STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345533	A. BUILDING _____ B. WING _____	06/04/2024

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THE CEDARS OF CHAPEL HILL	101 GREEN CEDAR LANE CHAPEL HILL, NC 27517

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E 000	Initial Comments An unannounced recertification survey was conducted on 6/2/24 through 6/4/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #6V2J11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 6/2/24 through 6/4/24. Event ID# 6V2J11.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		6/7/24

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

Electronically Signed | 06/20/2024

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F 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on records review, and staff interviews, the facility failed to include code status in the resident's record for 1 of 1 resident reviewed for Advance Directives (Resident #15). Findings included: Resident #15 was admitted to the facility on 1/30/24. The admission Minimum Data Set (MDS) assessment dated 1/30/24 revealed the resident was assessed as moderately cognitively impaired. Care Plan dated 4/8/24 indicated the resident had no care plan for Advanced Directives. The quarterly MDS dated 5/7/24 revealed the assessment was still in progress. Assessment indicated Resident #15 was severely cognitively impaired. Review of physician's orders on 6/2/24, revealed	F 578	Corrective Action for those affected by the alleged deficient practice - Facility reviewed resident's Advanced Directives and Code status with physician. Facility Physician completed a DNR form and gave an order for the resident to be a DNR on 06/03/2024. - The resident's care plan was updated to include Resident's preferences regarding Advanced Directive and relevant code status by facility's MDS coordinator on 06/03/2024. - In-service education was provided by DON to Nursing staff responsible for reviewing discharge orders for newly admitted residents on obtaining Physician's orders for Code Status and other Advanced Directives. Staff responsible for developing resident Care Plans was also in-serviced on ensuring all residents have Advanced Directives preferences documented as part of the	

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F 578	Continued From page 2 there was no active order for code status in Resident #15's Electronic Health Record (EHR). Review of the paper chart used in the facility on 6/3/24, the chart did not have physician orders related to the code status. The chart review revealed the orange-colored sheet for "Do not Resuscitate" (DNR) was from the discharging hospital. Review of the hospital discharge paperwork in the chart dated 1/30/24 revealed in discharge orders that the resident was a DNR and Do not intubate (DNI). An interview was conducted with Nurse #1 on 6/3/24 at 2:15 PM. Nurse #1 stated the code status was displayed on the paper chart of the resident. A red round sticker was placed on the outside of the charts for residents who had "DNR" as their code status and there was no sticker placed on the outside of the charts for residents on were on "Full Code" status. She indicated based on the resident's chart the resident was a "DNR". She further indicated that the resident had an orange sheet (golden rod) in the chart which indicated the resident was a DNR. Nurse #1 stated the admission nurse reviewed the medication and the code status with the physician and new orders received were entered in the chart by the admission nurse. During an interview on 6/3/24 at 2:30 PM, Nurse #2 stated she was the admitting nurse for Resident #15, and she typically only reviewed the discharge medication with the physician over the telephone. The code status was not discussed with the physician. She indicated the advance directive paper for DNR in the chart was from the hospital.	F 578	resident's comprehensive care plan. How the facility will identify other residents with the potential to be affected by the alleged deficient practice - All residents have the ability to be affected by the practice referenced. Given this the facility conducted an audit of all current resident's Medical record and care plans on 06/07/2024 to ensure all appropriate documentation was included regarding resident Code Status. Measures to be implemented to ensure that the alleged deficient practice will not recur - The facility will review and audit admission orders for Advance Directive for all new admissions weekly x3 months. The audit will include: Appropriate Documentation and physician orders for resident code status that aligns with the resident's stated preference. Documentation of resident's preference regarding code status to be included in the resident's Comprehensive Care Plan if available. How the Facility plans to monitor its performance to ensure solutions are sustained - The corrective actions and findings of weekly audits will be reported to the facility's QAPI committee monthly x 3 for review and determination of	

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F 578	Continued From page 3 During an interview on 6/4/24 at 10:32 AM, the Social Worker stated the advance directives were discussed with the resident and / or resident's representative during admission. The Social Worker indicated that she placed the "Advance Directive Form" in the resident's chart that indicated the resident's code status preference. The form contained the resident's preference and the signature of the resident or resident representative. The admitting nurse was responsible for conveying this information to the resident's physician. The Social Worker did not recall any specifics about Resident #15 code status but recollects talking to the resident. During a telephone interview on 6/4/24 at 1:37 PM, the Physician stated that the admitting nurse would reviewed with the physician the discharge medication and code status at the time of the admission / readmission from the discharge summary for any resident admitted to the facility. Sometimes the physician reviewed discharge papers. The Physician stated during the initial physician assessment the code status was discussed with the resident or representative to confirm their preferences. The Physician stated the code status order was signed, and/or verbal approval given. The admission staff would then enter the information in the resident's medical chart. During an interview on 6/4/24 at 2:00 PM, the Director of Nursing (DON) stated the admitting nurse was responsible to discuss the discharged medication and the code status of the resident with the physician. If the physician agreed and the verbal order was given, then this order was verified by 2 nurses and entered in the residents' medical records (electronic and paper chart). The	F 578	appropriateness of corrective actions and need for any additional corrective actions.	

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F 578	Continued From page 4 physician during the initial assessment discussed the code status and confirmed with the resident. If the resident elected to be a DNR then the form was completed by the nurse and signed by the physician. This form was then placed in the resident's paper chart. The DON indicated the resident was care planned based on his code status. The DON stated the order was not verified by the admitting nurse and new orders were not entered. The DON further stated the physician had mentioned in her admission assessment that the resident was a DNR, however no order was given.	F 578		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the regulatory timeframe (14 days of the Assessment Reference Date (ARD), the last day of the look-back period) as specified in the Resident Assessment Instrument (RAI) manual for 1 of 1 residents reviewed for resident assessment (Resident #2) and 1 of 1 resident reviewed for completion of quarterly assessment (Resident # 15). Finding included. 1. Resident #2 was admitted to the facility on 2/23/22	F 638	Corrective action for those found to have been affected by the alleged deficient practice -MDS coordinator was in-serviced on appropriate timeframes for Quarterly MDS completion and transmittal on 06/03/2024. - Appropriate MDS Assessments were completed signed and submitted for all residents referenced by MDS Coordinator on 06/05/2024. How the facility will identify others having potential to be affected by the alleged deficient practice	6/30/24

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F 638	Continued From page 5 Review of Resident #2's quarterly MDS assessments revealed the assessment had an Assessment Reference Date (ARD, the last day of the look-back period) of 4/3/24. The quarterly MDS dated 4/3/24 was in process and was incomplete. It was not signed by the Registered Nurse (RN) Assessment Coordinator, 60 days after the ARD date. During an interview on 6/03/24 at 11:46 AM, the MDS Nurse indicated she was hired on 4/1/24 and the facility had a remote MDS staff prior to her employment. She indicated some of the assessments were missed or incomplete. She stated the resident's quarterly assessment was partially completed and not yet signed by the RN. She indicated that assessments should be completed within 7 to 14 days from the ARD. 2. Resident # 15 was admitted to the facility on 1/30/24. Review of the resident's #15's quarterly MDS assessments revealed the assessment had an Assessment Reference Date (ARD, the last day of the look-back period) of 5/7/24. The quarterly MDS dated 5/7/24 was in process and was incomplete. It was not signed by the Registered Nurse (RN) Assessment Coordinator, 27 days after the assessment reference date. During an interview on 6/3/24 at 11:46 AM, the MDS Nurse stated indicated that assessments should be completed within 7 to 14 days from the ARD. She further stated that she ran weekly report to ensure all the assessments were completed within the required time frame. She indicated she must have overlooked and was an	F 638	- All residents have the ability to be affected by the alleged deficient practice. Given this the MDS Coordinator and DON conducted an audit of all current resident's MDS assessments for completion. Any assessments identified as being out of compliance were completed and submitted by MDS coordinator. Measures implemented to ensure the alleged deficient practice does not recur - DON or designee to audit quarterly MDS Assessments for all residents weekly x 3 months to ensure completion and timely submission. How the facility will monitor performance to make sure solutions are sustained -Results of weekly MDS completion audits will be reported to the facility's QAPI committee x 3 months for review of corrective actions and determination on need for any additional corrective action.	

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F 638	Continued From page 6 oversite of her. During an interview on 6/04/24 at 8:11 AM, the Director of Nursing (DON) stated that the previous MDS staff was let go in January 2024 as the MDS assessments were not completed in a timely manner. Until the facility could hire a new MDS staff, the MDS assessments were completed by a consulting company remotely. The consultant staff member was not completing the assessments in a timely manner. The DON indicated after multiple efforts to hire a MDS staff, the facility was able to hire a new staff on April 1st, 2024. The DON indicated that the facility had identified the issue with MDS assessments in January 2024 and had a plan of correction drafted. This plan of corrections has only been able to be implemented after the new staff member was hired in April 2024. The plan of correction was discussed in the Quality Assurance (QA) meeting in May and the MDS Nurse was given 90 days from the date of hire to complete the assessments. The MDS staff was trying to complete all incomplete MDS assessments from oldest to the newest. The DON indicated she reviewed the "MDS at risk for noncompliance" tool on the Electronic Medical Record (EMR) system weekly to ensure the assessments were completed. This was her monitoring tool. She indicated the completion date was June 30th. The quarterly assessments were also monitored in the same way. The plan of correction included all types of MDS assessments. Once the MDS staff completed the assessment the DON was made aware, and she would sign off on them as RN. The new staff had to be educated on how to transmit these completed MDS and it was still a work in progress.	F 638		

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F 638	Continued From page 7 During an interview on 6/4/24 at 9:06 AM, the Administrator stated the plan of correction was discussed in the QA meeting held on 5/16/24. This was a review of the April 2024 QA meeting. This was the first QA meeting after the MDS Nurse was hired. The completion date was discussed as 6/30/24 in the meeting. The facility was aware of the backlogs in MDS assessment and working to complete it in a timely manner.	F 638		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within	F 640		6/30/24

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F 640	Continued From page 8 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete and transmit Discharge Minimum Data Set (MDS) assessments within the required time frame for 4 of 4 residents (Resident #14, Resident #1, Resident #5, and Resident #13) selected for Resident Assessments. Findings included: 1. Resident #14 was admitted on 1/13/24 The last MDS assessment completed and transmitted was an admission MDS assessment dated 1/19/24.	F 640	How Corrective action will be accomplished for those affected by the alleged deficient practice - MDS coordinator was in-serviced on appropriate timeframes for MDS completion and transmittal on 06/03/2024. - All MDS assessments for residents referenced were transmitted by MDS Coordinator on 06/05/2024. How the facility will identify others have the potential to be affected by the alleged deficient practice	

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F 640	Continued From page 9 Review of the progress note by the Social Worker dated 5/19/24 revealed Resident #14 was moved to a non-certified bed in the facility on 5/15/24. Review of the discharge return not anticipated MDS assessment revealed an Assessment Reference Date (ARD) of 5/15/24 indicated the resident had a planned discharge and was moved to a non-certified bed in the nursing home. The assessment indicated it was incomplete and the assessment was still in process. During an interview on 6/3/24 at 11:46 AM, the MDS Nurse indicated the resident was discharged to a non-certified bed in the facility on 5/15/24 and the discharge MDS assessment was not completed. The MDS Nurse stated the assessment was incomplete and must have been overlooked. 2. Resident #1 was admitted on 1/11/24. The last MDS assessment completed and transmitted was an admission MDS assessment dated 1/19/24. Review of the progress note by the Social Worker dated 4/30/24 revealed Resident #1 was discharged home with her family. Review of the discharge return not anticipated MDS assessment revealed an Assessment Reference Date (ARD) of 4/30/24 indicated the resident had a planned discharge and was discharged to the community. The assessment indicated it was incomplete and the assessment was still in process. During an interview on 06/03/24 11:46 AM, the	F 640	- All residents have the ability to be affected by the alleged deficient practice. Given this an audit of all current residents was conducted by DON to identify any MDS Assessments that were in need of submission and transmittal. Measures implemented to ensure the alleged deficient practice does not recur -The DON or designee will audit MDS Assessments for all current residents for timely completion and transmittal weekly x 3 months. How the facility will monitor performance to make sure that solutions are sustained - The findings of completed audits will be reported to the facility's QAPI committee monthly x 3 months for review of corrective actions and determination on need for any additional corrective action.	

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F 640	Continued From page 10	F 640		

MDS Nurse indicated the resident's assessment must have been missed as the resident was initially discharged home and later was admitted to a non-certified bed in the facility. The assessment must have been missed and was still incomplete.

3. Resident #5 was admitted on 12/26/23.

The last MDS assessment completed and transmitted was an admission MDS assessment dated 1/2/24.

Review of the discharge return not anticipated MDS assessment revealed an Assessment Reference Date (ARD) of 1/31/24 indicated the resident had a planned discharge and was discharged to the community. The assessment indicated it was completed and signed by the RN nurse on 2/20/24. The assessment was not transmitted.

During an interview on 6/3/24 at 11:46 AM, the MDS Nurse indicated this assessment was completed by the previous remote MDS staff. She further indicated she was unsure why the assessment was not transmitted. MDS Nurse stated a completed and signed MDS assessment should be transmitted within 7- 14 days of completion.

4. Resident #13 was admitted on 12/8/23.

The last MDS assessment completed and transmitted was an admission comprehensive MDS assessment dated 12/15/23.

Review of the progress note by the Social Worker dated 12/29/23 revealed the resident was

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F 640	Continued From page 11	F 640		

discharged to a non-certified bed at the facility.

Review of the discharge return not anticipated MDS assessment revealed an Assessment Reference Date (ARD) of 12/29/23 indicated the resident had a planned discharge and the resident was discharged to a non-certified bed. The assessment indicated it was completed and signed by the RN nurse on 2/20/24. The assessment was not transmitted.

During an interview on 6/3/24 at 11:46 AM, the MDS Nurse indicated the assessment was completed by the previous remote MDS staff and unsure why this was not transmitted. A completed and signed MDS assessment should be transmitted within 7- 14 days from completion. The MDS Nurse indicated she was hired in April 2024 and was in the process of identifying assessments that were incomplete and/ or not transmitted.

During an interview on 6/04/24 at 8:11 AM, the Director of Nursing (DON) stated that the previous MDS staff was let go in January 2024 as the MDS assessments were not completed in a timely manner. Until the facility could hire a new MDS staff, the MDS assessments were completed by a consulting company remotely. The consultant staff member was not completing the assessments in a timely manner. The DON indicated after multiple efforts to hire a MDS staff, the facility was able to hire a new staff on April 1st, 2024. The DON indicated that the facility had identified the issue with MDS assessments in January 2024 and had a plan of correction drafted. This plan of corrections has only been able to be implemented after the new staff member was hired in April 2024. The plan of

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS OF CHAPEL HILL	101 GREEN CEDAR LANE CHAPEL HILL, NC 27517

(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
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correction was discussed in the Quality Assurance (QA) meeting in May and the MDS Nurse was given 90 days from the date of hire to complete the assessments. The MDS staff was trying to complete all incomplete MDS assessments from oldest to the newest. The DON indicated she reviews the "MDS at risk for noncompliance" tool on the Electronic Medical Record (EMR) system weekly to ensure the assessments were completed. This was her monitoring tool. She indicated the completion date was June 30th. The quarterly assessments were also monitored in the same way. The plan of correction included all types of MDS assessments. Once the MDS staff completed the assessment the DON was made aware, and she would sign off on them as RN. The new staff had to be educated on how to transmit these completed MDS and it was still a work in progress.

During an interview on 6/4/24 at 9:06 AM, the Administrator stated the plan of correction was discussed in the QA meeting held on 5/16/24. This was a review of the April 2024 QA meeting. This was the first QA meeting after the MDS Nurse was hired. The completion date was discussed as 6/30/24 in the meeting. The facility was aware of the backlogs in MDS assessment and working to complete it in a timely manner.