DEPARTN	VENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTERS	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	COM	E SURVEY PLETED
		345563	B. WING				C
NAME OF PR	OVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	12	/11/2015
					0011 PROVIDENCE ROAD WEST		
PAVILION I	HEALTH CENTER AT BI	RIGHTMORE			CHARLOTTE, NC 28277		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	483.10(b)(11) NOTIF (INJURY/DECLINE/F		F	157			1/8/16
	consult with the resid known, notify the resid or an interested famil accident involving the injury and has the po- intervention; a signific physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a ne existing form of treath consequences, or to treatment); or a decis						
	and, if known, the res or interested family m change in room or ro specified in §483.15 resident rights under	promptly notify the resident sident's legal representative nember when there is a ommate assignment as (e)(2); or a change in Federal or State law or red in paragraph (b)(1) of					
	the address and phor	ord and periodically update ne number of the resident's or interested family member.					
	by:	is not met as evidenced					
	failed to inform 1 of 1	esident interview the facility (#1) alert and oriented e in medication. Findings			The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the	do	
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE
	ally Signed						01/07/2016

Electronically Signed

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345563	B. WING				C 12/11/2015
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	12/11/2010	
					011 PROVIDENCE ROAD WEST		
PAVILION	HEALTH CENTER AT B	RIGHTMORE		-	HARLOTTE, NC 28277		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	COMPLETIO
F 157	Continued From pag	o 1		457			
1 157	Continued From pag	eı	F	157			
	included:				alleged deficiencies.		
					To remain in compliance with all Fede	ral	
		w revealed a hospital			and State Regulations the facility has		
		11/25/15 which stated, "Of			taken or will take the actions set forth this Plan of Correction. The Plan of	In	
		she has had a left septic					
		She has spiculated (lump of the surface) humerus, and			Correction constitutes the facility's allegation of compliance such that all		
		f bone eroded through her			alleged deficiencies cited have been c	vr	
		v was removed previously)			will be corrected by the date of dates	//	
		ff orthopaedic here, and the			indicated.		
	-	with a superficial suture. She			indicated.		
	is scheduled to see [-			F157		
		for follow up.					
	Discharge medication	ns included Keflex 500 mg			Corrective Action for Resident Affected	b	
	by mouth two times a						
	,	, ,			For resident # 1: Resident was discha	rged	
	The Minimum Data S	Set Assessment completed			12/12/2015.	0	
		at the resident was assessed					
	as being alert and or	iented with okay long and			Corrective Action for Resident Potentia	ally	
	short term memory.	, ,			Affected	5	
	Interview with Reside	ent #1 at 6:25 pm on			All alert and oriented residents who ha	ave	
	12/11/15 revealed the	at she was taking the			had a medication order change have t	he	
		n admitted to the facility to			potential to be affected by this practice	Э.	
		The resident reported that			On 01/05/2016 the nurse managers		
		continued by the facility			began reviewing the order list report fr		
		king me". The resident			the electronic health record. All current	nt	
		s ago she could not sleep			and discontinued medication orders		
		ell. The resident stated that			written in the last 60 days for active al	ert	
		nd sniffed everywhere and			and oriented patients were reviewed.	<i>c</i>	
	-	a bowel movement in the			Once medication changes were identi	fied,	
	bed. The nurse coul				the nurse managers ten went to each		
		stated that when she woke up			patient and explained to the patient wi		
	-	her face turned to the left			medications were changed. If the pati	ent	
		smell was coming from her			had any questions or concerns the		
		elbow had been removed).			physician was notified and corrective	hie	
	The resident stated t	hat she was told by the			actions identified and implemented. T	1115	
	social worker that the	hat she was told by the			was completed on 01/06/2016.		

Facility ID: 070529

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/08/2016 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345563	B. WING				C / 11/2015
NAME OF P	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12	
	HEALTH CENTER AT BI	RIGHTMORE		10	0011 PROVIDENCE ROAD WEST		
TAVILION				С	HARLOTTE, NC 28277		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From page	e 2	F	157			
		acility physician. The			Systematic Changes		
	orthopaedic physicar was supposed to hav elbow in January of 2 her orthopaedic phys surgery would have t elbow is infected, ma months. The residen	the earlier that day and that she re surgery to get a new 2016. Resident #1 said that incian told her that the o be delayed now that her hybe for as long as 6-9 ht stated, "It's taken away all e. I was hoping to live alone			On 01/04/2016 the Director of Nursin began inserviceing the full the full tim part time and prn nurses. Topics included: Notification of the patient w medications are changed or discontin and documentation of the notification the patient's medical record.	e, /hen iued	
	stopped the Keflex or Director of Nurses or	revealed that the facility n 12/5/15. Interview with the n 12/11/15 at 8:30 pm one talked to the resident			Any in-house staff member who did n receive in-service training by 01/08/20 will not be allowed to work until trainin completed. This information has been integrated the standard orientation training and required in-service refresher courses all employees and will be reviewed by Quality Assurance Process to verify th the change has been sustained.	016 ng is into in the for y the	
					Quality Assurance The Director of Nursing will monitor the issue using the QA Survey Tool. A medication order list report will be generated weekly that includes current and discontinued medications in the I days. The medications will be review for any changes and the nursing notes be checked to ensure that there is documentation of the notification. An issues will be reported to the Administrator. This will be done week for one month then a sample of 10 residents will be reviewed monthly tim two months or until resolved by Qualit Assurance Committee. Reports will be	nt ast7 ved s will y kly nes ty	

Event ID: 8YY211

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/08/2016 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345563	B. WING		1	C 2/11/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/11/2010
PAVILION	HEALTH CENTER AT BE	RIGHTMORE		10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157 F 309 SS=D	Continued From page 3 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.		F 15	presented to the weekly QA com the Administrator/ whoever to en corrective action initiated as app Compliance will be monitored an ongoing auditing program review weekly QA Meeting. The weekly Meeting is attended by the DON Nurse, MDS Coordinator, Unit M Support Nurse, Therapy, HIM, D Manager and the Administrator.	nsure propriate. nd ved at the y QA l, Wound lanager,	1/8/16
	by: Based on medical re interview and staff int communicate or coord the resident's orthopa discontinuing an antik (#1). The facility faile normal blood pressur to start diuretics when residents (#2). Findin Medical record review summary 11/25/15 fro "Of other concern is t	is not met as evidenced cord review, resident erview the facility failed to dinate the plan of care with bedic physician before biotic for 1 of 1 residents ed to clarify parameters of e for a resident with orders n blood was normal for 1 of 1 gs included: w revealed a discharge om the hospital which stated, hat she has had a left septic She has spiculated (lump of		The statements made on this P Correction are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with all and State Regulations the facility taken or will take the actions set this Plan of Correction. The Pla Correction constitutes the facility allegation of compliance such th alleged deficiencies cited have b will be corrected by the date or o indicated.	to and do in the Federal y has forth in n of y s at all peen or	

Facility ID: 070529

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				101 5			0.0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345563	B WING			(
	ROVIDER OR SUPPLIER	040000			TREET ADDRESS, CITY, STATE, ZIP CODE	12/	11/2015	
	ROVIDER OR SUFFLIER				0011 PROVIDENCE ROAD WEST			
PAVILION	HEALTH CENTER AT B	RIGHTMORE			HARLOTTE, NC 28277			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	Continued From pag	le 4	F 3	na				
		points on the surface)		03	F 309			
		f the spicules of bone eroded						
	through her skin. Sh	•			Corrective Action for Resident Affected			
	with a superficial sut	ure. She is scheduled to see			For resident #1: The resident was			
		for follow up."			discharged on 12/12/2015.			
	_	ns included Keflex 500 mg			For resident #2: The resident was			
	by mouth two times a	a day.			discharged on 11/29/2015.			
	The Minimum Data S	The Minimum Data Set Assessment completed						
	11/29/15 revealed th			Corrective Action for Resident Potential	ly			
	as being alert and or short term memory.	riented with okay long and			Affected			
	Interview with Deside	ant #1 at 6:25 nm an			All residents have the potential to be	-		
	Interview with Reside 12/11/15 revealed th			affected by this practice. On 01/05/2016 the nurse managers reviewed all currer				
		en admitted to the facility to			patients to identify those with active	11		
		. The resident reported that			orthopedic consults. All orders for the l	ast		
		scontinued by the facility			60 day were reviewed for those identifie			
		sking me". The resident			patients. If the patient had a medication			
	•	s ago she could not sleep			discontinued that pertained to the			
		nell. The resident stated that			orthopedic procedure the chart was			
		nd sniffed everywhere and			reviewed to verify that the orthopedic			
	bed. The nurse coul	a bowel movement in the			physician was aware of the change. If they were not notified of the change the			
		stated that when she woke up			orthopedic physician was notified via fa			
		h her face turned to the left			notification. This was completed on	^		
		smell was coming from her			01/05/2016.			
	elbow (the resident's	s elbow had been removed.)						
	The resident stated t	that she was told by the			On 01/05/2016 the nurse managers			
	social worker that the	that she was told by the e Keflex had been			began reviewing all current resident⊡s orders for orders requiring Blood Press	ure		
		facility physician. The			parameters to identify any that required			
	resident stated that s				parameters for administrations that wer			
	orthopaedic physical	n earlier that day. Resident			not clear or were missing. Specific			
		as supposed to have surgery			measurable parameters were obtained			
						be		
					completed by 01/07/2016.			
	to get a new elbow in resident stated that h	as supposed to have surgery n January of 2016. The ner orthopaedic physician v would have to be delayed			measurable parameters were obtained from the physician as needed. This will completed by 01/07/2016.	be		

Facility ID: 070529

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/08/201 M APPROVE D. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345563	B. WING _				(11/2015
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	HEALTH CENTER AT B	RIGHTMORE		10	0011 PROVIDENCE ROAD WEST		
				C	HARLOTTE, NC 28277		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From page	e 5	F 3	309			
		as infected, maybe for as					
		The resident stated, "It's			Systemic Changes		
	•	ppe for the future. I was			, 0		
	hoping to live alone a				On 01/04/2016 the Director of Nursin	g	
					began inservicing the full time, part ti		
	Review of the resider				and prn nurses. Topics included: en	•	
		I revealed that the facility			that orders entered into the electronic	0	
		n 12/5/15. Interview with the n 12/11/15 at 8:30 pm			health record have clearly defined measurable parameters for administr	ation	
		one talked to the resident			when required; ensuring that orthop		
	about stopping the K				are notified when orders related to th		
					orthopedics care are changed or	-	
	Resident #2 was adn	nitted to the facility on			discontinued. Inserviceing was comp	leted	
	11/26/15 at 3:54 with	diagnosis including artificial					
		roxysmal atrial fibrillation,			Any in-house staff member who did r		
		or depressive disorder and			receive in-service training by 01/08/2		
		ical record review revealed a			will not be allowed to work until traini	ng	
	nursing discharge su				has been completed.	inte	
	"Please check blood	home dose 40mg by mouth			This information has been integrated the standard orientation training and		
		actone (25mg by mouth daily)			required in-service refresher courses		
	• ·	can tolerate. Also resume			all employees and will be reviewed b		
		0 meq by mouth twice a day			Quality Assurance Process to verify t	-	
	when started back or				the change has been sustained.		
	Medical record review	w revealed that on 11/26/15			Quality Assurance		
		pressures was recorded as					
	0	nt recorded at 207 lbs. The			The Director of Nursing will monitor		
		sure was recorded as 111/66			issue using the QA Survey Tool. Ord		
	on 11/27/15. The fac	-			listing reports will be generated from electronic health records. Order listing		
	pressures or 110/723	and 104/62 on 11/28/15.			reports will be generated from the	ig	
	Review of nurses not	tes 11/28/15 at 6:34 pm			electronic health records. Orders will	'n	
		ident had a blister on her left			Blood Pressure monitoring will be		
		28/15 11:45 pm state, blister			reviewed for any missing or vague		
	-	eassessed 7 cm. The daily			parameters and orders that required		
		1/28/15 in the section			notification of the orthopedic physicia	ın.	
		/ered diagnosis state: "CHF			Corrective actions will be initaitied if		
	(congestive heart fail	ure)/Cardiac Disease			clarifications are needed. Any issues	will	

Facility ID: 070529

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345563	B. WING _			C 12/11/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
PAVILION	HEALTH CENTER AT BE	RIGHTMORE		10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	
F 309	resident was ordered Aldactone tab 25 mg 11/28/15. The reside Lasix on 11/28/15 at 9 her first dose of Aldac The residents weight pounds and her blood 11/29/15. Per nurses notes 11/2 taken to the hospital B Interview with the Dire at 7:49 pm revealed t	record revealed that the Potassium chloride 20 meq, and Lasix 40 mg on nt received her first dose of 5pm. Resident #2 received ctone on 11/29/15 at 8am. was documented at 234 d pressure as 89/54 on 29/15, Resident #2 was by her family member. ector of Nurses on 12/11/15 hat the charge nurse stated od pressure needed to be	F3	be reported to the Administ be done weekly for one more sample of 10 residents will monthly times two months resolved by Quality Assura Committee. Reports will be the weekly QA committee to Administrator/ whoever to a corrective action initiated a Compliance will be monitor ongoing auditing program to weekly QA Meeting. The v Meeting is attended by the Nurse, MDS Coordinator, U Support Nurse, Therapy, H Manager and the Administr Compliance date: 01/08/20	onth then a be reviewed or until nce e presented by the ensure is appropriate red and reviewed at t veekly QA DON, Wour Jnit Manage IIM, Dietary rator.	to e. he

Facility ID: 070529

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