activities of Daily Living. A nursing note dated 3/24/17 revealed that the resident was confused and disoriented. The resident followed someone on the elevator at 7:15 AM. Security was notified and security followed the resident until he returned to the unit.	F 157	This Plan of Correction constitutes the 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. F157 1.Actions taken for the residents affected by the alleged deficient practice: Resident #26 was admitted on 3/13/2017 with diagnosis of dementia. Because Carol Woods is a dementia inclusive community, Resident #26 is able to move about the 120 acres of Carol Woods property safely with assistance. The Facility utilizes safety measures such as Watch List so that staff can identify	

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F 157	Continued From page 2 A nursing note dated 3/25/17 revealed that the resident left the floor at approximately 3:45 PM on 3/25/17. Staff requested that the resident remain on the floor for the evening meal but resident #26 was agitated and left the hall. Security was alerted. At approximately 6:00 PM, the writer received a call from security inquiring if the resident had returned to the floor. The floor was searched and the resident was not found. The resident's family was called. The Director of Nursing was alerted at 7:00 PM along with the oncoming nurse. Security called at approximately 8:30 PM stating that the resident had been located in the lounge but was refusing to return to the building where he resided. The writer called the resident's family to ask for assistance in getting the resident to return to the unit but the family stated that there was nothing they could do. The writer (Nurse #1) went to the resident and asked him to return to the unit but the resident refused to do so. Security sat with the resident and contacted the resident's family again to see if they could get the resident to return to the unit. The resident's family attempted to get the resident to return to the facility but the resident still refused. Security sat with the resident and at approximately 9:30 PM, the resident and security returned to the Resident's old place of residence but the resident's family would not let him in. The DON was notified and instructed the writer (Nurse #1) to have the nursing assistant to stay with the resident and try to convince him to return to the facility. At 11:30 PM, the resident remained on the porch of his old residence with the Nursing Assistant. Security was on their way to assess the situation. Another nursing note dated 3/26/17, revealed that on 3/26/17 at 7:00 AM per shift report that the	F 157	residents that may need redirection on campus and the use of companions or staff support to accompany a resident to their requested destination. Resident #26 was monitored by Carol Woods staff throughout his time on Carol Woods property but away from skilled nursing unit during the referenced episode. Following the episode, the IDT met on 3/25/17 to review current safety practices (watch list, staff support) and discussed with family companionship options for the resident. 2.Identification of other who may be affected by the alleged deficient practice: Because this could potentially affect other residents, the IDT will complete 100% wander risk assessment on all active residents and meet to discuss interventions and update the Watch List for all who score at significant or serious risk. Lead Nursing Engagement Coach (DoN) or designee will notify the physician of all residents at this level of risk. The watch list will be updated and all staff notified of the update. Lead Nursing Engagement Coach (DoN) or nursing designee will also educate nursing staff regarding notification of physician of any accident or change in the resident condition by 01/05/2018. 3.Systems and measures to ensure that all alleged deficient practice does not occur: Physician will be notified if a resident on the Watch List leaves the facility who	

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F 157 Continued From page 3

resident spent the night outside of his cottage (old place of residence on the same grounds as the nursing home) with the Nursing Assistant and the Security officer. The resident's family members were inside of the cottage. On 3/26/17 at 7:52 AM, there was a called received from the communication desk that the resident needed a nurse as soon as possible and 911 was called. Per Nursing Assistant #1, early in the morning, the resident wandered to another building to use the restroom then entered the assembly hall and started vomiting and was slumped over into his hands and feet. The resident then crawled from the chair to the stage in the assembly hall then back to the assembly hall. Nursing Assistant #1 was with the resident and the resident had a flat affect and appeared very tired. The resident refused to be assessed and become combative with EMS and refused all care. On 3/26/17 at 8:50 PM, the resident was sent out to the hospital. The Emergency hospital physician called to clarify goals of care on 3/26/17 at 9:33 AM. The on call physician was called to give an update on the situation and obtain orders for the emergency room on 3/26/17 at 9:46 AM.

A telephone encounter note from the physician dated 3/26/17 at 9:51 AM stated that the patient with dementia had increased agitation and aggression. The patient left from the healthcare center and his family was terrified of him. The resident returned to the health care center and was found in the auditorium after emesis and "on all fours". The police were called and EMS. The resident was admitted to the hospital.

A security incident report dated 3/25/17 revealed that around 10:45 PM on 3/25/17, Nursing Assistant #1 came to relieve the 2 security

F 157

might be exhibiting signs or symptoms of illness or injury. LNEC to audit 5 resident charts weekly for Physician/NP notification of accident or significant change in condition weekly x 8 weeks then 12 random resident charts monthly x 4 months.

4.Monitoring compliance of the alleged deficient practice:

As part of the required emergency preparedness drill requirements, the missing resident plan will be a permanent annual drill.

Completion Date: 12/31/17

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F 157	Continued From page 4 officers.	F 157		

The hospital emergency room report dated 3/26/17 revealed that the resident was diagnosed with a Urinary Tract Infection.

Nursing Assistant #1 was interviewed on 11/14/17 at 4:12 PM. On Sunday night around 10:00 PM, he was at the cottage with the resident. He had worked with the resident a few times and that he was asked him to sit with Resident #26 and try to redirect him. He stated that the resident wanted inside his former house but the door was locked, so the resident knocked on the door. He stated that during the first hour the resident was standing and walking on the porch of the house. He stated that he stayed with the resident and moved with him. He got the resident to sit down and he played jazz music and a movie on his phone for the resident. The resident started to talk and told stories to him. Around 2:00 AM, the resident got up again and started knocking on the cottage's door again. Then the resident started walking towards the chapel around 6:15 AM or 6:45 AM. When they got to the chapel, the resident appeared really tired. The resident went and sat in a row when they got to the chapel. The resident started snoring and sleeping till about 7:00 AM in the chapel. He stated that he and the security officer sat behind the resident. He stated that his shift ended around 7:45 AM or 7:50 AM. When he was leaving, he saw that the staff were trying to call the doctor. The security officer was still with the resident when he left. The resident refused to drink anything except 1 sip of water earlier after being offered fluids. NA #1 stated that he did not talk to the nurse. The head nurse and the nurse on the floor knew where they were. He stated that they went and got the resident his

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F 157	Continued From page 5	F 157		

jacket, a blanket and had offered the resident coffee and water during the night. He also added that the resident had tried to leave the unit before.

Nurse #1 was interviewed on 11/14/17 at 4:46 PM. He stated that he worked 3:00 PM to 11:00 PM the night that the event with resident #26 happened. He stated he went to the Assembly hall (which was in a separate building than the nursing home) to try and convince the resident to come back to the unit around 9:00 PM. He stated that the resident was sitting in a chair relaxing and physically looked ok. No physical signs of distress were noted. He stated that he also called the resident's family. He added that he notified the Director of Nursing (who was at home) and the overnight supervisor about the situation. He stated that he did not notify the physician about the resident's behavior. He stated that NA #1 went down to sit with the resident around 10:30 PM/11:00 PM.

Nurse #2 who worked the night shift from 11:00 PM to 7:00 AM on 3/25/17 was no longer working at the facility and attempts to contact her for interview were unsuccessful.

The Security Officer was interviewed on 11/15/17 at 9:52 AM. He stated that the Director of Nursing (DON) knew about the situation and that he did not notify the physician.

The communication operator was interviewed on 11/15/17 at 2:12 PM. She stated that she had no part in communicating with the physician.

The physician was interviewed on 11/15/17 at 3:26 PM. She stated that she was the physician on call from Friday to Sunday (3/24/17- 3/26/17).

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F 157	Continued From page 6 She stated she was notified by the facility on 3/26/17 at 9:51 AM that the resident had left the facility and was vomiting, and that she would have documented it if they had called her before then. She stated that she gave orders for the resident to go to the emergency room when she was called. She stated that the resident was in a monitored setting, which was ok. She stated that she would expect to be notified if the resident was not in a place that was usual for the resident and she thought that was when she was notified for this event. An attempt to call the Medical Director on 11/15/17 at 2:36 PM was made but no return call was received. The DON was interviewed on 11/16/17 at 11:31 AM. She stated that it was documented that she was called in the afternoon or evening of 03/25/17 but was unsure of the exact time. She stated she had contacted the director of well-being and security. She added that the Administrator was out of town. She stated that once the facility knew the resident was at the cottage, they tried to redirect the resident and make sure that the resident was not in danger, that staff was with him and the resident was ok. She stated that she had communicated with staff multiple times that evening, day, and morning about the Resident's behavior. Nurse #2 had notified the physician in the morning when the resident was not feeling well. She stated that as soon as the resident was not feeling well, Nurse #2 called the physician. She would expect that the physician to be notified when the resident appeared sick and the physician was notified at that time.	F 157		

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F 241	Continued From page 7	F 241		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident’s individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews with resident and staff, the facility failed to answer resident's call bell who needing assistance to maintain dignity for 1 of 1 resident (Resident #38) who was reviewed for dignity. Findings included: Resident # 38 was admitted to the facility on 10/4/2017 with diagnoses of general weakness and heart failure. A review of the Admission Minimum Date Set (MDS) dated 10/10/2017 revealed that Resident # 38 was cognitively intact. Resident # 38 need extensive assistance with one person assist. However for transfer resident #38 needs two person physical assist for transfer. During an interview with Resident #38 on 11/14/2017 at 10 AM, Resident #38 indicated that during the night shift she had to wait for 30 minutes or long for staff to assist her to her bathroom. Resident # 38 indicated that because she wait so long she urinates on herself and that was not a great feeling. Resident # 38 also revealed "that when you're my age 15 minutes is a long time to wait to use the bathroom."	F 241	F241 1.Actions taken for the residents affected by the alleged deficient practice: It is important to recognize the correlation between resident satisfaction and call bell response times. Administrator met with Resident #38 to address call bell response times on 12/11/2017 and discussed resident rights and how to address concerns should the resident feel their voice was not heard. 2.Identification of other who may be affected by the alleged deficient practice: The Resident Life Coordinator or designee will perform a 100% audit for call bell response times over the 30 days for active residents by 12/15/2017 to review for prolonged call bell response. Any unacceptable call bell response time will be addressed. 3.Systems and measures to ensure that all alleged deficient practice does not occur:	12/31/17

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F 241	Continued From page 8 During an interview with Nurse # 1 on 11/16/2017 at 11 AM indicated that sometimes Resident # 38 had to wait for staff to help her to the bathroom but Resident #38 never complain to her about. "Nurse #1 indicated Resident #38 may had waited just a little over 20 minutes but not much longer." During an interview with the Director of Nursing (DON) and Administrator on 11/17/2017 2 PM revealed their expectation of staff answering call bell within a few minutes (10 to 15 minutes) that staff needs to provide care for residents. No residents needs to be waiting over 20 to 30 minutes for care.	F 241	To enhance resident dignity, the nursing staff will be educated on responding to call bells timely to ensure resident dignity by 1/8/2018. A Performance Improvement Project (PIP) will be implemented under the supervision of the Resident Life Coordinator to monitor for dignity related to call bell response times. The resident life coordinator will perform quality assurance monitoring to include 3 alert and oriented resident interviews along with 5 random call bell response audits per shift/weekly x 8 weeks then 10 interviews and 10 random call bell audits per shift/monthly x 4 months. 4.Monitoring compliance of the alleged deficient practice: The PIP will be monitored by the QAPI Committee. Completion Date: 12/31/2017	
F 272 SS=D	COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1) (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 272		12/31/17

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F 272	Continued From page 9 (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete Care Area Assessment Summaries which included underlying causes,	F 272	F272 1.Actions taken for the residents affected	

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F 272 Continued From page 10
risk factors, and factors to be considered in developing individualized care plan interventions for 1 of 1 residents (Resident #24) reviewed for indwelling catheter use.

Findings included:

Resident #24 was admitted to the facility on 10/31/17 with diagnoses that included Anemia, Congestive Heart Failure and Neurogenic Bladder.

Review of the resident's most recent comprehensive MDS (minimum Data Set) was dated 10/23/17 and coded as an admission assessment. The assessment had documentation of resident's cognition being moderately impaired. His genitourinary system was coded as having an indwelling catheter as well as having occasional episodes of bladder incontinence.

Review of the CAA (Care Area Assessment) revealed the assessment worksheet was incomplete and the narrative in the Analysis section did not include how the information was gathered, the underlying causes, risk factors or any necessary referrals that may have been needed regarding the use of an indwelling catheter. The only documentation on the Care Area Assessment worksheet read: "Resident with chronic indwelling urinary catheter, will care plan this CAA."

The MDS nurse was not available for interview.

During an interview with the DON (Director of Nursing) on 11/16/17 at 9:25am, she stated she was not sure why the Care Area Assessment

F 272

by the alleged deficient practice:

It is the expectation of the facility staff to code the Care Area Assessment of the Minimum Data Set (MDS) accurately to the best of the coder□s knowledge. Resident #24 was admitted to facility on 10/13/2017 with diagnosis of anemia, congestive heart failure and neurogenic bladder. The Care Area Assessment of the 10/23/2017 comprehensive assessment will be updated and corrected on 12/15/2017 and modification was submitted.

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 latest comprehensive Minimum Data Set (MDS) for all active residents as of 12/31/2017 to review for Care Area Assessment Summary completion and any updates will be submitted.

3.Systems and measures to ensure that all alleged deficient practice does not occur:

To ensure the completion of the Care Area Assessment worksheet the entire IDT team involved in completing the CAA worksheet will be in serviced by 12/31/2017 by the Lead Nursing Engagement Coach (DON) on the following:

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F 272	Continued From page 11 Worksheet was incomplete. She stated that the Quality Improvement Committee had identified some areas of concern with the MDS assessment and they had a consultant come and review the MDS. They had been trying to educate staff on correct documentation but it was going to take a while.	F 272	Care Area Assessment worksheet will be reviewed and education provided on the use of the CAA worksheet which includes underlying causes, risk factors, and factors to be considered in developing the individualized care plan interventions. 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 completion of the Care Area Assessment Summaries. The DON or designee will perform quality assurance monitoring to include monitoring of all comprehensive MDS assessments weekly for 8 weeks, then a sample of 10% random comprehensive Minimum Data Set (MDS) assessments to be monitored monthly for 4 months to ensure ongoing compliance. Completion date: 12/31/2017	
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (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	F 278		12/31/17

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	345199	A. BUILDING ______ B. WING ______	11/16/2017

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F 278	Continued From page 12 (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 record reviews and staff interviews, 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). Findings included: 1. Resident #9 was admitted to the facility 8/7/14	F 278	F278 I 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 #9 was admitted to facility on 08/07/2014 and has history of falls and fractured wrist. Resident was treated with	

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with diagnoses that included history of falls and a fractured wrist.

A review of Resident #9's most recent comprehensive MDS dated 6/12/17 was coded as an annual assessment. The assessment was coded as the resident had received antidepressant medication for 7 of 7 days of the assessment period. There was no diagnosis of depression marked on the MDS.

A review of Resident #9's most recent MDS was coded as a quarterly assessment with an Assessment Reference Date (ARD) of 8/29/17 revealed Resident #9 received an antidepressant medication 7 of 7 days of the assessment period. There was no diagnosis of depression marked on the assessment.

A review of the physician orders revealed an order was written on 7/13/16 that read Zoloft 50mg by mouth daily.

A review of physician orders revealed an order was written on 8/24/17 that read Zoloft 37.5mg by mouth daily for Depression.

A review of Resident #9's medication record (MAR) for June 2017 revealed the resident received Zoloft 50mg by mouth daily the entire month of June 2017. The order detail behind the medication listed on the MAR read: "Zoloft 50mg tablet by mouth daily; depression."

A review of Resident #9's August 2017 MAR revealed the resident received Zoloft 50mg by mouth daily from 8/1/17 through 8/24/17. The order detail behind the medication listed on the MAR read: "Zoloft 50mg by mouth daily for

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antidepressant for 7 of 7 days of the assessment period and diagnosis was not indicated on the MDS. A modification to the MDS will be completed on 12/15/2017.

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 to complete a 100% audit of latest Minimum Data Set (MDS) for all active residents to review for accurate diagnosis coding by 12/31/2017.

3.Systems and measures to ensure that all alleged deficient practice does not occur:

To enhance the accuracy of the Minimum Data Set (MDS) diagnosis coding the Clinical Support Specialist/MDS -coordinator will be in serviced by 12/31/2017 by the Lead Nursing Engagement Coach (DON) on the following:
Medication administration record diagnosis data must be reviewed and coded accurately on the MDS.

4.Monitoring compliance of the alleged deficient practice:

A quality assurance program will be implemented under the supervision of the Lead Nursing Engagement coach (DON) to monitor for potential and actual inaccuracies to coding of diagnosis on

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depression." The August 2017 MAR also revealed the resident received Zoloft 37.5 mg by mouth daily from 8/25/17-8/31/17. The order detail behind the medication listed on the MAR read: "Zoloft 37.5mg by mouth daily for depression."

During an interview on 11/16/17 at 10:30 am with the Director of Nursing (DON), the DON indicated depression should have been coded on Resident #9's MDS dated 6/12/17 and 8/29/17. During the interview, the DON stated it was her expectation that if a resident was receiving antidepressant medications, the diagnosis of Depression would be marked on the MDS assessment.

2. Resident #26 was admitted to the facility on 3/13/17 with the current diagnoses of dementia, syncope and depressed mood.

a.) A nursing note dated 3/24/17 revealed that the resident was confused and disoriented. The resident followed someone on the elevator at 7:15 AM. Security was notified and security followed the resident until he returned to the unit.

A nursing note dated 3/25/17 revealed that the resident left the floor at approximately 3:45 PM on 3/25/17. Staff requested that the resident remain on the floor for the evening meal but resident #26 was agitated and left. The resident was monitored as he left the building.

The resident's admission and discharge Minimum Data Set (MDS) dated 3/26/17 revealed the resident was rarely/never understood and did not have any behaviors or moods. The resident was independent with all Activities of Daily Living and was coded as not having any wandering behavior. The Care Area Assessment Summary revealed that the resident triggered for cognitive

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MDS assessment. The DON or designated nurse will perform quality assurance monitoring to include weekly monitoring of 5 random Minimum Data Set (MDS) assessments weekly for 8 weeks, then 10 random MDS assessments monthly for 4 months to ensure ongoing compliance. Any inaccurate diagnosis found will be corrected and modified if indicated. Any findings or trends will be submitted to the Quality Assurance Committee.

Completion Date: 06/30/2018

II

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 #26 was admitted to facility on 03/13/2017 with dementia and syncope. Staff noted wandering and care refusal behaviors which were not indicated on the MDS. A modification to the 3/26/17 and 4/29/17 MDS will be completed on 12/15/2017 to reflect noted behaviors.

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 Couch (DON) or designee to complete a 100% audit of latest Minimum Data Set (MDS) for all

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function, visual function and nutritional status. The resident did not trigger for wandering behaviors.

Medication Aide #1 was interviewed on 11/14/17 at 1:50 PM. She stated that the resident would wander sometimes. They would monitor the resident and would call downstairs to let security know if the resident was wandering.

b.) A nursing note dated 4/27/17 revealed that the resident refused his morning medications and spit them out.
A nursing note dated 4/28/17 stated that the resident refused dinner, taking in only minimal fluids and needed frequent reminders to drink.

A nursing note dated 4/28/17 stated the resident was alert but was resistive to care. The resident refused his morning medications after several attempts. The resident also refused his breakfast.

The resident's significant change MDS dated 4/29/17 revealed that the resident was rarely/never understood and had short term memory impairment. The resident had moderate impairment for decision making. The resident did not have any behaviors present and did not have any rejection of care.

Nurse #2 was interviewed on 11/15/17 at 9:39 AM. She stated that the resident would only take his medications in the dining room. In the mornings, the resident would sometimes refuse his medications. She stated she would typically attempt to give the resident his mediations 3 more times to see if he would take them.

The MDS nurse was unavailable to be

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active residents to review for behavioral inaccuracies by 12/31/2017.

3.Systems and measures to ensure that all alleged deficient practice does not occur:

To enhance the accuracy of the Minimum Data Set (MDS) behavior coding the IDT team will be in serviced by 12/31/2017 by the Lead Nursing Engagement Coach (DON) on the following:
Reviewing medical record data for behaviors and coding accurately on the MDS.

4.Monitoring compliance of the alleged deficient practice:

A quality assurance program will be implemented under the supervision of the Lead Nursing Engagement coach (DON) to monitor for potential and actual inaccuracies to coding of behaviors on MDS assessment. The DON or designated nurse will perform quality assurance monitoring to include weekly monitoring of 5 random Minimum Data Set (MDS) assessments weekly for 8 weeks, then 10 random MDS assessments monthly for 4 months to ensure ongoing compliance. Any inaccurate MDS assessments found will be corrected and modified. Any findings or trends will be submitted to the Quality Assurance Committee.

Completion Date: 12/31/2017

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F 278	Continued From page 16 interviewed during the duration of the survey. The Director of Nursing was interviewed on 11/16/17 at 11:31 AM. She stated that Quality Improvement had identified some areas of concern with the MDS assessment and they had a consultant come and review the MDS. They had been trying to educate staff on correct documentation but it was going to take a while. She added that she would expect for the MDS to be coded to correctly and for the care plan to be reflective of the resident.	F 278		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	F 280		12/31/17

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F 280	Continued From page 17 of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (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	F 280		

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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 reviews and staff interviews the facility failed to revise an indwelling catheter care plan for 1 of 1 resident (Resident #24) with an indwelling catheter that resulted in a urinary tract infection (UTI) and failed to revise a potential for falls care plan for 1 of 1 resident (Resident #11) that had repeated falls.

Findings included:

1) Resident #24 was admitted to the facility on 10/13/17 with diagnoses that included Congestive Heart Failure, Anemia, and Flaccid Neuropathic Bladder.

A review of Resident #24's most recent comprehensive Minimum Data Set (MDS) dated 10/23/17, coded as an admission assessment, revealed the resident was moderately cognitively impaired. The assessment had documentation of resident having an indwelling catheter.

F 280

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1.Actions taken for the residents affected by the alleged deficient practice:

The facility has the expectation the care plan resident interventions accurately to the best of the IDT knowledge. Resident #11 and #24 had missing revisions to care plans related to falls and Urinary tract infection respectively. The care plans for resident□s # 11 have been updated as of 12/11/2017. Resident # 24 is no longer an active resident therefore unable to be updated.

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 Couch (DON) or

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F 280	Continued From page 19 A review of Resident #24's active care plan dated 10/16/17, had a problem statement which read in part: Requires an indwelling catheter. The Goal was listed as: Resident will have no UTI's through next review date. The only update to the care plan was to "change foley monthly per provider order" dated 10/26/17. A review of Resident #24's physician orders revealed an order written on 10/31/17 for Cipro 500mg by mouth twice a day for a UTI. A review of laboratory results for Resident #24 dated 11/2/17 revealed resident was positive for greater than 100,000 colonies of CFU/ml Escherichia coli and greater than 100,000 colonies of Pseudomonas Aeruginosa. A review of Resident #24's physician order was written on 11/2/17 to Discontinue the Cipro and start Levaquin 750mg by mouth daily for five days for UTI. The MDS nurse was not available for interview during the survey. An interview was conducted with the DON (Director of Nursing) at 10:07am on 11/16/17 regarding Resident #24's care plan. During the interview, the DON stated the care plan should have been revised to reflect the UTI the resident was diagnosed with on 10/31/17. During the interview, the DON stated it is her expectation that if a resident was diagnosed with an infection, it would be care planned. 2. Resident #11 was admitted to the facility on 8/12/17 and his diagnoses included left hip	F 280	designated nurse will complete a 100% audit of all active residents (as of 12/5/2017) care plan to review for current fall interventions and active infections are on care plan by 12/31/2017 3.Systems and measures to ensure that all alleged deficient practice does not occur: To insure appropriate care plan progression, the IDT team will be in serviced by 12/31/2017 by the Lead Nursing Engagement Coach (DON) on the following: Care plan should be individualized for each resident and include current health conditions including active infections and safety interventions. 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 care plan compliance. The DON or designated nurse will perform quality assurance monitoring to include review of 5 random care plans to ensure current health conditions including fall interventions and active infections are care planned weekly for 8 weeks, them 10 care plans monthly for 4 months. Any findings or trends will be submitted to the Quality Assurance Committee. Completion Date: 12/31/2017	

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F 280	Continued From page 20 fracture, macular degeneration and orthostatic hypotension. A care plan for Resident #11 dated 8/14/17 identified a potential for falls related to unsteady gait and decreased mobility, decreased standing balance with risk for falls. The goal was to have no falls during the next 90 days. Interventions included lower extremity strengthening exercises and provide appropriate assistive devices. A Minimum Data Set (MDS) dated 11/9/17 for Resident #11 identified he had 2 or more falls without injury since the last assessment, his balance was unsteady and needed staff assistance to stabilize balance, he required extensive one person assistance with bed mobility and transfers and used a walker for mobility. A review of the incident reports, provided by the Director of Nursing (DON), identified the following for Resident #11. An incident report dated 9/25/17 at 7:10 pm for Resident #11 stated he was found sitting on the floor with his back up against the bathroom door frame. He was assessed for pain, injury and range of motion (ROM). He was assisted to his chair with the maxi-move lift. Resident #11 stated "I slipped out of bed onto the floor, it was an easy landing." An incident report dated 10/2/17 at 3:40 pm for Resident #11 stated resident was found in his room sitting on his buttocks with his back leaning against the foot rest of his recliner (foot rest was in the down position.) Resident stated "he was attempting to remove his shoes when he slid to	F 280		

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F 280	Continued From page 21 the floor from the recliner." Assessment performed and vital signs taken. Resident refused the lift and was able to stand with staff assistance and slid back into his chair. An incident report dated 10/15/17 at 2:30 pm for Resident #11 stated he was found on the floor in his room. Resident stated "I slid off the chair." He was on the floor approximately 2 feet from his recliner and was sitting upright. His walker was right in front of the entrance to the door. Assessed for injuries, pain and ROM. Assisted him to recliner with maxi-move lift. The MDS nurse was not available for an interview during the survey. An interview with the Administrator on 11/15/17 at 3:37 pm revealed it was his expectation that Resident #11 ' s care plan would be updated with his current health condition, including his actual falls.	F 280		
F 371 SS=D	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		12/13/17

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(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews the facility failed to seal, label and date opened food items, failed to discard an expired food item and failed to keep storage bins clean in 1 of 2 kitchens. The facility failed to ensure hair restraints were worn in 2 of 2 kitchens.

Findings Included:

1. An observation of the service kitchen on 11/13/17 at 10:45 am with the Dietary Manager (DM) revealed:

A. A 5 pound (lb.) container of cottage cheese was in the walk-in cooler and had an expiration date of 11/1/17.
B. A male employee with facial hair was working in the kitchen without a beard guard on.

An interview with the DM on 11/13/17 at 11:00 am revealed that the cottage cheese should have been taken out of service before the expiration date and that beard guards were not available.

2. An observation of the main kitchen on 11/13/17

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1.Actions taken for the residents affected by the alleged deficient practice:

At time of DHSR inspection on 11/13/2017, a food truck just delivered food to main kitchen that morning; these items were dated, labeled and placed in sealed containers by Chef and kitchen staff. The exterior of storage bins were cleaned in the main kitchen by kitchen staff on 11/13/2017. At time of DHSR inspection on 11/13/2017, all foods in the Building 4 (B4) Kitchen were inspected and confirmed to be within their expiration date by the Dietary Manager.

2.Identification of other who may be affected by the alleged deficient practice:

The Chef and kitchen staff insured other items in the main kitchen were dated, labeled and placed in clean sealed containers or bins.

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at 11:15 am with the DM and the Chef revealed:

A. The walk-in freezer contained 2 cases of beef liver that were not sealed and exposed to the air, 1 case of hamburger patties that was not sealed and exposed to the air, 1 case of sausage patties that was not sealed and exposed to the air and 1 case of baguettes that was not sealed and exposed to the air.
B. The walk-in cooler had a pan of cooked barley that was not covered, labeled or dated, a pan of tomato paste that was not covered, labeled or dated and a container of cocktail sauce that was not covered labeled or dated.
C. 3 of 3 ingredient bins had food spills on the tops of the bins.
D. 2 male employees with facial hair were preparing food and had no beard guards on.

An interview with Cook #1 on 11/13/17 at 11:30 am revealed he did not know he was supposed to wear a beard guard while cooking in the kitchen.

An interview with the Chef on 11/13/17 at 11:35 am revealed the food items in the walk-in cooler and freezer should have be sealed, labeled and dated. He stated the ingredient bin covers needed to be cleaned and he was not aware that beard restraints were required and he would need to purchase some.

An interview with the Administrator on 11/15/17 at 3:26 pm revealed he expected all exposed hair, including facial hair would be covered when working in the kitchen. He added it was his expectation that all food was covered, labeled and dated appropriately, all expired foods were discarded and that the ingredient bins would be clean.

Dietary Manager or designee inspected and confirmed all foods in Building 4 Health Center) to be within their expiration date.

By 12/13/2017, kitchen staff in main kitchen and B4 kitchen will be educated on appropriate hair restraints.

3.Systems and measures to ensure that all alleged deficient practice does not occur:

Reach in refrigerators as well as walk in coolers in the main kitchen will be checked each morning and night at closing to insure proper insulation. Also labeling and dating of food items will be performed by Chef or designee. Chef or designee will check storage bins each night at closing to insure bins are closed and clear of any spills or debris.

The B4 Kitchen maintenance and cleaning checklist, the PMAL Daily Checklist, has been revised to include a weekly inspection of all food items for expiration dates, using the B4 Kitchen Food Date Log, as overseen by the Dietary Manager or designee. The DS B4 Staff Orientation has been revised to include the expectation that staff wear hair restraints and beard guards whenever preparing or serving food. Also the B4 Kitchen Team Leader Daily Checklist has been revised to include inspecting all food items for expiration dates effective 12/13/17.

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 ______	11/16/2017

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 371	Continued From page 24	F 371	Staff will sign a notice by 12/13/2017 understanding that they must wear hair restraints and beard guards whenever they are preparing or serving food. 4.Monitoring compliance of the alleged deficient practice: Dietary manager or designee will perform daily quality checks of examining staff for appropriate hair restraints, labeling and dating opened food items in refrigerators and maintaining clean storage bins daily x 3 months. Completion date: 12/13/2017	
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must :	F 520		12/31/17

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F 520	Continued From page 25 (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (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. (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 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 September 2016. This was for a recited deficiency, which was originally cited in September 2016 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:	F 520	F520 1.Actions taken for the residents affected by the alleged deficient practice: A performance improvement project designed to improve MDS coding accuracy will be implemented through the QAPI Committee. It will include a SMART goal to measure performance, root cause analysis to determine the underlying cause of the problem and monitoring and evaluation of performance improvement. Efforts will be focused on sustainability, especially by addressing the root cause and by monitoring progress at monthly QAPI meetings. The PIP will be created	

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F 520	Continued From page 26 This tag is cross referenced to F 278 Based on record review and staff interviews 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 use. This tag was originally cited in September, 2016 during the recertification survey when the facility failed to code the Minimum Date Set for inaccurately assed a surgical wound as a pressure ulcer. This was evident in 1 of 2 sampled residents review for pressure ulcers (Resident #21). Interview with Director of Well-Being for facility on 11/16/2017 at 1:00 PM indicated her expectation for addressing repeat tags was to correct the violation by incorporating into the QAPI program and process. We would develop a PIP to include a goal, PDSA cycles and evaluation measures to ensure systemic and systematic resolution. The PIP would be followed at QAPI meeting to ensure sustainable improvement.	F 520	at the December 2017 QAPI Committee meeting. 2.Identification of other who may be affected by the alleged deficient practice: Because other quality areas may be affected, the QAPI Committee will set thresholds (minimum acceptable level of performance) for all of its current measures by end of February 2018. The committee will then prioritize performance improvement projects for those measures that do not meet the threshold. Priority will be based on, at minimum, prevalence, risk to resident well-being, potential to improve resident well-being, feasibility, and resident/staff interest. 3.Systems and measures to ensure that all alleged deficient practice does not occur: The QAPI program is being improved to consistently track and measure performance, establish goals and thresholds for performance measurement, identify and prioritize quality deficiencies, systematically analyze underlying causes of systemic quality deficiencies, develop and implement corrective action or performance improvement activities and monitor or evaluate the effectiveness of corrective action/performance improvement activities, revising as needed. We will especially focus on sustainable improvement by 1) implementing root cause analysis to address the underlying system problem,	

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F 520	Continued From page 27	F 520	2) monitoring and evaluating of performance improvement measures on an ongoing and regular basis at QAPI meetings, and 3) asking staff involved in and impacted by the process or problem being addressed to give input to the performance improvement project. Staff will be educated about the QAPI program and their role within it at department meetings 1/30/18 and 1/31/18. 4.Monitoring compliance of the alleged deficient practice: The QAPI Committee will develop measures of success for the QAPI program by end of June 2018. The executive leadership of the organization will be responsible for holding the QAPI Committee accountable to a successful QAPI program. Completion Date: 12/31/2017	