STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0494	A. BUILDING: _____ B. WING _____	C 02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND TERRACE	2300 ABERDEEN BOULEVARD GASTONIA, NC 28054

(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) COMPLETE DATE
L 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #983611.	L 000		

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F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herin. 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 facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction consititutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	03/11/2015

DHSR NH L&C Black Mountain WRO
Received
MAR 17 2015
by: vcl

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3-16-15

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 Date : 3-6-15

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct a comprehensive resident assessment for 4 of 19 sampled residents to identify how condition affected each resident's function and quality of life (Residents #23, #146, #228, and #130). The findings included: 1. Resident #23 was admitted to the facility on 01/13/15 with diagnoses which included a displaced right distal radial fracture with cast. Review of Resident #23's range of motion assessment dated 01/13/15 revealed documentation a right wrist to elbow cast which severely limited range of motion of the right upper extremity. Review of Resident #23's admission Minimum Data Set (MDS) dated 01/20/15 revealed an assessment of intact cognition. The MDS indicated Resident #23 required the extensive assistance of one person with toilet use and the limited assistance of one person with dressing. The MDS triggered the Care Area Assessment (CAA) of Activities of Daily Living (ADL). Review of the ADL CAA dated 01/26/15 revealed Resident #23 required limited/extensive assistance and listed the ADLs of bed mobility, transfer, ambulation, locomotion, dressing toilet use, hygiene and bathing. The CAA documented a recent hospitalization for an acute cerebral vascular accident and did not document the presence of the cast or limited range of motion.	F 272	Resident #23 was updated to reflect specific characteristics and risk factors on 03/11/2015. At the time of PoC the resident had already been discharged from the facility. The updated CAA was placed in the medical record. Resident #228 was updated to reflect specific characteristics and risk factors on 03/11/2015. At the time of PoC the resident had already been discharged from the facility. The updated CAA was placed in the medical record. Resident #146 was updated to reflect specific characteristics and risk factors on 03/11/2015. At the time of PoC the resident had already been discharged from the facility. The updated CAA was placed in the medical record. Resident #130 was updated to reflect specific characteristics and risk factors on 03/11/2015. At the time of PoC the resident had already been discharged from the facility. The updated CAA was placed in the medical record.	03/11/2015

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F 272	Continued From page 2 Further review of the CAA revealed there was no documentation of causes and contributing factors with supporting documentation specific to Resident #23. The CAA did not indicate an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Interview with Resident #23 on 02/10/15 at 8:37 AM revealed the cast on the right arm limited her independence in ADLs. Interview with the MDS Coordinator on 02/11/15 at 8:14 AM revealed he was not aware the CAA required documentation of resident specific characteristics and risk factors used in analysis and the decision to proceed to care plan. Interview with the Director of Nursing and Administrator on 02/11/15 at 9:00 AM revealed the CAA required a documented and detailed analysis. 2. Resident #228 was admitted to the facility on 01/24/15 with diagnoses which included right eye blindness. Review of Resident #228's admission Minimum Data Set (MDS) dated 01/31/15 revealed an assessment of intact cognition. The MDS indicated Resident #228 required the extensive assistance of one person with transfers and had a history of falls prior to admission to the facility. The MDS indicated Resident #228 should be assessed for falls. Review of Resident #228's clinical record revealed there was no documentation of a Care Area Assessment regarding falls.	F 272	The Director of Nursing will insure that all assessments are completed and in the resident charts on new admissions and review assessments and care plans prior to the weekly care team meeting. Nursing staff will be educated on the regulations requiring comprehensive assessment and the facility's policy. The Staff Development Cordinator will audit weekly for 4 weeks and then biweekly for 4 weeks and then monthly for 3 months to insure assessments are accurate and completed on those residents scheduled to be reviewed for the week according to the MDS schedule and those that have a change in condution or new orders that requre and assessment be completed. The Director of Nursing will be responsible for reviewing the audits and will report the audit findings to QA on a monthly basis.	03/11/2015

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F 272	Continued From page 3 Interview with Resident #228 on 02/10/15 at 9:57 AM revealed he adjusted to blindness in the right eye and asked staff to place the call light and urinal on his left side. Interview with the MDS Coordinator on 02/11/15 at 8:17 AM revealed there was no CAA regarding falls for Resident #228. The MDS Coordinator explained he was aware the assessment was overdue and would complete the assessment. Interview with the Director of Nursing and Administrator on 02/11/15 at 8:58 AM revealed a CAA should be completed at the time of an admission MDS assessment. 3. Resident #146 was admitted to the facility on 10/13/14 with diagnoses which included dementia. Review of Resident #146's admission Minimum Data Set (MDS) dated 10/20/14 revealed an assessment of short and long term memory loss. The MDS indicated Resident #146 demonstrated verbal behaviors directed toward others, disorganized thinking and required the limited assistance of one person with transfers and walking. The MDS triggered Care Area Assessments (CAA) in the areas falls. Review of a physician's order dated 10/21/14 revealed direction to schedule Haldol 0.25 milliliters (0.5 milligrams) in the morning and keep Haldol as needed. Review of the Care Area Assessment dated 10/24/14 revealed falls triggered due to impaired balance/standing/mobility related to general	F 272		

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F 272	Continued From page 4 weakness/debility, dementia, decreased endurance, medication side effects and advanced age. Further review of the CAA revealed there was no documentation of causes and contributing factors with supporting documentation specific to Resident #146. The CAA did not indicate an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Interview with the MDS Coordinator on 02/11/15 at 8:07 AM revealed he was not aware the CAA required documentation of resident specific characteristics and risk factors used in analysis and the decision to proceed to care plan. Interview with the Director of Nursing and Administrator on 02/11/15 at 9:00 AM revealed the CAA required a documented and detailed analysis. 4. Resident #130 was readmitted to the facility 11/07/14 with diagnoses which included Alzheimer's disease, failure to thrive, and chronic anemia. A review of an admission Minimum Data Set (MDS) dated 11/14/14 revealed Resident #130 had memory loss and severely impaired cognition. The MDS specified the resident was totally dependent on facility staff for all activities of daily living (ADL) care, had a feeding tube, and was readmitted with an unstageable pressure ulcer. Review of the medical record revealed the MDS did not contain Care Area Assessment (CAA) documentation that explained the underlying	F 272		

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F 272	Continued From page 5 causes, contributing factors, and risk factors related to ADL's, feeding tube, and the pressure ulcer. An interview was conducted with the MDS Coordinator on 02/10/15 at 2:44 PM. The MDS Coordinator stated he was so busy at the time this admission MDS was completed for Resident #130 that he may have overlooked writing CAA's for the triggered areas. The MDS Coordinator acknowledged CAA's should have been completed with this comprehensive MDS assessment. During a continued interview at 3:08 PM on 02/10/15, the MDS Coordinator stated he was unable to find any CAA's for Resident #130's admission MDS dated 11/14/14. Interview with the Director of Nursing and Administrator on 02/11/15 at 8:58 AM revealed a CAA should be completed at the time of an admission MDS assessment.	F 272		
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 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 323	Potentially hazardous chemicals were removed and secured after observation on 02/08/15 in room #'s 30, 33A, 40A, 42A and 45A. The facility will insure compliance with this regulation by conducting room checks each shift on the memory care units to insure resident rooms are free from potentially harmful chemicals or items.	03/11/2015

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F 323	Continued From page 6 interviews the facility failed to secure hazardous chemicals out of the reach of cognitively impaired residents in 5 of 15 resident rooms in the Special Care Unit. (Room # 's 30, 33, 40, 42 and 45). Findings Included: On 02/08/15 an observation of room 42 A at 11:30 AM and 2:20 PM revealed a bottle of spray aerosol room deodorizer and personal cleanser body wash in the bathroom, on the back of the toilet. On 02/08/15 an observation of room 45 A at 11:30 AM and 2:20 PM revealed a bottle of spray aerosol room deodorizer on the counter by the sink. On 02/08/15 an observation of room 40 A at 11:30 AM and 2:20 PM revealed a bottle of spray aerosol room deodorizer and personal cleanser body wash on the counter by the sink. On 02/08/15 an observation of room 30 at 11:30 AM and 2:20 PM revealed a container of germicidal wipes on the counter by the sink. On 02/08/15 an observation of room 33A at 11:30 AM and 2:20 PM revealed a bottle of spray aerosol room deodorizer, and personal cleanser body wash on the counter by the sink. Further observation revealed a container of germicidal wipes on the bedside dresser. Review of the personal cleanser body wash label revealed, Warnings: for external use only, avoid contact with eyes, keep out of reach of children, and in case of accidental ingestion, get medical help or contact a poison control center	F 323	All other resident rooms were checked on 02/12/2015 by the management team and there were no unsecure environmental hazardous chemicals present. All staff including housekeeping staff will be educated on the regulations that require these items be stored securely. The facility also provides locked spaces in each of the residents' room to store potentially hazardous items such as toiletry items and aerosol sprays. Room checks will be conducted by the Charge Nurses on all shifts on a daily basis. The Director of Nursing will audit room checks 2x week for 3 months. The audit results will be discussed monthly at the QA meeting by the nursing home administrator.	03/11/2015

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F 323	Continued From page 7 immediately. Review of the label for the spray aerosol room deodorizer revealed, keep out of reach of children. Review of the germicidal wipes label revealed, precautionary statements: Hazard to humans. Danger: causes irreversible eye damage. An interview with Nurse # 3 on 02/08/15 at 2:24 PM revealed the aerosol room deodorizer, personal cleanser body wash, and germicidal wipes should not have been left in resident rooms, within reach of residents. The items should have been locked up to prevent accidental ingestion of the products. An interview with the Director of Nursing and Administrator on 02/10/15 at 3:30 PM revealed that it was an expectation of staff to keep hazardous chemicals locked up, and not within reach of the residents.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329	Resident #109 ordered labs CMP, Hgb A1c and CBC were drawn on 02/17/2015 and reported to the physician. Audits will be conducted of 100% of resident labs by the Charge Nurse to insure compleance with this requirement and to insure residents receive labs on a timely basis as ordered. Audits will be conducted	03/11/2015

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F 329	Continued From page 8 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and the physician, the facility failed to obtain laboratory values ordered by the physician to monitor medications used to lower blood sugar, decrease edema and treat anemia for 1 of 7 sampled residents reviewed for unnecessary medications. (Resident # 109). The findings included: Resident # 109 was admitted to the facility on 05/18/10 with diagnoses which included diabetes mellitus, cerebrovascular accident, congestive heart failure and anemia. Review of Resident # 109's monthly physician orders dated 02/01/15 revealed medications included Levemir insulin 14 units subcutaneously every night to treat diabetes mellitus, Glucophage 1000 milligrams (mg) twice a day to treat diabetes mellitus, Ferrex 150 mg twice a day to treat anemia, Lasix 20 mg one-half tablet every morning to treat edema associated with congestive heart failure, Lovenox 80 mg 0.8	F 329	The facility will insure that each residents' drug regiment is free from unnecessary drugs. The facility will insure compliance with this regulation by providing an inservice education conducted by the staff development coordinator to all nursing staff on the requirements stated in this regulation and by the facility's policy. The nurse administrator will develop a lab administration book in which the charge nurse will insure all labs are received as ordered. The nursing home administrator will be responsible for reviewing audit results during the QA meeting on a monthly basis.	03/11/15

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F 329	Continued From page 9 milliliters (ml) every 12 hours and Coumadin 9 mg every day to treat cerebrovascular accident. The monthly physician's orders included directions to obtain a Hemoglobin A1c (Hgb A1c) blood test every 3 months, a complete blood count (CBC) every month and a complete metabolic panel (CMP) every 6 months. (A Hgb A1c blood test measures blood sugar attached to red blood cells in a 3 month period. A CBC measures hemoglobin and hematocrit levels. A CMP measures electrolyte levels). Review of the monthly physician orders from 05/01/14 through 01/01/15 revealed orders for these routine labs were listed each month. Review of Resident # 109's most recent Hgb A1c dated 08/11/14 revealed a result of 5.6% with a reference range of 4.2 % to 5.8%. Review of Resident #109 's most recent CBC dated 05/06/14 revealed a hemoglobin of 10.9 grams per deciliter (g/dL) with a reference range of 13.5 - 17.0 g/dL and a hematocrit of 33.3 % with a reference range of 40 - 54 %. Review of Resident # 109's most recent CMP dated 05/06/14 revealed a potassium of 4.4 milliequivalents per liter (mEq/L) with a reference range of 3.5 - 5.3 mEq/L and a glucose of 106 milligrams per deciliter (mg/dL) with a reference range of 70 - 110 mg/dL. Review of the facility's laboratory schedule revealed Resident # 109's Hgb A1c was scheduled to be completed in January, April, July and October and Resident #109 's CMP was scheduled to be completed in May and November. Resident # 109's CBC was scheduled to be completed every month.	F 329		

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F 329	Continued From page 10 An interview on 02/11/15 at 12:15 PM with the Director of Nursing (DON) about her expectation for labs to be completed as ordered by the physician revealed she expected the labs to be done as ordered. When asked if she had any explanation as to why the labs had not been obtained as ordered, she stated there had been multiple changes in the supervisory nursing roles over the past few months and she thought that was the reason the labs were missed. The DON stated the night shift supervisor was responsible for ordering routine labs and that position had been vacant for 5 or 6 months. The DON stated she didn't discover until 02/11/15 that the night shift supervisor was responsible for ordering routine labs. An interview on 02/11/15 at 1:46 PM with Resident # 109's physician about the labs not being obtained as ordered revealed he expected routine labs to be done as ordered. He stated he became the facility's Medical Director on 06/01/14 at which time he reviewed and approved the lab protocols for obtaining routine labs for medication monitoring. When asked if it was a concern that the routine labs had not been obtained as ordered, he stated his only concern was that if we say we are going to do it, we should do it. In his (this resident's) case, it probably doesn't make a huge difference but we should get a CBC now since he's on an anti-coagulant. The physician stated it was a standard of practice to get a Hgb A1c every 3 months.	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425		

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F 425	Continued From page 11 drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on resident, staff and physician interview, and record review, the facility failed to provide eye medication for 1 of 7 sampled residents who received medications (Resident #333). The findings included: Resident #333 was admitted to the facility on 02/05/15 with diagnoses which included glaucoma. Review of Resident #333's admission medication orders dated 02/05/15 revealed medications included Xalatan 0.005% one drop to both eyes at bedtime and Travatan Z 0.004% one drop to both eyes every morning. (Xalatan and Travatan are ophthalmologic medications used to treat glaucoma.)	F 425	Resident #333 received Travatan Z 0.004% and Xalatan 0.005% one drop to both eyes at bedtime as ordered on 02/11/2015. Audits will be conducted on 100% new admissions for 3 consecutive months. The facility will insure that residents receive routine and emergent drugs and biologicals. The facility provides pharmaceutical services to meet the needs of each resident. The facility provides the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. All nursing staff will receive an inservice on how to procure medications potentially missing during med pass. This inservice will be provided by the facility's licensed pharmacist. A baseline audit will be conducted on all new admissions by the assistant clinical manager 48 hours post admission. Pharmacy will also audit new admissions to insure residents are receiving medications as ordered on a monthly basis. The Director of Nursing will be responsible for reporting audit results at the monthly QA meeting.	03/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. BUILDING _____ B. WING _____	C 02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND TERRACE	2300 ABERDEEN BOULEVARD GASTONIA, NC 28054

(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 425	Continued From page 12 Review of Resident #333's admission nursing note dated 02/05/15 revealed an assessment of intact cognition. Review of Resident #333's February 2015 Medication Administration Record (MAR) revealed documentation of omitted doses of the Xalatan due to unavailability on 02/05/15 and on 02/06/15. Further review of Resident #333's February 2015 MAR revealed documentation of omitted doses of the Travatan Z on 02/06/15, 02/07/15, and 02/08/15 due to unavailability. Interview with Resident #333 on 02/11/15 at 12:20 PM revealed the facility did not provide eye drops until yesterday. Resident #333 explained a family member brought the medication used at home for staff to use over the weekend (02/07/15 and 02/08/15) but staff could not use one of the eye drops. Observation of the medication cart on 02/11/15 at 1:25 PM revealed the cart contained Resident #333's Xalatan and Travatan medication. Review of the pharmacy label revealed a dispense date of 02/05/15. Interview with Nurse #1 on 02/11/15 at 1:34 PM revealed she called the pharmacy yesterday (02/10/15) to request the order for the medication be filled. Nurse #1 reported the pharmacy delivered the medications on 02/05/15. Nurse #1 explained staff were unaware the medications were in the facility because they had been placed into the medication refrigerator. Nurse #1 reported Resident # 333 received the eye medication from home until yesterday (02/10/15). Interview with Nurse #2 on 02/11/15 at 1:42 PM revealed she informed Resident #333 the pharmacy did not deliver the eye medications. Nurse #2 explained she faxed a request to the pharmacy but would not expect a delivery of the	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND TERRACE	2300 ABERDEEN BOULEVARD GASTONIA, NC 28054

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F 425	Continued From page 13 medication until Monday (02/09/15). Nurse #2 reported she was not aware the medication was in the medication refrigerator. Nurse #2 reported she informed Resident #333's family member she could not administer the eye medications brought from Resident #333's home since the pharmacy label differed in drug name. Interview with Resident #333's physician on 02/11/15 at 2:12 PM revealed he expected medications to be available for administration. Interview with the Director of Nursing on 02/11/15 at 2:30 PM revealed she expected staff to call the pharmacy to determine if delivery occurred and to obtain medications for administration.	F 425		