PRINTED: 09/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345331	B. WING _		08/03/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5151 SARDIS ROAD CHARLOTTE, NC 28270	·
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 278 SS=D	(g) Accuracy of Assess must accurately reflect (h) Coordination A registered nurse must each assessment with participation of health (i) Certification (1) A registered nurse the assessment is coordinated to a coordinate (2) Each individual whassessment must significate (1) Each individual whassessment must significate (1) Under Medicare a who willfully and known (i) Certifies a material resident assessment penalty of not more thassessment; or (ii) Causes another in and false statement in subject to a civil mone \$5,000 for each asses (2) Clinical disagreem material and false statement in REQUIREMENT	sments. The assessment of the resident's status. Sust conduct or coordinate in the appropriate professionals. In must sign and certify that impleted. In completes a portion of the in and certify the accuracy of sessment. Sation ind Medicaid, an individual vingly- The and false statement in a is subject to a civil money in an \$1,000 for each dividual to certify a material in a resident assessment is ey penalty or not more than issment.	F 2	78	8/25/17
	facility failed to accura	iews and record review, the ately code the Minimum		Preparation and/or execution of the of Correction does not constitute	nis Plan

Electronically Signed

08/25/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		` '	(X3) DATE SURVEY COMPLETED			
		345331	B. WING		0	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , ,	
				5151 SARDIS ROAD		
SARDIS O	AKS			CHARLOTTE, NC 28270		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	Continued From page	e 1	F 27	8		
	(Resident #29), pread (Resident #53), and a	active diagnoses (Residents of 19 sampled residents		admission or agreement by the the truth of the facts alleged or conclusions set forth in this stat deficiencies. The Plan of Correprepared and/or executed solel it is required by the provisions and State law.	tement of ction is ly because	
	02/18/11 and to hosp Review of Resident # certification/recertificathe physician upon ac 08/01/16 and quarter	Resident #29 was admitted to the facility on /18/11 and to hospice care on 08/01/16. eview of Resident #29's hospice rtification/recertification statement signed by e physician upon admittance to hospice on /01/16 and quarterly thereafter revealed the		F 278 On 8/3/17, the surveyor interview MDS Coordinator and determing Resident #29 s MDS indicated resident received hospice care, the MDS did not indicate that the	ned d that the . However, ne resident	
	that the beneficiary is expectancy of six (6) terminal illness runs in Review of Resident # Minimum Data Set (Note that the MDS increceived hospice care	circumstances and I certify terminally ill with a life months or less if the ts normal course." 29's significant change MDS) dated 08/08/16 dicated Resident #29 e. The MDS indicated have a prognosis of life		had a prognosis of life expectar than 6 months. In addition, it was determined Resident #53 PASF coded on the MDS. Also, it was determined each of the active of for Resident #260 and Resident was not coded on the MDS. Fo #260, PAD/PVD was not coded Resident #323, Anxiety was no MDS Modifications were submit Resident #29, Resident #53, Ref #260, and Resident #323.	as RR was not s diagnosis at #323, or Resident d and for ot coded.	
	11/08/16 revealed the #29 received hospice Resident #29 did not expectancy of less th Review of Resident # 02/08/17 revealed the #29 received hospice	29's quarterly MDS dated e MDS indicated Resident care. The MDS indicated have a prognosis of life		MDS Coordinators will be provi education on RAI coding requir Director of Nursing or designee conduct weekly 10% audits of N assessment to ensure compliar coding active diagnosis. Any id- issues will be corrected at that addition, the Director of Nursing designee will conduct weekly 10 of Hospice and PASRR coding compliance. Any identified issue	rements. e will MDS nce with lentified time. In g or 00% audits to ensure	

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		345331	B. WING			08	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER	,	,	51	TREET ADDRESS, CITY, STATE, ZIP CODE 151 SARDIS ROAD HARLOTTE, NC 28270		
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F 278	05/08/17 revealed the #29 received hospice Resident #29 did not expectancy of less the Interview with the ME at 10:14 AM revealed prognosis of life experiments. The MDS Complysician did not signification during the MDS did not indicate Interview with the Direct at 1:28 PM revealed and reflect Resident 2. Resident # 53 was 07/06/2017. Review of the medical documented diagnostic bipolar disorder, and Review (PASRR) lev Notification for nursing residents documented as appropriate for Review of the annual PASRR was note cook Review of the MDS for 07/12/2017 revealed An interview on 08/03/12/2017 rev	#29's quarterly MDS dated e MDS indicated Resident e care. The MDS indicated have a prognosis of life an 6 months. DS Coordinator on 08/03/17 If Resident #29 had a ectancy of less than 6 oordinator explained the in Resident #29's hospice the look back period so the the correct prognosis. Hector of Nursing on 08/03/17 the MDS should be accurate the #29's prognosis of life. The readmitted to the facility on All record dated 08/02/2017 The is that included Asperger's, chronic anxiety. In ission Screening Resident the II Determination the II Determination the phome applicants and display in the placement the sident #53. MDS dated 03/08/2017	F	278	corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertificate survey results in no repeat citations. The Director of Nursing will be responsible for implementing the acceptable plan of correction.	t	

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F 278	PASRR was omitted been coded. An interview on 08/0 DON indicated she	ge 3 12/2017 coding for the d. She stated it should have 03/2017 at 3:37 PM with the expected accuracy of the RR II would be coded.	F 21	78			
	Diagnoses included (PVD), peripheral ar venous hypertensio right and left lower earth bilateral lower earth bilateral lower earth bilateral lower extremities, at to both legs and 2 sprogress note and put ocleanse the wour Santyl ointment (de emulsion gauze to twith an ABD pad, seevery 8 hours/twice Review of Resident Data Set (MDS) as revealed that in seconds	as admitted to the facility on a peripheral vascular disease reterial disease (PAD), chronic in (idiopathic) with ulcers of extremities, thrombocytosis, extremity edema, among ew revealed a physician's def/19/17 which documented admitted to the facility with ous stasis ulcers to bilateral indicasessed with 1+ edema itasis ulcers to both legs. The ohysician's order documented indicases, pat dry, apply 30 grams bridement) and an oil he wound bed daily, cover ecure with gauze and change daily and as needed. #260's admission Minimum is sessment, dated 6/23/17, tion 10100, the diagnoses of ot coded as active diagnoses.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII				(X3) DATE SURVEY COMPLETED	
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F 278	Continued From pag Review of the June 2		F 2	278				
	Administration Recor	d for Resident #260 t received routine treatment						
	MDS Coordinator staphysician's/nurse prowhen coding active of assessment/plan second list a diagnoses with diag	ction of the progress note did with current treatment, she inoses as active. The MDS tated that the 6/19/17 note for Resident #260 did nt of the stasis ulcers, but did						
	director of nursing (Dexpected the MDS to The DON further state treatment Resident # ulcers, the diagnoses been recorded as an MDS or the MDS Coclarified the active diagnoses and hypertension. The Set (MDS) dated 7/2 323 received 7 days	pON) revealed that she be completed accurately. The death and the current the deceived for the stasis of PAD/PVD should have active diagnoses on the cordinator should have agnoses with the physician. The sadmitted to the facility on the est that included dementia the admission Minimum Data 10/17 indicated Resident # of an antianxiety medication. The deceived residuals are actived to the facility of the admission of the side of the facility of the admission of the side of the facility of the active of the side of the facility of the faci						
		led a medication I dated July 2017, indicated						

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(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 DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 278	Continued From page	e 5	F 2	278		
	Resident # 323 receit 7/14/17 to 7/20/17.	ved Xanax 0.5 mg daily from				
	care document dated as an active diagnosi review also revealed	ed a hospital summary of 7/14/17, indicated anxiety s for Resident # 323. Record a hospital summary of care /17, revealed anxiety as an tesident # 323.				
	the MDS nurse stated was supposed to be staff, therapy, hospital from the resident's chindicated the admissi Resident # 323 was antianxiety medicatio stated the MDS was anxiety. The MDS nudiagnoses on the doc dated 7/14/17 and 7/	on MDS dated 7/20/17 for coded as received 7 days of m. The MDS nurse also not coded for diagnosis of rese further indicated the cuments from the hospital 16/17 would not be included the diagnoses were not				
F 309	(DON) indicated she chart and the diagnost the discharge papers should have been co stated her expectatio coded correctly for the diagnoses.	I, the Director of Nursing reviewed Resident's # 323 sis of anxiety was listed on from the hospital and ded on the MDS. The DON his were for the MDS to be resident to show the active PROVIDE CARE/SERVICES	F3	309		8/30/17
SS=D	FOR HIGHEST WEL 483.24 Quality of life					0.30/17

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PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
residents. Each res facility must provide services to attain or practicable physical well-being, consiste comprehensive asset 483.25 Quality of care is a fapplies to all treatmet facility residents. Bat assessment of a residents received accordance with propractice, the comprehensive in a comprehe	ident must receive and the the necessary care and maintain the highest, mental, and psychosocial nt with the resident's essment and plan of care. Ire fundamental principle that ent and care provided to used on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered esidents' choices, including e following: Int. Issure that pain management is so who require such services, essional standards of practice, person-centered care plan, oals and preferences. Illity must ensure that re dialysis receive such with professional standards prehensive person-centered	F 309	F 309 Surveyor□s review of Resident #260 Resident #323 nurse□s notes, bowel bladder reports, and staff interviews	

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CARRIO	A 1/ 0			5151 SARDIS ROAD		
SARDIS O	ANS			CHARLOTTE, NC 28270		
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F 309	Continued From pag	e 7	F 30	9		
	(Residents #260 and	#323).		determined that the bowel prote	ocol was	
		s admitted to the facility on		not implemented after consecute each resident did not have door of bowel movements. Resident assessed on 8/3/17 for bowel resident.	tive days umentation t #260 was	
		cognitive impairment, chronic		and did not require prn medica		
	pain, peripheral vasc			bowel movement. Resident #3		
	, , ,	leg pain, peripheral artery		assessed on 8/1/17 for bowel r		
		ilure to thrive, among others.		and standing order was implen 8/1/17.	nented on	
		w for Resident #260 revealed				
		ss note dated 6/19/17 which		Nurses will be inserviced on im		
	this Resident.	ation has been an issue" for		the □Physician Standing Order Program for Constipation□ for residents. CNAs will be inservice	triggered	
		#260's admission Minimum essment, dated 6/23/17,		importance of accurate docume CareTracker of bowel moveme		
	understood, had imp	nt #260 was rarely/never aired cognition, and was bowel with no constipation.		ensure triggered residents rece accordance with the bowel pro		
	aiways incontinent of	bower with no constipation.		Unit Supervisors will run a daily	,	
	Review of the facility	's "Physician Standing		CareTracker report to identify r		
	-	am for Constipation", dated		that did not have documentation		
		d instructions to "Implement		movement within 72 hours. The		
	one of the following r	nedications if resident		Supervisor will alert the assign	ed nurse to	
	complains of constipa	ation or no bowel movement		implement the bowel program.	Director of	
	(BM) in 72 hours:			Nursing or designee will monitor		
	· Check for in			report weekly, to identify reside		
		one by mouth twice a day for		not have documentation of a bo		
	48 hours			movement within 72 to ensure	•	
		grams by mouth mixed with		with the bowel program implem		
		eded (hold for loose bowels)		Any identified issues will be co		
	other day as needed	ppository one rectally every		that time. Results of the monitor shared with the Administrator a	-	
	oniei day as needed	IOI TO HOUIS		of Nursing on a weekly basis a		
	Review of nurse's no	tes and a July 2017 bowel		QAPI monthly. QAPI committee		
		r Resident #260 revealed no		consider discontinuing monitor		
	_ ·	BM or check for impaction		subsequent surveys through th	•	
		n from 7/8/17 through		recertification survey results in		

Facility ID: 923444

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 309	7/26/17 (7 consecut 2017 Medication Ad Resident #260 also medication for constiper the facility's Phy Program for Constiper Continued review of Resident #260 routing medications that inceffect: Norco 7.5-3 every 12 hours Transderm micrograms, apply of An interview with nuat 10:45 AM revealed to Resident #260 and incontinent of bowel not recall if Resident movement on dates was not documented. An interview with NA revealed she worked regularly, the reside but she could not readditional bowel modocumented. During an interview 2:33 PM, the nurse streminding one of the movement for Residence all the date. Nurse recall the date.	ve days) and 7/20/17 through ve days). Review of the July ministration Record (MAR) for revealed no administration of ipation for the same dates sician Standing Orders/Bowel ation. the July 2017 MAR revealed nely received the following lude constipation as a side 325 miligrams 1 tablet orally all Fentanyl Patch, 12 ne patch every 72 hours rse aide (NA) #4 on 8/03/17 d she routinely provided care d that the resident was . NA #4 stated that she could it #260 had a bowel that she provided care if it	F 309	citations. The Director of Nursing will be responsible for implementing the acceptable plan of correction	

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F 309	that the nurse could in protocol. Nurse #1 all did not void after the she would notify the she would notify the she would notify the she would notify the should in the she would in the she would in the should implement star management protocol not successful notify reviewed the MAR, in records for Resident and confirmed that the should insplement star management protocol. On 8/3/17 at 3:04 PM administrator indicate management protocol nurses. An interview on 8/03/revealed she recalled times, "I went a little" stay to observe whet a BM and that she could be she would be she could be she will be she could be she whet a BM and that she could be she will be sh	movement in 72 hours, so mplement the bowel so stated that if the resident protocol was implemented,	F 30	09			
	and hypertension. The Set (MDS) dated 7/20 323 was rarely or new extensive assistance	ne admission Minimum Data 0/17 indicated Resident # over understood and required with activities of daily living. ted Resident # 323 was					

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F 309	constipation that rea the following medica of constipation or no hours. 1. Check for imp 2. Senekot-S or hours or 3. Miralax 17 grafluid everyday as needed at the following notes and a indicated no BM from record review for Renursing notes and a indicated no BM from record review did no checked for an impa Record review further Administration Record traveled no med Resident # 323 for notes aides were surin the computer and Nurse # 3 stated a Bif the resident did no protocol should be for stated she did not reproblems with consti	led a standing order for d in part: Implement one of tions if Resident complains bowel movement (BM) in 72 paction are by mouth twice a day for 48 pams by mouth mixed with eded or pository one rectally every at 48 hours. Pesident # 323 revealed bowel and bladder report that an 7/16/17 to 7/23/17. The at indicate Resident # 323 was action from 7/16/17 to 7/23/17. For revealed a Medication and (MAR) dated July 2017 dication was given to be BM in 72 hours. M Nurse # 3 indicated the poposed to document the BMs notify the nurse of no BM. M report was ran nightly and thave a BM then the bowel bellowed. Nurse # 3 further call Resident # 323 having pation or being on the list for rese # 3 indicated she had not	F3	09		
	Aide # 3 stated, the	If an interview with Nurse nurse aides documented a BM in the computer and				

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F 309	shift if the resident did nurse would give the Aide # 3 then stated she before of Resident # 3 Aide # 3 indicated she of the resident not ha recall the other dates On 8/3/17 at 2:56 PM (DON) indicated the residents' BM in the composed to notify the BM. The DON then stranged to administ The DON went on to have a BM every three protocol was supposed stated Resident # 323 7/24/17, 7/26/17, and confirmed that Reside from 7/16/17 to 7/23/12 was no documentation Resident # 323 to have no BM. The DON furth were for the nurse aid no BM in 3 days and the bowel protocol.	o notify the nurse on that a not have a BM and the resident medication. Nurse she had notified the nurse 323 not having a BM. Nurse e notified the nurse last night ving a BM but she could not the Director of Nursing nurse aides documented the are tracker and were en nurse on that shift if no tated the nurse was er medication if needed. Say if the residents did not e days then the bowel ed to be followed. The DON B had a BM on 7/15/17, 7/30/17. The DON stated there in on the July 2017 MAR for the received medication for ther stated her expectations de to notify the nurse when for the nurse to implement	F	309			
F 315 SS=D	protocol to be followe 483.25(e)(1)-(3) NO (d he expected for the BM d by the nurses. CATHETER, PREVENT UTI,	F;	315			8/30/17
		nsure that resident who is and bowel on admission					

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F 315	continence unless or becomes such the to maintain. (2) For a resident woon the resident's continence to the end of the resident's clinical continence to the end of the resident's clinical continence to the end of the resident's clinical continence to the end of the resident's continent of the resident's continent of the end of the resident's continent of the resident of the r	and assistance to maintain his or her clinical condition is nat continence is not possible with urinary incontinence, based omprehensive assessment, the exthat- enters the facility without an is not catheterized unless the ondition demonstrates that a necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary is incontinent of bladder the treatment and services to cot infections and to restore extent possible. with fecal incontinence, based omprehensive assessment, the exthat a resident who is el receives appropriate ices to restore as much normal	F 31	F 315 Surveyor□s review of Resident #211 physician□s orders, Medication	1□s
	for urinary catheter			Administration Record and staff inter	rviews

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		345331	B. WING		08	/03/2017
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP C 5151 SARDIS ROAD CHARLOTTE, NC 28270		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 315	Findings included: Resident # 211 was facility on 4/14/16 with neurogenic bladder chronic kidney dise. Review of the signiful Set (MDS) dated 4/211 was cognitively assistance with activation had an indwelling of day look back periodindicated Resident catheter since admitrials, and had routing the routing trial and repart of the routing trial and	s originally admitted to the with diagnoses that included with Foley catheter, and ase. ficant change Minimum Data (20/17 indicated Resident # vintact, required limited ivities of daily living (ADL), and atheter in place during the 7 vid. The care area assessment # 211 had an indwelling ission, had 2 failed voiding ne urology appointments. Field a doctor order for red 5/3/17 that read in part: read the properties of the eat again one month later. Field 17 indicated Resident # 211 atheter due to hypertonia and compliance. The care plan rear plan interventions catheter care every shift, and gist as needed.	F 3	determined that the physici remove the resident scatt voiding trial and to change June, was not followed. On resident was assessed and not to have adverse effects trial not being initiated and not being changed in June. Nursing staff will be educat implementing physician ord catheter care. Unit Supervix will conduct weekly 10% auresidents with catheters to compliance. Any identified corrected at that time. Resimonitoring will be shared with Administrator and Director weekly basis and with QAP period of 90 days at which of monitoring will be determed QAPI Committee. The Director of Nursing will responsible for implementing acceptable plan of corrections.	neter for a the catheter in 8/2/17 I determined from voiding the catheter ed on ders for sor or designee udits of ensure issues will be ults of the vith the of Nursing on a I monthly for a time frequency nined by the	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345331	B. WING		08/03/2017
NAME OF PR	ROVIDER OR SUPPLIER			, 00.00.2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 315	Foley catheter every Record review did not change for Resident Record review did not Resident # 211 in Ju Record review reveat 211 revealed the induremoved on 7/28/17 Foley catheter was compared to be charn Nurse # 2 stated Resident wording trial and reinserted. Nurse # 2 change the catheter in the facility catheter changed on another On 8/2/17 at 12:08 P	month. In reveal a Foley catheter # 211 in June 2017. In reveal a voiding trial for the 2017. It reveal a Foley catheter the 2017. It reveal a voiding trial for the 2017. It reveal a Foley catheter the 2017. It reveal a voiding trial for the 2017. It revea	F 3:	· ·	
	6/15/17. The DON al Resident # 211 was failed voiding trial. The was no documentation Resident # 211 was voiding trial was come say that the catheter changed on 7/28/17. The DON also stated catheter was suppose 6/30/17. The DON for	every month written on so stated the catheter for changed on 5/31/17 after a ne DON then indicated there on that the catheter for changed in June 2017 or a pleted. The DON went on to for Resident # 211 was after a failed voiding trial. I that Resident # 211 ed to been changed around rther stated her expectations staff to follow the doctor's			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY PLETED	
		345331	B. WING _			08/	03/2017
NAME OF P	ROVIDER OR SUPPLIER		•	51	TREET ADDRESS, CITY, STATE, ZIP CODE 151 SARDIS ROAD HARLOTTE, NC 28270		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	Continued From page	e 15	F:	315			
F 323 SS=D	was supposed to hava after the 5/31/17 date stated the facility was monthly catheter charbecause that was the The MD further stated effects from the cather Resident # 211. On 8/2/17 at 2:53 PM Administrator reveale the doctor orders to b 483.25(d)(1)(2)(n)(1)-HAZARDS/SUPERVIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	e a voiding trial a month as ordered. The MD also supposed to complete nges for Resident # 211 current recommendation. If there was no adverse eter not being changed for an interview with the d his expectations were for e followed as written. (3) FREE OF ACCIDENT SION/DEVICES are that - conment remains as free as as is possible; and elives adequate supervision es to prevent accidents. accility must attempt to use es prior to installing a side or ide rail is used, the facility installation, use, and ails, including but not limited	F	323			8/30/17

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		345331	B. WING		08/03/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5151 SARDIS ROAD CHARLOTTE, NC 28270		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 323	from bed rails prior (2) Review the risks the resident or resident the appropriate for the facility failed to temperatures below for 1 of 4 sampled for 1 of 4 sampled for 1 of 4 sampled for 1 of 4 review of the water 5-7, 2017 revealed room randomly selewith the range of 10 (F.) A review of the incidence appropriate for the facility f	dent for risk of entrapment to installation. s and benefits of bed rails with dent representative and obtain rior to installation. bed's dimensions are resident's size and weight. NT is not met as evidenced dions, staff and resident at # 219), and record review maintain hot water (120 degrees Fahrenheit (F) hallways. (Hall 300). er temperature logs for July hot water temperatures at ected from each hallway were 03-116 degrees Fahrenheit. dent report log for May-July noidents related to water in	F 323	,	in d valve se. and es nce. eam hed ne e
	residents' rooms re	water temperatures in vealed hot water temperatures touch by running water on		compliance. The outside maintenance team clear schedule to check the mixing valve a flush any debris will be increased fro quarterly to monthly. The Hot Water	ning and

Facility ID: 923444

AND DLAN OF CORRECTION IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345331	B. WING		08/03/2017
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 323	08/01/2017 at 08:5 08/01/2017 at 09:39 08/01/2017 at 11:29 An interview on 08/ Resident # 219 (whrevealed he used the stated the water	7 AM room 306 9 AM room 311 8 AM room 312 701/2017 at 11:28 AM with rooresided on the 300 Hall) re sink in his room and he roo	F 323		ater hitored and/or hies will the hig on a hy for a hierory hierory hierory hierory hierory hierory hierory hierory
	Room 312 hot water Room 311 hot water Room 306 hot water While the water ten the administrator re temperature observadditional resident temperature had be 300, 302, 308, 310 An interview on 08/ #1 revealed he rand	01/2017 at 5:07 PM with MS domly tests water			
	Resident # 219 (wh revealed he used the stated the water wat	no resided on the 300 Hall) the sink in his room and he as too hot. (Resident #219's (MDS) dated 05/10/2017 tole to participate in daily It water temperatures on PM on the 300 hallway taken aff (MS) #1 with the ent revealed: For temperature 124 degrees F. For temperature 123 degrees F. For temperature 124 degrees F. For temperature 125 degrees F. For temperature 126 degrees F. For temperature 127 degrees F. For temperature 128 degrees F. For temperature 129 degrees F.		be corrected at that time. Results of monitoring will be shared with the Administrator and Director of Nursir weekly basis and with QAPI monthly period of 90 days at which time freq of monitoring will be determined by QAPI Committee. The onsite Maintenance Mechanic weesponsible for implementing the	the g c y fo uer the

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345331	B. WING _		0	8/03/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5151 SARDIS ROAD CHARLOTTE, NC 28270	·	
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F 371 SS=E	did calibrate it. An interview on 08/02 Safety Officer (SO) for has had no concerns regular rounding or at meetings for the past randomly tested the ware safety committee month and no hot was been brought to the constant of the constant	last four years. He stated he 1/2017 at 09:16 AM with the r the facility revealed she about hot water on her the bimonthly safety year. She stated she vater temperatures. There e meetings every other ter temperature issues had committee. 1/2017 at 12:06 PM with the d he expected the hot water sidents' room to be between 10 PROCURE, ERVE - SANITARY 10 rom sources approved or rry by federal, state or local 10 rod items obtained directly subject to applicable State ulations. 11 snot prohibit or prevent roduce grown in facility compliance with applicable		371		8/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345331	B. WING		08/03/2017
NAME OF PE	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 151 SARDIS ROAD CHARLOTTE, NC 28270	00/00/2011
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 371	foods brought to reside visitors to ensure safe handling, and consumant this REQUIREMENT by: Based on observation record review, the fact with the correct sanitificality failed to store freezer with labels incopened and date to use (Pancakes, chicken, I dish of diced pears and the refrigerator. Findings included: 1. A review of the fact and procedures regard machine procedures regard machine procedure do the chlorine concentrate per million (ppm). A review of the sanitize 28-31, 2017 revealed ppm. On 07/31/2017 at 09: stated she had tested morning and it registed a pon the bottle of strips	egarding use and storage of dents by family and other e and sanitary storage, aption. is not met as evidenced ins, staff interviews and cility failed to sanitize dishes zer concentration. The opened frozen foods in the	F 371	F 371 On 7/31/17, the surveyor observed DA checking the concentration of chlorine solution following the sanitizing cycle. test strip did not register 50 parts per million (PPM). The facility replaced the sanitizer bucket and primed the sanitize pump. Afterwards, the Food Service Director tested the sanitizer at the dish machine and the sanitizer test strip wa registering between 50 ppm □ 100 ppr for the sanitizing cycle. All the breakfas dishes were then run through the dish machine again, to be sanitized. On 8/2/17, the surveyor observed the following items in the freezer that were opened with no label including name of the item, date opened and use by date omelets; 6 pancakes; peas; 10 chicker breasts. Kitchen staff were able to ider with certainty that the omelets, pancak peas, and chicken breasts were opened on 8/1/17. Each of these items were the properly labeled with the name of the item, date opened and use by date. In addition, the surveyor observed the	The Per Son t t t to
	they run the dishes the then let them rest. The	ay and recorded it on the log.		following items in the refrigerator that were opened with no label including na of the item, date prepared and use by	me

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		345331	B. WING		08	3/03/2017
NAME OF P	ROVIDER OR SUPPLIER	•	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
0.4.00.10.0				5151 SARDIS ROAD		
SARDIS O	AKS			CHARLOTTE, NC 28270		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	Continued From page	e 20	F 3	71		
	It was tested before to breakfast dishes toda 75ppm. At 09:59 AM checking the concent solution following the	they had started washing the ay and was recorded at DA #1 was observed tration of the chlorine sanitizing cycle. The test		date: dish of fruit and a glass of beverage. Each of these items discarded. All dishwashing staff will be ed	were	
		50 parts per million (ppm).		test the sanitizer before sanitizer	•	
		ted two more times and each not indicate 50 ppm. The		for each meal and again after of dish sanitizing. In addition, I		
	•	on was tested in the dish		install an alarm that will sound		
		nitizing cycle was finished.		chemical is low, alerting staff to		
				out the 5-gallon premixed buck		
		:01 AM, DA #2 pressed the		sanitizer. The dish machine da	-	
		al flow machine on top of the the dish machine again. The		checklist will be completed befafter each meal and will be mo		
		on was tested in the rinse		compliance by the Administrate		
		chine after the sanitizing		designee weekly. Any identifie		
	cycle. It appeared to	•		be corrected at that time. Resu		
		AM, DA #3 tested the		monitoring will be shared with	the	
		on with a new bottle of		Administrator and Director of N		
	chlorine tests strips.	It did not register 50 ppm. It		weekly basis and with QAPI m	onthly.	
	appeared to register	10 ppm.		QAPI committee will only cons		
				discontinuing monitoring if sub	•	
		:11 AM the chemical drum		surveys through the annual red		
	was replaced with a machine sanitizing cy			survey results in no repeat cita	itions.	
	machine samuzing cy	ycie.		Dietary staff will be inserviced	on food	
	An observation on 07	7/31/2017 at 10:27 AM the		sanitation policy which will incl		
		cian from the vendor checked		requirements. The daily labeling	•	
	the machine. He sta	ted the sanitizing cycle		dating checklist, which defines		
	should register 50 pp	om on the tests strips for this		of food items, times, initials, ar	nd	
	machine. He stated	the probe was not inserted		corrective action, will be utilize	d twice per	
	correctly. He stated t	he facility has replaced the		day by the General Manager a	ınd/or	
		primed the sanitizer pump.		designee. The Administrator a		
		achine was sanitizing upon		designee, will monitor for comp		
	his arrival at the facili	ity.		weekly. Any identified issues v		
				corrected at that time. Results		
		:29 AM the Food Service		monitoring will be shared with		
	Director tested the sa and the sanitizer test	anitizer at the dish machine strip was registering		Administrator and Director of N weekly basis and with QAPI m	•	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345331	B. WING		08/0	03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5151 SARDIS ROAD CHARLOTTE, NC 28270		
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F 371	cycle. The FSD tested strip into the rinse was the sanitizing cycle. Of the FSD stated all brest through the dish mach all of them could not be lunchtime, they would lunch. Interview with the FSI AM revealed his expessanitizing cycle would the chlorine chemical sanitizing part of the color	o ppm for the sanitizing of the sanitizer by dipping the ter in the dish machine after on 07/31/2017 at 10:30 AM sakfast dishes would be run nine again to be sanitized. If the washed again by use paper products at a continuous that the have the correct amount of at 50 ppm of the during the dish washing cycle. In 08/03/2017 at 12:06 PM he stated he expected the the dish machine was in the quired to sanitize the dishes in gwas going on to assure terms were sanitized when in the dish machine. B/02/2017 at 04:17 PM the food storage: In one of the during the dishes in the dish machine. B/02/2017 at 04:17 PM the food storage:	F 37	QAPI committee will only consider discontinuing monitoring if subsequer surveys through the annual recertifica survey results in no repeat citations. The General Manager will be respons for implementing the acceptable plan correction.	ation	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		(X3) DATE COMP	SURVEY LETED	
		345331	B. WING _			08/	03/2017
NAME OF PE	ROVIDER OR SUPPLIER			51	REET ADDRESS, CITY, STATE, ZIP CODE 51 SARDIS ROAD HARLOTTE, NC 28270		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371 F 490 SS=E	Administrator reveale items are labeled with opened and the date. An interview on 08/03 FSD revealed he exp the refrigerators and and have a use by dastaff were responsible storage areas including dry storage. 483.70 EFFECTIVE ADMINISTRATION/R 483.70 Administration A facility must be admenables it to use its refficiently to attain or practicable physical, well-being of each restricted in the properties of acility record review, failed to monitor implementation by: Based on observation facility record review, failed to monitor implementation by the facility's Assurance committee and sustain an effective and sust	d by date. 2/2017 at 12:06 PM with the dhe expected that all food a what it is, the date it was to use it by. 2/2017 at 3:30 PM with the ected all foods that are in freezer to be labeled, dated the on them. He stated all the for labeling items in the engineezer, refrigerators and the freezer, refrigerators and the esources effectively and maintain the highest mental, and psychosocial sident. 2 is not met as evidenced the facility's administration emented procedures put into Quality Assessment and to maintain compliance we system to manage vices (Residents #29, #53, in the state of the system to manage vices (Residents #29, #53, in the system to manage vices	F 2	1 90	F 490 The facility will be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Corrective Action Plan and plan for the facility's administration to monitor implemented procedures put into place the facility's Quality Assessment and		8/30/17

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				5151 SARDIS ROAD	
SARDIS O	AKS			CHARLOTTE, NC 28270	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 490	Continued From page	e 23	F 490		
	Based on staff intervi	ews and record review, the		Assurance Committee to maintain	
	facility failed to accura	ately code the Minimum		compliance and sustain an effective	
	Data Set (MDS) relate	ed to prognosis of life		system to manage resident care and	
	(Resident #29), pread	dmission screening		services, to be reviewed with the Qual	ity
	(Resident #53), and a	active diagnoses (Resident		Assurance and Performance	
	#260 and Resident #3 residents who require	323) for 4 of 19 sampled		Improvement (QAPI) Committee.	
	·			Corrective Action: F520	
	1b. Cross reference -	F309			
				The facility will maintain a Quality	
		ews and medical record		Assessment and Assurance committee	
	-	ed to implement a bowel		with members including the Director of	
	program for constipat	ion to 2 of 4 sampled		Nursing Services, the Medical Director	
	residents reviewed w	ho had no indication of a		his/her designee, and at least three ot	her
	bowel movement for	greater than 72 hours		members of the facility's staff.	
	(Residents #260 and	#323).			
				Corrective Action Plan and plan for	
	1c. Cross reference -	F371		monitoring to sustain an effective Qua	
				Assessment and Assurance Program,	
		ns, staff interviews and		be reviewed with the Quality Assurance	
		cility failed to sanitize the		and Performance Improvement (QAPI)
		ct sanitizer concentration.		Committee.	
		tore opened frozen foods in			
	the freezer with labels	s including the name, date		We feel what led to this deficiency was	s a
	opened and date to u	se by on the items.		monitoring period through the QAPI	
	(Pancakes, chicken, p	peas omelets), and a small		committee that was too brief. Our 90 d	ay
	dish of diced pears ar	nd a thickened beverage in		monitoring resulted in 100% compliand	ce
	the refrigerator.			in these areas, as tracked by our QAP	1
				committee. However, had we lengther	ied
	1d. Cross reference -	F520		the monitoring period for these deficie	nt
				areas from 90 days to 6 months or 1 y	ear,
	Based on observation	ns, staff interviews and		perhaps we would not have had repea	t
	review of medical and	facility records, the facility's		issues.	
	Quality Assessment a				
	committee failed to m	aintain implemented		As a result, our Plan of Correction for	our
		tor these interventions that		repeat citations F278, F309, F371 and	
		o place in July 2016. This		F520 is to continue monitoring through	
	-	ciency that was originally		QAPI the audit processes and operation	
		a Recertification/Complaint		compliance until our next annual	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOWN (EACH CORRECTIVE		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 490	survey and subseque current Recertification were in the areas of maintain well-being, a continued failure of the surveys of record showinability to sustain an Program. An interview on 8/3/1 administrator reveale facility's QAA commit quarterly to assess the administrator stated to meetings, participants reports/data to identificate a plan for constated that resident a accuracy remained a days until the facility and then it was removed the attributed continued department to staff tu continued monitoring that perhaps the areas	Intly recited on the facility's in survey. The deficiencies esident assessments, and dietary services. The lee facility during 2 federal low a pattern of the facility's effective Quality Assurance. 7 at 4:37 PM with the dietath the managed the tee which met at least lee needs of the facility. The hat during the quarterly QAA is reviewed trending/tracking ly resident concerns that recition and monitoring. He is sessments related to MDS QAA agenda item for 90 archieved 100% accuracy led from the QAA's agenda. Led concerns in the dietary recover and the need for a the administrator stated is of resident assessment, rices and QAA should have	F 4	recertification survey (roug from now). Provided this ar recertification survey result citations for F278, F309, F3 we would then discontinue through our QAPI Committ Corrective Action: F278 On 8/3/17, the surveyor int MDS Coordinator and dete Resident #29 s MDS indic resident received hospice of the MDS did not indicate the had a prognosis of life expethan 6 months. In addition, determined Resident #53 F coded on the MDS. Also, it determined each of the act for Resident #260 and Reswas not coded on the MDS #260, PAD/PVD was not conceed the mass of the most resident #323, Anxiety was MDS Modifications were sure Resident #29, Resident #5 #260, and Resident #323. MDS Coordinators will be peducation on RAI coding redirector of Nursing or designed conduct weekly 10% audits assessment to ensure commoding active diagnosis. Ar issues will be corrected at addition, the Director of Nudesignee will conduct weekly 10% audits and PASRR concompliance. Any identified	ts in no repeat 371 and F520, monitoring tee. derviewed the emined cated that the care. However, nat the resident ectancy of less it was PASRR was not to was tive diagnosis sident #323, S. For Resident oded and for its not coded. Aubmitted for its not coded. Aubmitted for its not coded equirements. It is of MDS in pliance with my identified that time. In ursing or kly 100% audits ding to ensure	

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5151 SARDIS ROAD CHARLOTTE, NC 28270)E	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRI			(X5) COMPLETION DATE
F 490	Continued From page	e 25	F 4	corrected at that time. Results monitoring will be shared with Administrator and Director of weekly basis and with QAPI of QAPI committee will only condiscontinuing monitoring if suit surveys through the annual resurvey results in no repeat cit. The Director of Nursing will be responsible for implementing acceptable plan of correction. 8/30/17 Corrective Action: F309 Surveyor serview of Reside Resident #323 nurse snotes bladder reports, and staff inte determined that the bowel pronot implemented after consect each resident did not have do of bowel movements. Resident assessed on 8/3/17 for bowel and did not require prn medic bowel movement. Resident # assessed on 8/1/17 for bowel and standing order was imple 8/1/17. Nurses will be inserviced on in the physician Standing Order program for Constipation for residents. CNAs will be inserviced importance of accurate docur Care Tracker of bowel movements registered residents recorded to the physician registered residents recorded to the physician control of the physician control of the physician control of the physician standing order was implested to the physician standing order to t	en the Nursing on a monthly. Isider Ibsequent Eccrtification tations. e the Int #260 and so the solution of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	_	(X3) DATE SURVEY COMPLETED	
		345331	B. WING _			08/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 5151 SARDIS ROAD CHARLOTTE, NC 282		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	
F 490	Continued From pag	e 26	F	Unit Supervisors of CareTracker report that did not have movement within Supervisor will also implement the boo Nursing or design report weekly, to not have docume movement within with the bowel pro Any identified issust that time. Results shared with the A of Nursing on a w QAPI monthly. Queonsider disconting subsequent surver recertification surveitations. The Director of Nuresponsible for imacceptable plan of 8/30/17 Corrective Actions of Nuresponsible for imacceptable plan of solution following test strip did not million (PPM). The sanitizer bucket a pump. Afterwards Director tested the	ort to identify residents documentation of bow 72 hours. The Unit ert the assigned nurse wel program. Director nee will monitor the identify residents that entation of a bowel 72 to ensure complian ogram implementation uses will be corrected as of the monitoring will dministrator and Direct yeekly basis and with API committee will onling monitoring if eys through the annual vey results in no repeatursing will be inplementing the of correction.	#1, The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED			
		345331	B. WING		08/0	3/2017		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 5151 SARDIS ROAD CHARLOTTE, NC 28270				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI)		PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	Continued From pag	e 27	F 49	registering between 50 ppm □ 10 for the sanitizing cycle. All the brodishes were then run through the machine again, to be sanitized. On 8/2/17, the surveyor observed following items in the freezer that opened with no label including nathe item, date opened and use by omelets; 6 pancakes; peas; 10 cb breasts. Kitchen staff were able twith certainty that the omelets, papeas, and chicken breasts were on 8/1/17. Each of these items who properly labeled with the name of item, date opened and use by date addition, the surveyor observed the following items in the refrigerator were opened with no label including the item, date prepared and use date: dish of fruit and a glass of the beverage. Each of these items who discarded. All dishwashing staff will be educted the sanitizer before sanitizing for each meal and again after confiding the sanitizer. In addition, Ecc install an alarm that will sound who chemical is low, alerting staff to cout the 5-gallon premixed bucket sanitizer. The dish machine daily checklist will be completed before after each meal and will be moniticed to compliance by the Administrator and designee weekly. Any identified is be corrected at that time. Results monitoring will be shared with the Administrator and Director of Nur	eakfast e dish d the t were ame of y date: 6 hicken to identify ancakes, opened were then of the the that ling name se by chickened were cated to g dishes mpletion olab will hen the change t of PPM e and tored for and/or ssues will s of the e			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345331	B. WING		08/03/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5151 SARDIS ROAD CHARLOTTE, NC 28270	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 490	Continued From page	28	F 490	weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertificati survey results in no repeat citations. Dietary staff will be inserviced on food sanitation policy which will include labe requirements. The daily labeling and dating checklist, which defines location of food items, times, initials, and corrective action, will be utilized twice play by the General Manager and/or designee. The Administrator and/or designee, will monitor for compliance weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing of weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. The General Manager will be responsite for implementing the acceptable plan of correction.	eling s on on on on ole
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(COMMITTEE-MEMB QUARTERLY/PLANS	ERS/MEET	F 520	8/30/17	8/30/17
		ntain a quality assessment			
	and assurance comm	ittee consisting at a			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345331	B. WING		08/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5151 SARDIS ROAD CHARLOTTE, NC 28270	,
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 520	(iii) At least three ot staff, at least one of administrator, owne individual in a leade (g)(2) The quality as committee must: (i) Meet at least qua coordinate and eval identifying issues w assessment and as necessary; and (ii) Develop and impaction to correct ide	cursing services; ector or his/her designee; her members of the facility's who must be the ir, a board member or other ership role; and essessment and assurance exterly and as needed to funct activities such as eith respect to which quality surance activities are element appropriate plans of intified quality deficiencies;	F 5.	20	
	Secretary may not records of such com such disclosure is resuch committee with section. (i) Sanctions. Good committee to identificationis will not sanctions. This REQUIREMENT by: Based on observative review of medical and such committee to identification of the sanctions.	ormation. A State or the require disclosure of the mittee except in so far as related to the compliance of the requirements of this. If aith attempts by the regular are a basis for the used as a basis for the requirements of this be used as a basis for the requirements of this the requirements of this relations. If a solution is not met as evidenced the requirements of the requirements of this requirements of this requirements of the require		F 520 The facility will maintain a Quality	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345331	B. WING		08/03/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2017	
			5	5151 SARDIS ROAD		
SARDIS O	AKS		(CHARLOTTE, NC 28270		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 520	Continued From page	÷ 30	F 520			
1 320	committee failed to me procedures and monithe committee put into was for 3 recited deficited June 2016 on a survey and subseque current Recertification were in the areas of maintain well-being, a continued failure of the surveys of record showing included: This tag is cross reference— Based on staff intervite facility failed to accurate the facility failed to accurate the facility failed to accurate the facility was original accuracy of resident and resident assessments regarding the prognos screening and active	aintain implemented tor these interventions that to place in July 2016. This ciency that was originally Recertification/Complaint intly recited on the facility's in survey. The deficiencies esident assessments, and dietary services. The lie facility during 2 federal law a pattern of the facility's effective Quality Assurance. F 278 ews and record review, the lately code the Minimum led to prognosis of life dmission screening lactive diagnoses (Resident 323) for 4 of 19 sampled lad an MDS. ally cited in June 2016 for lassessments related to land recited for accuracy of so on the current survey lass of life, preadmission diagnoses.	F 520	Assessment and Assurance committed with members including the Director Nursing Services, the Medical Directions/her designee, and at least three members of the facility's staff. Corrective Action Plan and plan for monitoring to sustain an effective Control Assessment and Assurance Progration be reviewed with the Quality Assurand Performance Improvement (Quality Committee). We feel what led to this deficiency monitoring period through the QAP committee that was too brief. Our semination of the period for these defiareas, as tracked by our Committee. However, had we length the monitoring period for these defiareas from 90 days to 6 months or perhaps we would not have had registed. As a result, our Plan of Correction for repeat citations F278, F309, F371 and recertification survey (roughly one semination). Provided this annual recertification survey results in no recitations for F278, F309, F371 and we would then discontinue monitoring through our QAPI Committee.	or of ctor or e other Quality am, to ance API) was a 'I Oo day iance API hened icient 1 year, peat for our and ugh rational year repeat F520,	
	1b. Cross reference -	F 309				
		ews and medical record ed to implement a bowel		Corrective Action: F278		

Facility ID: 923444

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345331	B. WING	B. WING		08/	/03/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5′	151 SARDIS ROAD		
SARDIS O	AKS			С	HARLOTTE, NC 28270		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 520	Continued From page	e 31	F:	520			
		tion to 2 of 4 sampled		220	On 8/3/17, the surveyor interviewed th	Δ	
		ho had no indication of a			MDS Coordinator and determined	C	
		greater than 72 hours			Resident #29 s MDS indicated that the	e	
	(Residents #260 and				resident received hospice care. However		
	(I toolaonto #200 ana	<i>11020).</i>			the MDS did not indicate that the resid		
	The facility was origin	nally cited in June 2016 for			had a prognosis of life expectancy of le		
		implementing a physical			than 6 months. In addition, it was		
	_	ation for respiratory services			determined Resident #53 PASRR was	not	
		eing on the current survey			coded on the MDS. Also, it was		
	regarding implementation of a bowel				determined each of the active diagnos	is	
	management prograr				for Resident #260 and Resident #323,		
					was not coded on the MDS. For Resid	ent	
	1c. Cross reference -	F 371			#260, PAD/PVD was not coded and fo	r	
					Resident #323, Anxiety was not coded		
	Based on observation	ns, staff interviews and			MDS Modifications were submitted for		
	record review, the fac	cility failed to sanitize the		Resident #29, Resident #53, Reside			
	dishes with the corre	ct sanitizer concentration.			#260, and Resident #323.		
	_	tore opened frozen foods in					
		s including the name, date			MDS Coordinators will be provided		
	opened and date to u				education on RAI coding requirements		
		peas, omelets), and a small			Director of Nursing or designee will		
	-	nd a thickened beverage in			conduct weekly 10% audits of MDS		
	the refrigerator.				assessment to ensure compliance with		
	<i>c</i>				coding active diagnosis. Any identified		
	· · · · · · · · · · · · · · · · · ·	nally cited in June 2016 for			issues will be corrected at that time. In		
	•	ed to labeling/dating opened			addition, the Director of Nursing or	-1:4-	
		expired foods and recited			designee will conduct weekly 100% au		
	for dietary services o	_			of Hospice and PASRR coding to ensu		
	opened foods.	tion and labeling/dating			compliance. Any identified issues will be	ЭЕ	
	opened loods.		corrected at that time. Resu		monitoring will be shared with the		
	An interview on 8/3/1	7 at 4:37 PM with the			Administrator and Director of Nursing	nn a	
		ed that he managed the			weekly basis and with QAPI monthly.), i u	
		tee which met at least			QAPI committee will only consider		
	_	ne needs of the facility. The			discontinuing monitoring if subsequent		
		that during the quarterly QAA			surveys through the annual recertificat		
		s reviewed trending/tracking			survey results in no repeat citations.		
		fy resident concerns that					
		prection and monitoring. He			The Director of Nursing will be		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED	
		345331	B. WING _	B. WING			03/2017
NAME OF P	ROVIDER OR SUPPLIER			51	TREET ADDRESS, CITY, STATE, ZIP CODE 151 SARDIS ROAD HARLOTTE, NC 28270	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	accuracy remained a days until the facility and then it was remothe attributed continudepartment to staff to continued monitoring that perhaps the area	assessments related to MDS a QAA agenda item for 90 achieved 100% accuracy oved from the QAA's agenda. and concerns in the dietary curnover and the need for g. The administrator stated as of resident assessment, ervices and QAA should have	F	520	responsible for implementing the acceptable plan of correction. 8/30/17 Corrective Action: F309 Surveyor s review of Resident #260 a Resident #323 nurse s notes, bowel a bladder reports, and staff interviews determined that the bowel protocol wanot implemented after consecutive day each resident did not have documenta of bowel movements. Resident #260 w assessed on 8/3/17 for bowel movement and did not require prn medication for bowel movement. Resident #323 was assessed on 8/1/17 for bowel movement and standing order was implemented a 8/1/17. Nurses will be inserviced on implement the Physician Standing Orders, Bowel Program for Constipation for triggere residents. CNAs will be inserviced on timportance of accurate documentation CareTracker of bowel movements, to ensure triggered residents receive care accordance with the bowel program. Unit Supervisors will run a daily CareTracker report to identify residents that did not have documentation of bow movement within 72 hours. The Unit Supervisor will alert the assigned nurse implement the bowel program. Directo Nursing or designee will monitor the report weekly, to identify residents that not have documentation of a bowel	and s s s s s s tion r as r ting el d he in s vel	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED	
		345331	B. WING _		_	08/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 5151 SARDIS ROAD CHARLOTTE, NC 28270		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From pag	e 33	F	movement within 72 with the bowel prog Any identified issue that time. Results of shared with the Adn of Nursing on a wee QAPI monthly. QAF consider discontinuing subsequent surveys recertification surversitations. The Director of Nursing responsible for implication acceptable plan of the same of the sam	PI committee will only ing monitoring if is through the annual by results in no repeat sing will be lementing the correction. F371 Veyor observed DA #1 intration of chlorine is sanitizing cycle. The gister 50 parts per facility replaced the diprimed the sanitizer the Food Service sanitizer at the dish unitizer test strip was in 50 ppm 100 ppm cle. All the breakfast in through the dish be sanitized.	,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345331	B. WING		08/03/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5151 SARDIS ROAD CHARLOTTE, NC 28270			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 520	Continued From page	ne 34	F 520	breasts. Kitchen staff were able to id with certainty that the omelets, pance peas, and chicken breasts were oper on 8/1/17. Each of these items were properly labeled with the name of the item, date opened and use by date. addition, the surveyor observed the following items in the refrigerator that were opened with no label including of the item, date prepared and use by date: dish of fruit and a glass of thick beverage. Each of these items were discarded. All dishwashing staff will be educated test the sanitizer before sanitizing disfor each meal and again after compliants of dish sanitizing. In addition, Ecolablinstall an alarm that will sound when chemical is low, alerting staff to char out the 5-gallon premixed bucket of sanitizer. The dish machine daily PP checklist will be completed before an after each meal and will be monitore compliance by the Administrator and designee weekly. Any identified issues be corrected at that time. Results of monitoring will be shared with the Administrator and Director of Nursing weekly basis and with QAPI monthly QAPI committee will only consider discontinuing monitoring if subseques surveys through the annual recertific survey results in no repeat citations. Dietary staff will be inserviced on for sanitation policy which will include la requirements. The daily labeling and dating checklist, which defines locations.	akes, ned then ell in the name y tened do to shes etion will the nage M and do for /or es will the ag on a the nation and beling		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 5151 SARDIS ROAD CHARLOTTE, NC 28270	ODE		
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F 520	Continued From page	35	F 5	of food items, times, initials corrective action, will be ut day by the General Manag designee. The Administrate designee, will monitor for concept weekly. Any identified issurcorrected at that time. Resmonitoring will be shared what Administrator and Director weekly basis and with QAF QAPI committee will only of discontinuing monitoring if surveys through the annual survey results in no repeat. The General Manager will for implementing the acceptorrection. 8/30/17	ilized twice per and/or or and/or compliance es will be ults of the with the of Nursing op monthly. Consider subsequent al recertificatic citations.	on a on	