STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345449	A. BUILDING ______ B. WING ______	03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	115 WHITE ROAD KING, NC 27021

(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 582 SS=B	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. (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	F 582		4/13/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 04/07/2018

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 582	Continued From page 1 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 staff interviews and medical record review, the facility failed to provide a CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare part A services to two of three residents (Residents #49 and 65) reviewed for SNF Beneficiary Protection Notification Review. Findings included: 1. Resident #49 was admitted to the facility under part A Medicare services on 12/20/17. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #49's responsible party on 1/12/18. The notice indicated that Medicare coverage for skilled services were to end 1/16/18. The resident remained in the facility when Medicare coverage ended. A review of the medical record revealed a	F 582	Tag 0582-483.10 Medicaid/Medicare Coverage Liability Notice Root Cause Analysis Based on the root cause analysis by the facility staff and the facility Executive Director, it was determined that there was a lack of clear understanding of the regulatory requirement to provide a skilled Nursing Facility Advanced Beneficiary Notice(SNF ABN) prior to discharge from Medicare Part-A services for residents who planned to remain in the facility for long term care. Immediate Action Resident #65 was provided an ABN on 3/29/2018 by the facility's Social Services Director. Resident #49 no longer resides at the facility Identification of others On 3/22/2018 a 100% audit of the last 30	

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F 582	Continued From page 2 CMS-10055 SNF ABN was not provided to the resident or responsible party. An interview was completed with the Social Services Director on 3/15/18 at 3:39 PM. She stated when a resident's part A Medicare benefits were coming to an end she initiated the non-coverage letter and contacted the family. She said she only used the ABN form when a resident's payor source was Medicare part B. She said she was unaware that she was supposed to use the ABN forms for part A Medicare discharges. An interview was completed with the Administrator on 3/16/18 at 10:45 AM. He stated the Social Service Director was unaware that the ABN form was to be completed after a part A Medicare stay and the resident remained in the facility. He said he expected the ABN notice be issued when a resident remained in the facility following a part A Medicare stay. 2. Resident #65 was admitted to the facility on 1/17/18. Medicare part A skilled services began 2/6/18. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #65's responsible party on 2/12/18. The notice indicated that Medicare coverage for skilled services were to end 2/14/18. The resident remained in the facility when Medicare coverage ended. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the resident or responsible party.	F 582	days of discharges was conducted by the Social Services Director to determine others who may have been affected by the alleged deficient practice. No others were identified. Systematic Changes On 4/2/2018, education was provided by the nurse consultant to the Social Services Director regarding the regulatory requirements for issuing an ABN. The education included that residents who remain in the facility after Medicare Part-A services have ended require an ABN be given. Beginning 4/2/18, the Social Services Director will maintain a log of residents who are discharged from Medicare Part-A services and plan to remain in the facility for long term care. On this log will be the resident name, date of Medicare Part-A discharge and the date the ABN was provided, The log will be kept in a binder along with a copy of the ABN that has been provided to Long term care residents. Monitoring Beginning 4/9/18, the Executive Director or facility designee will review the Medicare Part-A discharge binder weekly and validate that the ABN has been provided to those Long Term Care residents who's Medicare Part-A services have ended. The Executive Director will sign the Medicare Part-A discharge log weekly for 4 weeks then monthly for 3 months. Findings will be reported to the QAPI committee for recommendations or	

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F 582	Continued From page 3 An interview was completed with the Social Services Director on 3/15/18 at 3:39 PM. She stated when a resident's part A Medicare benefits were coming to an end she initiated the non-coverage letter and contacted the family. She said she only used the ABN form when a resident's payor source was Medicare part B. She said she was unaware that she was supposed to use the ABN forms for part A Medicare discharges. An interview was completed with the Administrator on 3/16/18 at 10:45 AM. He stated the Social Service Director was unaware that the ABN form was to be completed after a part A Medicare stay and the resident remained in the facility. He said he expected the ABN notice be issued when a resident remained in the facility following a part A Medicare stay.	F 582	modifications until a pattern of compliance is achieved.	
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 observation, staff interviews and record review the facility failed to accurately code limited range of motion on the comprehensive Minimum Data Set (MDS) assessment for 1 of 6 residents (Resident #38) reviewed for limited range of motion and failed to accurately code on the comprehensive Minimum Date Set (MDS) assessment a level two PASRR (Preadmission Screening and Resident Review) for 2 of 2 residents (Resident #90 and Resident #67)	F 641	F 0641-483.20 Accuracy of Assessments Root Cause Analysis Based off the root cause analysis by the facility administrative staff and the facility Executive Director(ED), it was determined that the directions provided in the Resident Assessment Instrument(RAI) for coding of limited ROM was not clearly understood. The team also determined	4/13/18

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F 641 Continued From page 4
reviewed for PASRR.

Findings included:

1. Resident #38 was admitted to the facility on 6/23/17 with diagnoses that included, in part, of hemiplegia following cerebral infarct.

A review of the annual comprehensive MDS assessment dated 6/30/17 indicated Resident #38 was coded as having no impairment to the upper or lower extremity.

A review of the care plan updated 1/16/18 revealed a care plan problem of, "At risk for complications related to flaccid right upper extremity (RUE), contracture to right hand/digits." The care plan goal included, "Will not develop any further contractures through next review."

On 3/13/18 at 3:44 PM an observation of Resident #38 revealed her right hand was closed. Upon interview, Resident #38 stated she was unable to open up her right hand and demonstrated the same.

A review of the Contracture Risk Review dated 6/23/17 revealed there was limited range of motion to Resident #38's upper extremity and there was impairment on one side.

On 3/15/18 at 10:06 AM an interview was completed with the MDS Nurse. She stated she did not code limited range of motion impairment on the MDS because Resident #38 was slightly limited in the use of her right hand and participated with care, however, she said the resident used her left hand when she completed care because she was unable to use the right

F 641

that other sources of documenting ROM were not consistently reviewed prior to coding of the MDS. In addition, the facility did not have a clearly defined process for ensuring that PASRR level two was accurately coded on the MDS.

Immediate Action
On 3/15/18 the MDS coordinator completed a modification to the annual comprehensive assessment dated 6/30/17 for resident #38 identifying the limited ROM on one side.
On 3/15/18, Resident #90 MDS dated 9/16/17 was modified by the MDS coordinator to include PASRR level 2.
On 3/15/18, Resident #67 MDS dated 10/1/17 was modified by the MDS Coordinator to include the PASRR level 2.

Identification of others
To identify the other residents who may have been affected by the alleged deficient practice, the MDS Coordinator completed a 100% audit of the current residents coding of ROM. This audit included review of the coding of limited ROM on the most recent MDS completed January 1 to March 31, as well as a review of therapy quarterly screens for contractures and the Nursing Contracture Risk Review to ensure all were accurately coded. This audit was completed by 4/6/18.
The Social Services Director completed a 100% audit of current residents on 3/15/18 to determine if there was others who may have a PASRR level 2 that were not coded on the MDS.

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F 641	Continued From page 5 hand, which was her dominant side. On 3/15/18 at 10:23 AM an interview was completed with nurse aide (NA) #1. She reported Resident #38 opened her right hand "very little" and was unable to use her right hand when she completed personal hygiene/care. NA #1 said Resident #38 washed her face, brushed her hair and teeth, applied make-up and fed herself with her left hand because she was unable to use her right hand when she performed care. On 3/15/18 at 2:35 PM an interview was completed with the Director of Nursing (DON). She stated after she read the care plan she expected that limited range of motion would have been coded on the MDS. 2. Resident # 90 was admitted to the facility on 2/19/17 with diagnosis, in part, of anxiety disorder, depression and unspecified psychosis. A review of the North Carolina Medicaid Uniform Screening Tool (NC MUST) PASRR history revealed that Resident #90 was determined to be a PASRR Level 2. (The purpose of the Level II screening is to assure that individuals with serious mental illness entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services). A review of the comprehensive Minimum Data Set (MDS) assessment dated 9/16/17 indicated Resident # 90 had not been evaluated by Level II PASRR to determine if he had a serious mental illness. An interview was conducted on 3/15/18 at 2:09 PM with MDS Nurse #1. She revealed she got PASRR information from the Social Worker when	F 641	No other residents were identified as having inaccurately coded ROM status or inaccurate PASRR status on the MDS assessments reviewed. Systematic Changes Education was provided by the Nurse Consultant on 4/2/18 regarding the RAI directions for coding of limited ROM. This education was provided to the MDS coordinators and included ensuring that therapy screens and the nurse Contracture Risk Review are considered along with the MDS Coordinators assessment prior to coding the MDS. Beginning 4/2/18 the Social Services Director will maintain a current list of residents who have a PASRR level 2. The list will be up dated upon any new admission with a level 2 PASRR or change in status of current residents. the Social Services Director will provide this updated list to the MDS Coordinator Monthly. The MDS Coordinator will ensure coding on the MDS is appropriate. Monitoring Beginning 4/9/18, the MDS Coordinators will review 5 resident assessments weekly to ensure that coding is accurate for ROM and for Level 2 PASRRs. This review will be documented on an on-going log for MDS coding accuracy and will be maintained in a binder by the MDS coordinator. This will continue for 4 weeks and then will continue monthly for 3 months, Findings will be reported to the QAPI committee for recommendations or modifications until a pattern of compliance	

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F 641	Continued From page 6	F 641		

the resident was admitted and verified it with the medical record. She stated she would speak to the Social Worker to find out what happened with PASRR coding for Resident #90.

An interview was conducted on 3/15/18 at 4:10 PM with the Social Worker. She revealed she does not give the MDS nurse PASRR information and noted the MDS Nurse was responsible for obtaining it from the medical record and completing that section of the MDS.

A follow up interview was conducted on 3/16/18 at 8:20 AM with MDS Nurse #1. She revealed she missed the PASRR information because she thought it came from the Social Worker and she didn't receive anything from the Social Worker.

An interview was conducted with the Administrator on 3/16/18 at 9:22 AM. He revealed his expectation was that MDS ' s be accurate and they had already started a new system of checks and balances starting with admissions.

3. Resident #67 was admitted to the facility on 6/17/13 with diagnosis that included intellectual disability.

A review of the North Carolina Medicaid Uniform Screening Tool (NC MUST) PASRR history revealed that Resident #67 was determined to be a PASRR Level 2. (The purpose of the Level II screening is to assure that individuals with serious mental illness entering or residing in Medicaid-certified nursing facilities receive

Provider's plan of correction (F 641): is achieved.

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F 641	Continued From page 7	F 641		

appropriate placement and services). Record review revealed she was assessed as a level 2 PASRR due to the diagnosis of intellectual disability.

Review of the annual Minimum Data Set (MDS) dated 10/1/17 revealed it was not coded as "yes" for a level 2 in section A1500 for PASRR.

Review of the Care Area Assessments under "findings" revealed Resident #67 triggered for problems in cognition due to short and long-term memory and poor decision making due to her intellectual disability.

Interview on 3/15/18 at 2:09 PM with the MDS Nurse #1 revealed the Social Worker provides her with a list of residents who have a level 2 PASRR. Further interview revealed she was not sure why Resident #67 did not have the level 2 coded on the annual MDS. The MDS nurse indicated she would verify information that was in the chart during the assessment. Interview revealed she had missed coding the level 2 on the MDS for Resident #67.

An interview was conducted with the Administrator on 3/16/18 at 9:22 AM. He revealed his expectation was that MDS ' s be accurate and they had already started a new system of checks and balances starting with admissions.