STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345199	A. BUILDING _____ B. WING _____	C 08/28/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 8/26/2019 through 8/28/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID HURH11.	E 000		
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the Recertification Survey and complaint investigation. 7 of the 7 complaint allegations were unsubstantiated. Event ID #HURH11.	F 000		
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 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	F 656		9/25/19

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

Electronically Signed | 09/20/2019

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F 656	Continued From page 1 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 observations, record review, and staff interviews the facility failed to implement a care plan for 1 of 2 residents reviewed for hearing (Resident #17). The findings included: Resident #17 was admitted to the facility on 08/02/2019. Resident #17 diagnoses included anxiety disorder, depression, cataracts and hearing loss. A review of the most recent comprehensive Minimum Data Set (MDS) dated 08/09/19 revealed Resident #17 had moderate cognitive impairment and required extensive assistance of staff members for most activities of daily living. The MDS further revealed that Resident #17 had adequate hearing with hearing aid. The care plan was reviewed and further revealed	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 Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected. As of 09/16/2019 a review of all current	

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F 656	Continued From page 2 that no plan had been established for hearing deficits or hearing aid use. An observation of Resident #17 was made on 08/27/19 at 8:50 AM, and bilateral hearing aids were being placed by Nurse #1. On 08/27/19 at 3:03 PM an interview was conducted with Nurse #1 and she reported that Resident #17 wore hearing aids regularly. An interview was conducted on 08/28/19 at 9:54 AM with MDS Coordinator #1. After review of the MDS, the MDS coordinator stated Resident #17 had not been care planned for hearing deficits and it had been missed. An interview with the Director of Nursing (DON) on 08/28/19 at 4:19 PM revealed that the care plan should have been initiated. An interview with the Administrator on 08/28/19 at 4:39 PM revealed that the resident should have been care planned for hearing deficits.	F 656	resident□s most recent MDS assessment was completed by DON for diagnosis of hearing loss or impairment. All Resident□s comprehensive care plans were reviewed for care planning related to hearing loss or impairment as indicated by most recent MDS. 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 with a diagnosis of hearing loss or impairment have the ability to be affected by this practice. MDS coordinator was educated by DON regarding Care Planning related to hearing loss or impairment; as indicated by presence of diagnosis on MDS assessment. 3. Measures to be put into place to ensure this practice does not recur. Beginning 09/25/2019 DON or designee will complete an audit of 100% of comprehensive MDS assessments weekly X4 weeks followed by an audit of 50% of comprehensive MDS assessments weekly x 8. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur Findings of these audits will be reported to facility's QAPI committee by the DON or designee for identification of trends, and	

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F 656	Continued From page 3	F 656	determination of need for further corrective action, monthly x3.	
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 observation, record review and staff interview the facility failed to update a care plan 1 of 2 Residents (Resident #18) reviewed for a catheter.	F 657	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	9/25/19

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F 657	Continued From page 4 The findings included: Resident #18 was admitted to the facility on 7/12/19 with diagnosis that included orthostatic hypertension, unspecified urine retention, unspecified open wound of the left leg. Review of the most recent Minimum Data Set (MDS) assessment dated 8/1/19 revealed Resident #18 required extensive assistance for toileting and had an indwelling catheter. The MDS further revealed Resident #18 was cognitively intact. Review of nursing note dated 7/18/19 revealed Resident #18's indwelling catheter was removed on 7/18/19. A review of Resident #18 care plan revealed that the resident was care planned for indwelling catheter. The interventions included perform catheter care, measure urinary output, assess urine color, odor, and amount. An observation of Resident #18 on 8/26/19 at 11:34 am revealed two urinals at his bedside. The Resident was further observed not to have had an indwelling catheter. Interview with Resident #18 on 8/27/19 at 3:09 pm revealed his catheter was removed a few days after arriving to the facility. An interview was conducted with MDS Coordinator in conjunction with record review on 8/28/19 at 2:34 pm. The MDS coordinator stated that she was aware of the catheter being	F 657	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. As of 09/16/2019 Care Plans for all current residents were reviewed for accuracy related to the presence of indwelling catheter and relevant updates. 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 with an indwelling catheter have the potential to be affected by this practice. DON provided education to MDS Coordinator related to timing of care plan revisions 3. Measures to be put into place to ensure this practice does not recur. Beginning 09/25/2019 DON or designee will complete 100% audit of Care Plans related to indwelling catheter weekly x 4, followed by a 50% audit of Care Plans related to indwelling catheter weekly x 8.	

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F 657	Continued From page 5 discontinued but did not know how to take information out of the computer. Interview with the MDS Coordinator on 8/28/19 at 2:34pm revealed she was aware Resident #18's catheter was discontinued but did not know how to remove the information from the computerized care plan. An interview was conducted with the Director of Nursing (DON) on 08/28/19 at 2:54 pm, she stated that she had spoken with the MDS Coordinator about the care plan being updated and that the indwelling catheter had been removed. The DON stated that the MDS Coordinator told her she was afraid to remove the care plan due to her fear that the care plan would disappear and there would be no evidence that the catheter was ever on the care plan. An interview was conducted with the Administrator on 08/28/19 at 04:37 pm. He revealed that the care plan should have been revised.	F 657	4. How corrective action(s) will be monitored to ensure the deficient practice will not recur. Findings of these audits will be reported to facility's QAPI committee by the DON or designee for identification of trends, and determination of need for further corrective action, monthly x3.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		9/25/19

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F 690	Continued From page 6 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and nurse practitioner interview the facility failed to remove to an indwelling catheter as instructed by the nurse practitioner for 1 of 1 Resident (Resident #74) reviewed for a catheter. The findings included: Resident #74 was admitted to the facility on 8/23/19 with a diagnosis that included unspecified fracture of the left femur, constipation, and mixed incontinence. The Admission Minimum Data Set (MDS) assessment dated 8/23/19 revealed Resident #74 was moderately cognitively	F 690	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	

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F 690	Continued From page 7 impaired, was totally dependent on staff for toileting and had an indwelling catheter. Review of Nurse Practitioner clinical admission note dated 8/23/2019 stated a drug regimen review was competed upon admission and stated changes were made from the hospital discharge summary that included (#5) that stated to leave the indwelling catheter in place until resident had a bowl movement (BM). The note continued with will reassess on Monday, 8/26/2019. Review of Resident #74's Bowel movement record, revealed the resident had a Bowel Movement on 8/24/2019 and two Bowel Movements on 8/26/2019. Observation of Resident#74 on 08/26/19 at 3:01 PM revealed the resident had a urinary catheter bag at bedside that was draining, clear light-yellow liquid. Interview on 8/27/2019 at 8:25am with the Nurse Practitioner revealed that she attended Nursing report on 8/23/2019 during shift change and communicated to the staff that Resident #74's indwelling catheter was left in place on admission due to the Resident not having a BM while hospitalized. She also stated that Resident #74's urinary catheter should have been removed after the Resident's first BM on 8/24/2019 as written in the Admission Clinical Note and following physician notification communicating the removal. Interview with Nurse #3 on 8/28/2019 at 9:40 am revealed she did not see the Nurse Practitioner's instructions dated 8/23/2019 regarding the information to leave the catheter in place until Resident had a bowel movement, therefore did	F 690	admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected. As ordered on 08/28/2019 the indwelling catheter was removed for resident #74. 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 with an indwelling catheter have the potential to be affected by the alleged deficient practice. As of 09/20/2019 all providers received in-service education regarding placing instructions related to indwelling catheter care in the form of a provider order. 3. Measures to be put into place to ensure this practice does not recur. Beginning 09/25/2019 Facility will monitor provider notes for 100 % of residents with an indwelling catheter weekly x 4 weeks. Followed by a review of 50% of residents with an indwelling catheter weekly x 8 weeks, to ensure all instructions related to care for an indwelling catheter care are included in a provider order. 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur. Findings of these audits will be reported to facility's QAPI committee by the DON or	

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F 690	Continued From page 8 not notify the Nurse Practitioner nor the on-call Provider regarding Resident #74's BM on 8/24/2019. Interview with Director of Nursing (DON) and 8/26/2019 at 4:10 PM revealed Nurse Practitioner instructions should have been followed. The DON continued that removal of the catheter was most likely missed because it was not transcribed to a physician order after the instructions were written. Had the note been transcribed to an order the nurse would have seen it and the catheter would have been removed following the resident's BM and physician notification.	F 690	designee for identification of trends, and determination of need for further corrective action, monthly x3.	