AMENDED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 02/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH CARE CENTER	1735 TODDVILLE RD CHARLOTTE, NC 28214

(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 226 SS=B	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement the policy related to screening of new hires for two (2) of five (5) sampled employees. The facility failed to check criminal background checks for Nursing Assistant (NA) #2 and failed to check references for NA #2 and NA #3. The findings are: A facility policy entitled Administrative Policies and Abuse Procedures Abuse/Neglect/Misappropriation/Crime, dated 08/03/11, read in part under screening: "Criminal background and reference checks are performed on all employees. 1. NA #2's employee file revealed the date of hire was 01/30/12. Information within the file indicated NA #2 did not have a criminal background check result and no references at the time she was hired. On 02/07/12 at 11:07 AM the Human Resources Manager, who had the responsibility of obtaining background checks and references on new employees stated she did not obtain a criminal background check on NA#2 or references on	F 226	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. **How the corrective action will be accomplished for the resident(s) affected.** Employee # 2 had the reference check and Employee #3 criminal background check completed at the time the file was noted by the surveyor by the Human Resource Manager. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Human Resource Manager will audit employee files by 3/1/2012 to ensure completion of criminal background and reference checks.	3/1/12 3/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Todd W. Barnes — TITLE: Administrator — (X6) DATE: 2/24/12

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.

Original signature

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 02/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH CARE CENTER	1735 TODDVILLE RD CHARLOTTE, NC 28214

(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 226	Continued From page 1 NA#2 before she was hired. She stated she missed checking NA#2's criminal background check and references. On 02/07/12 at 11:30 AM the Administrator was interviewed. He revealed the facility abuse procedure required evidence that criminal background checks and references should be completed before Nursing Assistants were hired. He stated his expectation was those documents should have been obtained. 2. NA #3's employee file revealed the date of hire was 01/30/12. Information within the file indicated NA#3 did not have references completed at the time she was hired. On 02/07/12 at 11:07 AM the Human Resources Manager, who had the responsibility of obtaining background checks and references on new employees stated she had not obtained reference checks for NA#3 before she was hired. She stated she missed checking NA#3's references. On 02/07/12 at 11:30 AM the Administrator was interviewed. He revealed the facility abuse procedure required evidence that criminal background checks and references should be completed before Nursing Assistants were hired. He stated his expectation was those documents should have been obtained.	F 226	**Measures in place to ensure practices will not occur.** Regional Human Resource Manager will audit 10 new hire files during monthly visits for a period of 2 months, then 5 new hire files audited each visit thereafter. **How the facility plans to monitor and ensure correction is achieved and sustained.** Human Resource Manager to report audit results to QA committee monthly for 3 months to ensure compliance and revise POC as needed. The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance, All alleged deficiencies cited have been or will be completed by the dates indicated.	3/1/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 02/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH CARE CENTER	1735 TODDVILLE RD CHARLOTTE, NC 28214

(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 323	Continued From page 2 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide a fall intervention for one (1) of three (3) sampled residents. (Resident #4). The findings are: Resident #4 was admitted to the facility with diagnoses including Alzheimer's dementia and degenerative joint disease. The latest Minimum Data Set (MDS) dated 11/17/11 indicated Resident #4 was assessed with impaired memory and cognition and required extensive staff assistance for transfers. The MDS specified the resident had not experienced a fall in the past three (3) months. A review of Resident #4's medical record revealed a nurse progress note dated 02/03/12 written by Licensed Nurse (LN) #1 at 6:30 PM. The note specified Resident #4 was found on the floor beside her bed by a nursing assistant. A review of Resident #4's care plan revealed an intervention dated 02/03/12 specified a bed alarm would be utilized while the resident was in bed. An interview with Unit Manager #1 on 02/07/12 at 9:10 AM revealed the bed alarm was	F 323	**How corrective action will be accomplished for each resident found to have been affected by the deficient practice** – Resident # 4 Bed Alarm was immediately placed on resident and checked to ensure it functioned properly. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice** – Nursing Assistants and Licensed Nurses will be in-serviced on Device logs, proper storage and functioning of devices on 2/27/2012 by Staff Development, Weekend Supervisor, and Unit Manager.. An audit was completed on 2/23/2012 by Unit Managers to check to ensure that devices are functioning properly and care plans reviewed and updated. Device logs were placed at the Nursing Station on each unit, and on the MAR. **Measures to be put in place or systemic changes made to ensure practice will not re-occur-** All resident devices will be audited weekly by Unit Manager, Supervisor, and DON for accuracy and compliance. This will be weekly x 1 month then daily after the falls meeting. The results of the audits will be reviewed. during the Fall Committee meeting weekly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 02/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH CARE CENTER	1735 TODDVILLE RD CHARLOTTE, NC 28214

(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 323	Continued From page 3 implemented on 02/03/12. An observation at the time of this interview revealed a bed alarm could not be located in Resident #4's room. An observation on 02/07/12 at 2:45 PM revealed Resident #4 was lying in bed. No bed alarm was observed. An interview with Nursing Assistant (NA) #1 on 02/07/12 at 2:47 PM revealed the nursing assistants who had placed Resident #4 in the bed after lunch should have positioned and activated a bed alarm. At this time, NA #1 was unable to locate a bed alarm on the resident's bed or in her room. Continued interview with Unit Manager (UM) #1 on 02/07/12 at 2:55 PM revealed the bed alarm should be in place and activated when Resident #4 was in bed. At this time, UM #1 found a bed alarm on top of the resident's clothes closet in her room. UM #1 was observed attempting to place and activate the alarm and was unable to successfully do so. UM #1 stated the alarm was not working properly and should have been turned in for repair. UM #1 added he expected the nursing assistants to implement interventions to prevent falls and injury as outlined on the resident's care plan and to replace equipment that malfunctioned.	F 323	**How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** The audits will be presented to QA&A Committee by DON monthly and Quarterly thereafter for a period of 6 months to monitor for continued compliance and revisions as needed.	