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	345199	A. BUILDING _____ B. WING _____	02/09/2023

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

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E 000	Initial Comments An unannounced Recertification survey was conducted on 02/06/23 through 02/09/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 42RQ11.	E 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		3/9/23

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

Electronically Signed | 03/01/2023

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F 582	Continued From page 1 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the Centers for Medicare & Medicaid Services (CMS) Notice of Medicare Non-Coverage Letter (NOMNC, CMS-10123 form) for 1 of 3 sampled residents reviewed for beneficiary protection notification review (Resident # 73). Findings included: Resident # 73 was admitted to the facility on 8/10/22 with diagnoses that included cerebral infarction due to thrombosis of left vertebral artery; Type 2 diabetes mellitus with hyperglycemia, and muscle weakness and abnormalities of gait. The resident was	F 582	How corrective action will be accomplished for residents affected by deficient practice: The resident affected by the deficient practice self-discharged in October 2022, and did not experience a negative impact by her decision. No corrective action is possible since nearly four months have passed. How the facility will identify other residents having the potential to be affected by the same deficient practice: We currently have 2 residents on a Medicare stay in our facility. The Business	

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F 582	Continued From page 2 discharged on 10/31/22. A review of the Skilled Nursing Beneficiary Protection Notification Review form revealed Resident #73's Medicare Part A services started on 8/10/22 and the last covered day was 10/31/22. The form further revealed that the facility initiated the discharge from Medicare Part A services when benefit days were not yet exhausted. The discharge was planned between the care team and the resident. The medical record review further revealed that the NOMNC letter which explained the Medicare A coverage for skilled services was not issued to the Resident #47 or the resident's representative. During an interview on 2/9/23 at 10.08 AM, the Accounting manager stated the resident's benefits had not been exhausted and the resident was not provided the NOMNC form as it was an oversight due to staff issue. The accounting manager further stated she was not in the office that week and the staff responsible just quit the organization and hence it was not completed. On 2/8/23 at 2:39 PM an interview was conducted with the Administrator and Director of Nursing (DON). The DON stated the resident prior to her discharge went home on a Leave of Absence (LOA). The DON further stated upon return to the facility the resident had initiated the discharge process. Care team and therapy agreed the resident had met her goals and safe discharge process was put in place. The Administrator stated it was more resident initiated discharge versus benefit exhaustion or reduction in the resident's services. The Administrator stated as the resident initiated the discharge, the NOMNC was not provided to the resident. It was	F 582	Office and Interdisciplinary Care Team will be in close communication regarding discharge plans for these individuals so the NOMNC can be issued at least 48 hours prior to discharge. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " The Accounting Coordinator or designee will issue the CMS-10123 form to residents at least 48 hours prior to discharge. " The Daily Stand-Up Notes, emailed each weekday by a member of the Interdisciplinary Care Team, will inform the Accounting Coordinator and other Business Office staff in a timely manner of planned discharges through a new prominent section labeled Discharges at the top of the Notes. " As an additional measure, the discipline who is initiating the discharge (for example, Social Work, Physical Therapy, etc.) will email the Interdisciplinary Discharge Tracking Form, that also includes the planned discharge date, and will be emailed to the Business Office at least 48 hours before a planned discharge. " The Accounting Coordinator or designee will continue to use the admission/discharge checklist and packet already developed and in use. How the facility plans to monitor its performance to make sure solutions are sustained: " The Health Information Specialist or	

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F 582	Continued From page 3 overlooked by staff.	F 582	designee will perform a monthly audit of NOMNC letters issued, and will report findings to the QAPI team in advance of that group's monthly meeting. " The Quality Assurance/Performance Improvement (QAPI) Team meets monthly and will review the audit's findings to monitor the performance for this new practice. Include dates when corrective action will be completed: " Corrective action will be completed by March 9, 2023.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		3/9/23

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F 867	Continued From page 4 §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F 867		

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F 867	Continued From page 5 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its	F 867		

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F 867	Continued From page 6 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification surveys dated 10/7/21 in order to achieve and sustain compliance. This was for recited deficiency on a recertification survey on 2/9/23. The deficiency was in the area of Medicaid/Medicare Coverage/Liability Notice. The continued failure during one federal survey of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: F582 - Based on record review and staff interviews, the facility failed to provide the Centers for Medicare & Medicaid Services (CMS) Notice of Medicare Non-Coverage Letter (NOMNC, CMS-10123 form) for 1 of 3 sampled residents reviewed for beneficiary protection notification review (Resident # 73). During the previous recertification survey on 10/7/21, the facility failed to provide a Centers for	F 867	How corrective action will be accomplished for residents affected by deficient practice The QAPI team advised that members of the Interdisciplinary Team meet with the Administrator and Accounting Manager to identify the defect in the process that contributed to the deficient practice of failing to issue the NOMNC. This group determined that communication vehicles required enhancement to ensure the Business Office staff is informed of upcoming discharges for the facility. 2 existing written notifications were modified to highlight information about discharges for the Business Office staff. The group also determined that the existing checklist and packet in use by the Business Office should continue to be used. The QAPI Team will review performance of the plan of correction for F582 at its monthly meetings. How the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 867	Continued From page 7 Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (NOMNC) letter for discharge from Medicare Part A services for 2 of 3 residents reviewed for beneficiary protection notification review. An interview with the Administrator was conducted on 2/09/23 at 2:54 PM. The Administrator stated the Quality Assurance (QA) committee does 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System change and addition task would put in place as needed to resolve the issue. The Administrator further stated that for the last citation the performance improvement plan was in place. The old plan would be revisited and analyzed to see where the failures, and where the breakdown happened. The root cause would be revisited and new interventions, monitoring tools would be put in place. Audit / education would be completed as needed. The new process will be put in place as a plan of correction to ensure compliance. The team would continuously monitor until the deficient area concerns have been resolved. The Administrator indicated that all citations were discussed in the QAA meeting including any repeat citation.	F 867	We currently have 2 residents in our facility on Medicare who have the potential to be affected by the same deficient practice. The QAPI Team will meet monthly to review performance of the plan of correction for F582. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " The Health Information Specialist will perform a monthly audit of NOMNC letters issued and will submit findings to the QAPI Team. " The QAPI Team will monitor the performance of the plan of correction for F582 for 12 months. " If the findings from the monthly audit indicate that a NOMNC was not issued as required, the QAPI team will designate an individual to conduct an investigation as to why the NOMNC was not issued as required. " The QAPI team will review findings of the follow-up investigation and will recommend appropriate changes to the process. How the facility plans to monitor its performance to make sure solutions are sustained: " The Quality Assurance/Performance Improvement (QAPI) Team meets monthly and will monitor the performance for this new practice. Include dates when corrective action will be completed: " Corrective action will be completed by	

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F 867	Continued From page 8	F 867	March 9, 2023.	