DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				<u>IO. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		345350	B. WING		0	C 5/03/2018
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD		0/00/2010
	ND TERRACE			2300 ABERDEEN BOULEVARD		
				GASTONIA, NC 28054		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	00		
	complaint investigatio	cited as a result of the n. Event ID# MHPG11.				
F 640 SS=E		g Resident Assessments (4)	F 64	10		5/25/18
	a facility completes a facility must encode th each resident in the fa (i) Admission assessmen (ii) Annual assessmen (iii) Significant change (iv) Quarterly review a (v) A subset of items of reentry, discharge, an (vi) Background (face is no admission asses §483.20(f)(2) Transm after a facility complet a facility must be cap CMS System informa contained in the MDS	ng data. Within 7 days after resident's assessment, a he following information for acility: ment. ht updates. e in status assessments. assessments. upon a resident's transfer, hd death. -sheet) information, if there assment. itting data. Within 7 days tes a resident's assessment, able of transmitting to the				
	CMS and the State. §483.20(f)(3) Transm 14 days after a facility assessment, a facility	dardized edits defined by ittal requirements. Within completes a resident's must electronically transmit nd complete MDS data to				
		nent. nt. e in status assessment.				(X6) DATE
	cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATUR	.⊏	TITLE		05/25/2018

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.

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM): 05/31/2018 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345350	B. WING			C 03/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
			2	300 ABERDEEN BOULEVARD		
COURTLA	ND TERRACE		0	GASTONIA, NC 28054		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 640	 (v) Significant correction assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, and (viii) Background (face initial transmission of does not have an adm §483.20(f)(4) Data for transmit data in the for for a State which has by CMS, in the format approved by CMS. This REQUIREMENT by: Based on record revifacility failed to compl MDS (Minimum Data to transmit Admission assessments within th of 6 residents (Resider #19) reviewed for Rest Findings included: 1. Resident #33 was a 02/22/17 with multiple diabetes, hypertensio dementia. A review of Resident an Assessment Refer 04/03/18 and was correst. 	 ion of prior full assessment. on of prior quarterly upon a resident's transfer, id death. e-sheet) information, for an MDS data on resident that hission assessment. mat. The facility must rmat specified by CMS or, an alternate RAI approved is pocified by the State and is not met as evidenced ew and staff interviews, the ete a Significant Change Set) assessment and failed , Annual and Quarterly MDS he required time frame for 6 ent #33, #1, #2, #3, #4, and sident Assessments. admitted to the facility on e diagnoses that included in, depression, and #33's most recent MDS had ence Date (ARD) of led as a significant change OS was noted to be "in 	F 640	The statements included are not an admission and do not constitute agreement with the alleged deficiencie herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To rem in compliance with all federal and state regulations, the facility has taken or wi take the actions set forth in the followir plan of correction, and constitutes the facility allegation of compliance. All alleged deficiencies cited have been o will be completed by the dates indicate AFFECTED RESIDENTS: Resident # 33 Gignificant change MI assessment was completed and transmitted on 5/3/18. Resident # 1, Resident #2, Resident # Quarterly MDS assessment was transmitted on 5/1/18.	ain e ll og r d. DS	
	During an interview or	n 05/01/18 at 3:14 PM the		Resident # 3 - Annual MDS assessme	nt	

Facility ID: 953123

If continuation sheet Page 2 of 23

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	OMB NO. 0	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLET	
			A. DOILDING		с	
		345350	B. WING		05/03/2	2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				2300 ABERDEEN BOULEVARD		
COURTLA	ND TERRACE			GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE C	(X5) OMPLETIO DATE
E 0.40						
F 640			F 64	-		
		ne was the one responsible		was signed and transmitted on 5		
		mitting completed MDS		Resident #19 Admission MDS	was	
	were in the process of	IDS Nurse explained they of switching computer		transmitted on 5/1/18.		
		eek she ran a submission		POTENTIALLY AFFECTED RES		
	to be signed and tran	the MDS assessments ready		POTENTIALLY AFFECTED RES	DIDENTS.	
		IDS assessment was		All residents have the potential to	a ha	
		oved by the Centers for		affected by this deficient practice		
		I Services (CMS) it would				
		accepted." She confirmed		MDS Coordinators completed au	udit of	
		e MDS for Resident #33 was		resident MDS assessments and		
		versight and would need to		transmission on 5/25/18.		
	be completed and tra	•		All resident MDS assessments h	ave heen	
		ansninted.		completed and transmitted withir		
	During an interview of	on 05/02/18 at 12:51 PM the		required time frame as of 5/25/18		
		DON) stated it was her			5.	
	expectation for MDS			The root cause analysis revealed	aub tedt f	
		mitted within the required		to the facility is still in process of		
	time frames.			to a new Electronic Health Reco		
				system, the report generated from		
				facility 's new EHR system did r		
	2. Resident #1 was a	admitted to the facility on		capture completed resident MDS		
		e diagnoses that included		assessments therefore complete		
	heart failure, hyperte	-		assessments were not transmitte		
				the required time frame.	-	
	A review of Resident	#1's most recent MDS had		The resident MDS significant cha	ange	
		and was coded as a quarterly		assessment that was not comple	-	
		DS was noted to be "in		timely by the MDS Assessment N		
				SYSTEM CHANGE:		
	•	on 05/01/18 at 3:14 PM the				
		ne was the one responsible		The MDS Coordinator and MDS		
		mitting completed MDS		Assessment Nurse were re-educ		
		IDS Nurse explained they		Director of Nursing on 5/21/18 or		
		of switching computer		completion and transmission of r		
	-	eek she ran a submission		MDS significant change assess	nent.	
		the MDS assessments ready smitted. She further		MDS Coordinator contacted Mat		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING С 345350 B. WING 05/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2300 ABERDEEN BOULEVARD COURTLAND TERRACE GASTONIA, NC 28054 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 640 Continued From page 3 F 640 explained when an MDS assessment was Project Manager on 5/2/18 for further transmitted and approved by CMS it would assistance on generated the appropriate indicate "production accepted." She was unable MDS Report that will capture completed to explain why Resident #1's guarterly MDS resident MDS assessments and are ready assessment dated 03/19/18 was showing as in for signature and transmission. process and confirmed the MDS assessment was completed and should have been transmitted. MDS Coordinator will run esignatures by User Report weekly to ensure all During an interview on 05/02/18 at 12:51 PM the completed resident MDS assessments Director of Nursing (DON) stated it was her are signed and transmitted timely. expectation for MDS assessments to be completed and transmitted within the required MONITORING: time frames. An audit tool was developed to monitor compliance with timely completion and 3. Resident #2 was admitted to the facility on transmission of resident MDS 12/08/17 with multiple diagnoses that included assessments. diabetes, arthritis and Alzheimer's disease. Director of Nursing or designee will audit A review of Resident #2's most recent MDS had completion and transmission of resident an ARD of 03/19/18 and was coded as a guarterly MDS assessments weekly x 4 weeks, g 2 assessment. The MDS was noted to be weeks x 4 weeks, then g monthly x 3 "finalized." months During an interview on 05/01/18 at 3:14 PM the Ongoing audits will be determined based MDS Nurse stated she was the one responsible on results of prior audits. Audit tools will for signing and transmitting completed MDS be reviewed weekly by Administrator assessments. The MDS Nurse explained they and/or Director of Nursing and during were in the process of switching computer monthly Quality Assurance and Performance Improvement Committee systems and each week she ran a submission report that indicated the MDS assessments ready meeting. to be signed and transmitted. She further The Director of Nursing will be explained when an MDS assessment was transmitted and approved by CMS it would responsible for implementing the indicate "production accepted." She confirmed acceptable plan of correction as outlined Resident #2's quarterly MDS assessment dated above. 03/19/18 was completed and should have been transmitted.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 953123

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/31/2018 / APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345350	B. WING					C 03/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
COURTIA					2300 ABERDEEN BOULEVARD			
COURTER					GASTONIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 640	Director of Nursing (Dexpectation for MDS acompleted and transmitime frames. 4. Resident #3 was acoustic transmittime frames. 4. Resident #3 was acoustic transmittime frames. 4. Resident #3 was acoustic transmitter of the second s	n 05/02/18 at 12:51 PM the pON) stated it was her assessments to be nitted within the required dmitted to the facility on e diagnoses that included #3's most recent MDS had nd was coded as an annual DS was noted to be n 05/01/18 at 3:14 PM the e was the one responsible nitting completed MDS DS Nurse explained they f switching computer tek she ran a submission he MDS assessments ready smitted. She further DS assessment was oved by CMS it would iccepted." She confirmed MDS assessment dated ted and should have been d.	F	640				

Facility ID: 953123

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/31/2018 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345350	B. WING					C 03/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	•	
COURTLA	ND TERRACE				2300 ABERDEEN BOULEVARD GASTONIA, NC 28054			
					·	0000000000		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE
F 640	Continued From page	• 5	F	640				
	01/19/17 with multiple hypertension, diabete	e diagnoses that included s and dementia.						
		#4's most recent MDS had and was coded as a quarterly DS was noted to be						
	MDS Nurse stated sh for signing and transmassessments. The M were in the process of systems and each we report that indicated t to be signed and transmitted and appro- indicate "production a Resident #4's quarter	eek she ran a submission he MDS assessments ready smitted. She further DS assessment was						
	Director of Nursing (December 2017) Director of Nursing (December 2017)	n 05/02/18 at 12:51 PM the OON) stated it was her assessments to be nitted within the required						
		admitted to the facility on e diagnoses that included betes.						
	assessments reveale Payment System (PP of 03/14/18 and an ad	#19's most recent MDS d a 5-day Prospective 'S) assessment with an ARD dmission MDS with an ARD hission MDS was noted to						

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345350	B. WING				C 103/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
COURTLA	ND TERRACE			23	00 ABERDEEN BOULEVARD		
				G/	ASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	be "in process."		F	640			
	MDS Nurse stated sh for signing and transm assessments. The M were in the process o systems and each we report that indicated to to be signed and trans explained when an M transmitted and appro- indicate "production a Resident #19's insura admission MDS asses and transmitted separ	ek she ran a submission he MDS assessments ready smitted. She further DS assessment was oved by CMS it would accepted." She stated due to ance policy the PPS and ssments were completed rately. She confirmed the d 03/14/18 for Resident #19					
	Director of Nursing (December 2017) Director of Nursing (December 2017)	nitted within the required	F	641			5/25/18
	resident's status. This REQUIREMENT by: Based on record revi facility failed to accura Data Set (MDS) to ref	t accurately reflect the is not met as evidenced ew and staff interviews, the ately code the Minimum flect the Level II ing and Resident Review			The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and	5	

Event ID: MHPG11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345350 B. WING 05/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2300 ABERDEEN BOULEVARD COURTLAND TERRACE GASTONIA, NC 28054 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 7 F 641 (Resident #51) identified as PASRR Level II. federal regulations as outlined. To remain in compliance with all federal and state Findings included: regulations, the facility has taken or will take the actions set forth in the following Resident #51 was admitted to the facility on plan of correction, and constitutes the 09/26/16 with multiple diagnoses that included facility s allegation of compliance. All bipolar disorder and anxiety. alleged deficiencies cited have been or will be completed by the dates indicated. Review of the Annual MDS dated 03/12/18 AFFECTED RESIDENT: revealed Resident #51 was not considered by the state Level II PASRR process to have a serious This deficient practice affected Resident # mental illness and/or intellectual disability. The 51. Resident s MDS Assessment has results of this screening and review are used for been modified on 5/18/18 to accurately formulating a determination of need, code Level II PASARR on the determination of an appropriate care setting and assessment. This corrected MDS formulating a set of recommendations for assessment was transmitted on 5/21/18. services to help develop an individual's plan of care. POTENTIALLY AFFECTED RESIDENTS: Review of the Skilled Nursing Facility (SNF) Level II authorization dated 03/27/17 for Resident #51 Residents with Level II PASRR are at risk indicated she was approved for a level II PASRR to be potentially affected by this deficient number with no expiration date. practice. During an interview on 05/03/18 at 3:30 PM the MDS Coordinators completed audit of MDS Nurse stated she was under the assumption residents with Level II PASRR on 5/18/18 that last year Resident #51 had received a to ensure Level II PASARR is accurately lifetime PASRR that was not considered a Level coded on resident s MDS assessment. II. The MDS Nurse reviewed the SNF Level II authorization dated 03/27/17 for Resident #51 The root cause analysis revealed and confirmed the approval indicated a Level II inaccurate coding of the Level II PASARR PASRR. on resident s MDS assessment was secondary to PASRR documentation was During an interview on 05/03/18 at 6:09 PM the not available in resident s chart during Admissions Coordinator confirmed the SNF Level the period resident MDS Assessment was II authorization dated 03/27/17 for Resident #51 completed. was the most recent PASRR approval received. During an interview on 05/03/18 at 7:20 PM the SYSTEM CHANGE:

FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE	D. 0938-039 SURVEY PLETED
			A. BUILDING	<u> </u>		C
		345350	B. WING		05/	03/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
COURTL	AND TERRACE			2300 ABERDEEN BOULEVARD GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 641		ge 8 I it was his expectation for to be accurately coded.	F 64		tor of coding of start in A of th Level of the in the the list com the re II ation for inary formation int enter ion. update SRR	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/31/2018 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345350	B. WING			C 05/03/2018	
NAME OF P	ROVIDER OR SUPPLIER	l	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COURTLA				2	300 ABERDEEN BOULEVARD		
				G	ASTONIA, NC 28054		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	CFR(s): 483.25(n)(1)- §483.25(n) Bed Rails The facility must atter alternatives prior to in a bed or side rail is us correct installation, us rails, including but no elements. §483.25(n)(1) Assess entrapment from bed §483.25(n)(2) Review bed rails with the resi	-(4) mpt to use appropriate istalling a side or bed rail. If sed, the facility must ensure se, and maintenance of bed t limited to the following s the resident for risk of rails prior to installation.		641	MDS Coordinator and MDS Assessmen Nurse will audit resident MDS Assessments for accurate coding of Le II PASARR weekly x 4 weeks, q other week x 2 weeks, then q monthly x 2 months. Ongoing audits will be determined base on results of prior audits. Audit tools wi be reviewed weekly by Administrator and/or Director of Nursing and during monthly Quality Assurance and Performance Improvement Committee meeting. The Director of Nursing will be responsible for implementing the acceptable plan of correction as outline above.	evel ed II	5/25/18

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		MEDICAID SERVICES	(X2) MUI T	TIPI F	CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, í				PLETED
				_		С	
		345350	B. WING			05	/03/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COURTLA	ND TERRACE			23	300 ABERDEEN BOULEVARD		
COUNTER				G	ASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	Continued From page	e 10	F	700			
		e that the bed's dimensions		, 00			
		e resident's size and weight.					
	§483.25(n)(4) Follow	the manufacturers'					
		d specifications for installing					
	and maintaining bed						
		Γ is not met as evidenced					
	by: Based on observatio	ons, record review, resident,			The statements included are not an		
		he facility failed to assess			admission and do not constitute		
	the need for side rails	-			agreement with the alleged deficiencies	5	
	reviewed for side rail	s who were using ¼ side			herein. The plan of correction is		
		#236, #39, #3, #17, #38,			completed in compliance of state and		
	and #51).				federal regulations as outlined. To remain		
	Findings Included:				in compliance with all federal and state regulations, the facility has taken or will		
					take the actions set forth in the followin		
	1. Resident #232 was	s admitted to the facility on			plan of correction, and constitutes the	9	
		ses that included pneumonia			facility s allegation of compliance. All		
	and partial intestinal				alleged deficiencies cited have been or		
					will be completed by the dates indicated	d.	
		ssion Minimum Data Set					
	, ,	8 revealed Resident #232			AFFECTED RESIDENTS:	-	
		t and required extensive nobility, transfers, dressing,			Residents # 232, 236, 39, 3, 17, 38, an 51 were affected by this deficient practi		
		al hygiene. Bed rails were not			Corrective actions for these residents	ce.	
	coded under Section				includes Bed Rail Resident Assessmen	ıt	
		-			were completed on 5/2/18. Facility		
	A review of the medic	cal record revealed Resident			obtained Informed Consent for Bed Rai	ils	
	#232 had no side rail	assessment.			after providing the resident and		
					responsible party the brochure from U	.S.	
	Resident #232:	ations were conducted of			Department of Health and Human Services and Food and Drug		
					Administration Center for Devices and		
	On 04/30/18 at 11:45	AM Resident #232 was			Radiological Health on "A Guide to Be	d	
		de rails were up on both			Safety", and reviewing the risks and		
	sides of the bed.				benefits of bed rails with resident and		
		PM Resident #232 was			responsible party.		
	resting in bed with ev	es closed and ¼ side rails					

Facility ID: 953123

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345350 B. WING 05/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2300 ABERDEEN BOULEVARD COURTLAND TERRACE GASTONIA, NC 28054 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 700 Continued From page 11 F 700 were up on both sides of the bed. POTENTIALLY AFFECTED RESIDENTS: On 05/03/18 at 09:25 AM Resident #232 was All residents have the potential to be sitting up in bed feeding herself breakfast and 1/4 side rail were up on both sides of the bed. affected by this deficient practice. On 05/02/18 at 3:15 PM an interview was Resident Bed Rail Assessments were conducted with the Nursing Supervisor (NS) who completed on all current residents on stated the facility did not conduct side rail 5/2/18 and 5/3/18. Informed Consent for assessments on residents. She stated she would Bed Rails were also obtained from speak with the Director of Nursing (DON) residents and/or responsible party. because no side rail assessments were Potential risks and benefits of the use of conducted. bed rails were discussed with resident and/or responsible party. On 5/2/18 at 4:05 PM an interview was conducted with the Administrator and DON who stated they CaroMont Regional Medical Center were unaware side rail assessment were required Maintenance Staff completed Bed Rail and confirmed no side rail assessments had been Audit on 5/18/18. completed. The root cause analysis revealed, the On 05/03/18 at 9:26 AM an interview was facility failed to develop bed rail risk conducted with Resident #232 who stated she assessment based on bed rails definition liked to have side rails on the bed because she of "adjustable metal or rigid plastic bars was able to position herself in the bed by using that attach to the bed in variable sizes". the side rails. The facility failed to identify appropriate alternatives for beds that have bed rails of On 05/03/18 at 10:30 AM an interview was various sizes with bed controls attached to the bed. conducted with the DON who stated there was no rhyme or reason as why the nurse or nurse aide used side rails for the resident. The DON stated SYSTEM CHANGE: there was no formal guideline, procedure, or assessment for side rail use in the facility. The Staff in-service on appropriate use of bed DON stated some families were old school and rails, including alternatives prior to wanted side rails used for the resident. The DON installation of bed rails was initiated on stated some residents came to facility from the 5/2/18 and completed on 5/6/18. Any staff hospital and wanted to continue the use of side member on LOA or otherwise out will be rails. The DON stated some staff used side rails educated prior to returning to assignment. for resident safety and further stated the facility had no formalized assessment developed and Bed Rail Assessment Risk Form has been implemented for side rail use. developed and will be completed on all

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIDI	LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
						С
		345350	B. WING			05/03/2018
NAME OF PR	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP	P CODE	
COURTLA	ND TERRACE			2300 ABERDEEN BOULEVARD GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A(CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 700	Continued From page	e 12	F 70	0		
				new admissions and whe	en residents are	
		is admitted to the facility on ses that included cerebral		readmitted back to the fac	cility.	
	vascular accident and			Current residents will also	o be assessed	
				quarterly or when signific	ant change has	
		ssion Minimum Data Set		been identified, for use of		
		8 revealed Resident #236		utilizing the Bed Rail Asse	essment Risk	
	U	and required extensive nobility, transfers, dressing,		Form.		
		al hygiene. Bed rails were not		Individual bed rail evaluat	tions will include	
	coded under Section	• •		data collection analysis a		
				of potential alternative be		
		cal record revealed Resident		bed rails are deemed neo	-	
	#236 had no side rail	assessment.		appropriate, the facility w		
	An checketick was			education to resident and		
	9:43 AM and revealed	conducted on 04/30/18 at		representative pertaining benefits of bed rail use.	to the fisk and	
	observed lying in bed					
		rails were up on both sides		Informed Consent for Bed	d Rails Form has	
	of the bed.			also been developed and		
				completed and obtained t		
	On 05/02/18 at 3:15 F			and/or responsible party	when	
	stated the facility did	ursing Supervisor (NS) who		appropriate.		
		dents. She stated she would		The brochure A Guide to	Bed Safety has	
	speak with the Direct			been added in the Reside	•	
	because no side rail a	- · ·		Packet.		
	conducted.					
	On E/0/40 -1 4:05 D14	l on intonvinuumen en-du-t-d		The facility 's Bed Rail P		
		an interview was conducted rand DON who stated they		revised and updated. Em provided education on Be		
		ail assessment were required		namely risk identification	•	
		e rail assessments had been		of entrapment and other	•	
	completed.			during orientation and on	going programs.	
				CaroMont Regional Medi		
		AM an interview was		Maintenance Staff will co		
		lent #236 who stated she		of all bed frames and bed		
	helped her with positi	on her bed because they		as part of a regular maint to identify areas of possib		

Facility ID: 953123

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/31/2018 RM APPROVED IO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DA	E SURVEY IPLETED
		345350	B. WING		0	C 5/03/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
COURTLA	ND TERRACE			300 ABERDEEN BOULEVARD GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	Continued From page	13	F 700			
	rhyme or reason as w used side rails for the there was no formal g assessment for side r DON stated some fan wanted side rails used stated some residents hospital and wanted to rails. The DON stated	DN who stated there was no hy the nurse or nurse aide resident. The DON stated uideline, procedure, or ail use in the facility. The nilies were old school and d for the resident. The DON s came to facility from the o continue the use of side some staff used side rails d stated the facility had no nt developed and		The facility will purchase minir new resident beds by 6/30/18. will purchase the remainder 60 beds by end of 2019. MONITORING: An audit tool was developed to compliance with completion of Risk Assessment. Assistant Clinical Nurse Mana audit completion of Bed Rail R Assessment Form q week x 4 weeks x 2, q month x2 then qu Results of the quarterly inspect	The facility D resident	
	with behavioral disturl and congestive heart A review of the Admis dated 02/20/18 noted cognitive impairment a assistance of staff for Bed rails were not coo A review of the medic #39 had no side rail a On 05/03/18 at 7:47 A observed, in his room bed. The bed was ag rail was observed in the the head of the bed.	es which included dementia bances, syncope, diabetes failure. sion Minimum Data Set Resident #39 had severe and required extensive bed mobility and transfers. ded under Section P0100a. al record revealed Resident ssessment. M Resident #39 was , seated on the side of his ainst the wall and a 1/4 side ne upright position, towards Resident #39 was observed rail for support while seated		CRMC Maintenance Staff will discussed in the Safety Comm Meeting and during the Quality and Performance Improvemen Ongoing audits will be determin on results of prior audits. Audi be reviewed weekly by Admini and/or Director of Nursing and monthly Quality Assurance an Performance Improvement Co meeting. The Facility Administrator and Nursing will be responsible for implementing the acceptable F outlined above.	be hittee y Assurance ht Meetings. ined based t tools will strator during d mmittee Director of	

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	-	D HUMAN SERVICES			FOR	D: 05/31/2018 M APPROVED
STATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DAT	O. 0938-0391 E SURVEY PLETED
		345350	B. WING		05	C 5/ 03/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
			2	300 ABERDEEN BOULEVARD		
COURTLA	ND TERRACE		G	GASTONIA, NC 28054		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	Continued From page	9 14	F 700			
	Nursing and they both side rail assessments confirmed no side rail completed. On 05/03/18 at 2:40 F care guide (used to kui individual residents) v an area under the cat the need for "side rail: Resident #39 was bla rails." On 05/03/18 at #1 stated she routinel Resident #39 resided rails up on all of the re assisted them with rep Assistant #1 stated sh	Aministrator and Director of a stated they were unaware were required and assessments had been PM the nursing assistant how specific needs of vas reviewed and included egory equipment to address s". The care guide for nk beside the area for "side t 2:42 PM Nursing Assistant y worked on the hall where and typically put 1/4 bed esidents to use when she positioning. Nursing he was not aware of any t staff know whether or not				
	05/18/15 with multiple Alzheimer's disease. A review of the annua dated 03/20/18 revea severely impaired in o extensive to total staff mobility, transfers, dre personal hygiene. Be being used under Sec	cognition and required f assistance with bed essing, toileting, and ed rails were not coded as				
	#3 had no side rail as					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2018 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345350	B. WING		-		C 03/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
COURTLAND TERRACE				300 ABERDEEN BOULEV ASTONIA, NC 28054	ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	Continued From page	e 15	F 700				
	Resident #3 lying in b against the wall and a opposite side of the b Resident #3's room o 05/02/18 at 8:45 AM r wall with a ¼ side rail the bed. Resident #3 was unal cognition. An interview on 05/02 Nursing Supervisor (N not conduct side rail a She stated she would Nursing (DON) becau were conducted. An interview on 05/02 Administrator and DC unaware side rail assi confirmed no side rail completed. 5. Resident #17 was 12/04/15 with multiple Alzheimer's disease. A review of the quarter (MDS) dated 01/17/18 was severely impairer total staff assistance of dressing, toileting, an	ed. Observations of n 05/01/18 at 3:15 PM and revealed the bed against the up on the opposite side of oble to be interviewed due to 1/18 at 3:15 PM with the NS) revealed the facility did assessments on residents. speak with the Director of use no side rail assessments					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/31/2018 / APPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345350	B. WING			_		C 03/2018	
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-		
COURTLA	ND TERRACE				2300 ABERDEEN BOULEV GASTONIA, NC 28054	ARD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 700	A review of the medic #17 had no side rail a An observation of Res 04/30/18 at 2:50 PM r against the wall with a opposite side of the b Resident #17's room 05/02/18 at 11:01 AM the wall with a ¼ side of the bed. Resident #17 was una cognition. An interview on 05/02 Nursing Supervisor (N not conduct side rail a She stated she would Nursing (DON) becau were conducted. An interview on 05/02 Administrator and DC unaware side rail ass confirmed no side rail completed. 6. Resident #38 was 01/17/14 with multiple Lewy body dementia, rheumatoid arthritis. A review of the quarte (MDS) dated 02/19/18 was severely impaired total staff assistance of	al record revealed Resident ssessment. sident #17's room on revealed the bed pushed up a ¼ side rail up on the ed. Observations of on 05/01/18 at 2:38 PM and revealed the bed against rail up on the opposite side able to be interviewed due to 2/18 at 3:15 PM with the NS) revealed the facility did assessments on residents. I speak with the Director of use no side rail assessments	F	700					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2018 / APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345350	B. WING		_		C 03/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
COURTLA	ND TERRACE			300 ABERDEEN BOULEV BASTONIA, NC 28054	ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	Continued From page rails were not coded a P0100A. A review of the medic #38 had no side rail a An observation of Res 05/01/18 at 12:07 PM up against the wall wi opposite side of the b Resident #38's room revealed the bed agai rail up on the opposite Resident #38 was una cognition. An interview on 05/02 Nursing Supervisor (N not conduct side rail a She stated she would Nursing (DON) becau were conducted. An interview on 05/02 Administrator and DO unaware side rail asso confirmed no side rail completed.	e 17 as being used under Section al record revealed Resident ssessment. sident #38's room on revealed the bed pushed th a ¼ side rail up on the ed. An observation of on 05/02/18 at 12:10 PM inst the wall with a ¼ side e side of the bed. able to be interviewed due to 1/18 at 3:15 PM with the NS) revealed the facility did assessments on residents. speak with the Director of ise no side rail assessments	F 700				
	dated 03/12/18 reveal severely impaired in c	l Minimum Data Set (MDS) led Resident #51 was					

Facility ID: 953123

If continuation sheet Page 18 of 23

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/31/2018 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		345350	B. WING				C / 03/2018
NAME OF PF	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	ND TERRACE			230	0 ABERDEEN BOULEVARD		
				GA	STONIA, NC 28054		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 700	Continued From page	: 18	F 7	00			
	transfers, dressing, to hygiene. Bed rails w under Section P0100/	ere not coded as being used					
	A review of the medic #51 had no side rail a	al record revealed Resident ssessment.					
	Resident #51 lying in against the wall and a opposite side of the b Resident #51's room 05/02/18 at 10:11 AM	-					
		able to be interviewed due to					
	Nursing Supervisor (N not conduct side rail a She stated she would	/18 at 3:15 PM with the NS) revealed the facility did assessments on residents. speak with the Director of se no side rail assessments					
F 745 SS=D	Administrator and DO unaware side rail asso confirmed no side rail completed.	7/18 at 4:05 PM with the N revealed they were essments were required and assessments had been Related Social Service	F 7	45			5/25/18
	maintain the highest p	y must provide al services to attain or practicable physical, mental I-being of each resident.					

Facility ID: 953123

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	OF DEFICIENCIES	MEDICAID SERVICES		רוסי ר	CONSTRUCTION		TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· /	MPLETED
			A. BOILDI	<u> </u>			С
		345350	B. WING				5/03/2018
NAME OF P	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE				
				23	300 ABERDEEN BOULEVARD		
COURTLA	ND TERRACE			G	GASTONIA, NC 28054		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
		- 10	1				
F 745	1.0		E F	745			
		is not met as evidenced					
	by: Based on medical re	cord review and interviews			The statements included are not an		
		otain a psychiatric referral for			admission and do not constitute		
	1 of 1 sampled reside			agreement with the alleged deficiencie	es		
	psychosocial needs.			herein. The plan of correction is			
				completed in compliance of state and			
	The findings included			federal regulations as outlined. To ren			
					in compliance with all federal and stat		
	Resident #39 was ad with diagnoses which			regulations, the facility has taken or w			
	behavioral disturbance			take the actions set forth in the followi plan of correction, and constitutes the	ng		
				facility s allegation of compliance. All			
	Review of the admiss			alleged deficiencies cited have been o			
	dated 02/20/18 noted	Resident #39 had severe			will be completed by the dates indicate		
	cognitive impairment,	, behaviors which included					
		rejection of care and was			AFFECTED RESIDENT:		
		anti-anxiety and hypnotic			This deficient practice affected Reside		
	medications. The Ca				#39. Corrective action for this residen		
		dmission assessment			includes assessment and evaluation t	•	
	included a review of I			Psychiatrist on 5/2/18. Psychiatrist wil			
	displayed behaviors a and rejection of care.			continue to follow resident and provide medically related and necessary	3		
	diagnoses: hyperten			intervention to attain or maintain the			
		ire, coronary artery disease			highest practicable physical, mental a	nd	
	-	y can cause resident to have			psychosocial well-being.		
	feelings of apprehens	sion, irritability and					
	restlessness. Demer	ntia can cause resident to			POTENTIALLY AFFECTED RESIDEN	ITS:	
		ehension, irritability and			An audit of all current residents with		
		ntia can cause resident to			physician ordered psychiatric services		
	have mood changes,				referrals and consult will be completed		
	emotions. Hypertens	-			or before 5/26/18, to assure all physic ordered psychiatric referrals or consul		
		and irritability. Changes in In cause significant mood			have been sent and received by the	15	
		s at risk for further behavioral			psychiatric provider.		
	-	incourage compliance and					
	appropriate behavior.				The root cause analysis revealed that	the	
	encouragement and				Social Services Coordinator failed to s		
					the referral to the provider after physic	nian	

Event ID: MHPG11

Facility ID: 953123

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	MPLETED
			A. DOILDING			С
		345350	B. WING		0	5/03/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		0.00.2010
COURTLAND TERRACE				2300 ABERDEEN BOULEVARD		
COURTLA	ND TERRACE			GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
		- 00				
F 745			F 74	-	,	
		plan for Resident #39 dated		order for psychiatric servi and signed consent was		
	and approaches:	e following problem areas		resident signed consent was		
		ed a psychotropic medication			arty.	
		ety, insomnia and dementia				
		roaches to this problem area				
		ch services as indicated.				
	-At risk for falls relate	ed to new admission, mental		SYSTEM CHANGE:		
	status, recent fall, his	story of previous falls,				
	-	le standing and walking and		Administrator will utilize J		
		tions. After the fifth fall post		discuss appropriate work		
		ach was written to consult		improvement efforts with		
		ehaviors and medication		Coordinator assigned to a		
	review.			Employee will return from 6/21/18.	I FIVILA ON	
	Review of physician (orders for Resident #39		0/21/18:		
		dministered on a daily basis		A referral log has been de	eveloped to	
		i-anxiety) 7.5 milligrams		document and track psyc	-	
		azadone (anti-depressant)		and consults. Social Serv		
	50 milligrams at bedt			Coordinators will maintain	n log and keep	
	(anti-psychotic) 2.5 m	nilligrams at bedtime. On		records of psychiatric refe	errals and	
		an ordered a psychiatric		consults. (See Attachme	nt A)	
	consult related to cor	nbative behaviors.				
	D · · · · · ·			Social Services Coordina		
		progress notes included a		Assistant Clinical Nurse		
	visit on 4/6/18 noting	g his medications" and "may		re-educated on 5/22/18 b Nursing on the process o	-	
		e if patient continues to be		referrals and consults. A		
	uncooperative and re			employees involved in the		
				referral process who are		
	Review of the medica	al record of Resident #39		otherwise out will be re-e		
	revealed the following	•		returning to work.	-	
		sed all morning medication.				
		ff and other residents while		MONITORING:		
	-	d combative behavior.		An audit tool was develop		
		ised blood sugar check.		compliance with psychiat		
	Patient states, I don't			consults. Director of Nurs		
		sed 1:00 PM medication fused shower X 3 per nurse		will conduct audits of refe completion and appropria		
	1 US/ZO/ IN-Resident re	aused shower X 3 der nurse	1	COMPLETION and appropria		1

Facility ID: 953123

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY COMPLETED	
	CONNECTION	IDENTIFICATION NONDER.	A. BUILDING	3	C	
		345350	B. WING		05/03/201	8
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
COURTLAND TERRACE				2300 ABERDEEN BOULEVARD GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X: ACTION SHOULD BE COMPL TO THE APPROPRIATE DAT DIENCY)	ETIO
F 745	Continued From page	e 21	F 74	15		
	and nursing assistant combative in shower 04/12/18-Nurse spok	t on hall. Resident became		weekly x (4) weeks, q 2 monthly x 2. Ongoing audits will be a	determined based	
	(on the unit Resident psychiatrist or psychi- in the facility once a w The nursing supervise physician's order for a	PM the nursing supervisor #39 resided) stated the atric nurse practitioner was week to assess residents. or stated if there was a a psychiatric referral it had to		on results of prior audit be reviewed weekly by and/or Director of Nurs monthly Quality Assura Performance Improven meeting.	Administrator ing and during nce and	
	arrangements could to nursing supervisor sta Responsible Party for consent for psychiatri if the social worker has	the facility social worker so be made for services. The ated she knew the r Resident #39 signed the ic services but wasn't aware ad been in contact with the o arrange an assessment for		The Director of Nursing responsible for impleme acceptable plan of corre above.	enting the	
	she was covering for managed care for Re returned back to work Worker #1 stated she period of time when c (like what Resident # psychiatric service bu	05/01/18 at 5:08 PM Social Worker #1 stated e was covering for Social Worker #2 (who naged care for Resident #39) until she urned back to work on 05/03/18. Social rker #1 stated she knew there had been a iod of time when certain insurance coverage e what Resident #39 had) was not covered for rchiatric service but knew that had changed in ril and now psychiatric services would be				
	covered. Social Worl practitioner's office to referral for services for reported they were no 04/13/18 for a psychi	ker #1 called the psychiatric o see if they had received the or Resident #39 and they ot aware of the order dated atric consult. Social Worker not explain what happened.				
	he was not aware of	AM the psychiatrist reported the 04/13/18 consult for #39 until 05/01/18. The				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2018 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY LETED			
		345350	B. WING _				C 03/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
COURTLAND TERRACE				23	300 ABERDEEN BOULEVARD		
COURTEA	IND TERRACE			G	ASTONIA, NC 28054		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 745	Continued From page psychiatrist stated he happened and was in Resident #39. On 05/02/18 at 10:45 (covering Resident #3 physician orders to be for a psychiatric const On 05/02/18 at 1:00 F stated she expected p followed and was not for a psychiatric const communicated to the On 05/03/18 at 2:00 F she was dependent o orders for a psychiatrist consult because she o noted she could not e On 05/03/18 at 7:00 F there had been insura until April but that had	AM the Nurse Practitioner AM the Nurse Practitioner By stated she expected followed; including orders ult. PM the Director of Nursing ohysician orders to be aware the 04/13/18 order ult had not been office of the psychiatrist. PM Social Worker #2 stated n nurses to provide her with ic consult. Social Worker #2 t was not informed of the did not know about it and explain what happened. PM the Administrator stated ance coverage issues up		745			
	when ordered by the Administrator stated h happened.	physician. The ne could not explain what					

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