	-	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY IPLETED
		345008	B. WING		C 03/22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				300 PROVIDENCE ROAD		
COMPLET	E CARE AT MYERS PAR	(N		CHARLOTTE, NC 28207		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP		COMPLETION DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	OPRIATE	
				,		
F 000	INITIAL COMMENTS		F 00	00		
		ed on May 7, 2018 and the				
		nd F 849 but decreased the				
		"D" for no actual harm with				
	-	than minimal harm that is				
	not immediate jeopar	-				
F 578	· ·	ntnue Trmnt;FormIte Adv Dir	F 57	78		4/19/18
SS=D	CFR(s): 483.10(c)(6)((8)(g)(12)(i)-(v)				
	.					
		ht to request, refuse, and/or				
		t, to participate in or refuse				
		rimental research, and to				
	formulate an advance	e directive.				
	\$492 10(a)(9) Nothing	a in this paragraph should be				
		g in this paragraph should be				
		t of the resident to receive cal treatment or medical				
		dically unnecessary or				
		alcally unnecessary of				
	inappropriate.					
	8483 10(a)(12) The f	acility must comply with the				
		d in 42 CFR part 489,				
	subpart I (Advance D					
		ts include provisions to				
		ritten information to all adult				
		the right to accept or refuse				
	medical or surgical tre					
	, and the second s	nulate an advance directive.				
	-	itten description of the				
		plement advance directives				
	and applicable State					
		nitted to contract with other				
		information but are still				
	legally responsible for					
	requirements of this s	•				
		ual is incapacitated at the				
	time of admission and					
		ate whether or not he or she				
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	F	TITLE		(X6) DATE

Electronically Signed

TITLE

04/16/2018

PRINTED: 05/29/2018

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.

	DF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	OMPLETED
						С
		345008	B. WING			03/22/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
COMPLET	E CARE AT MYERS PAP	sk	300 PROVIDENCE ROAD			
		uv		CHARLOTTE, NC 28207		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 578	Continued From page	e 1	F 57	8		
1 010		ance directive, the facility				
		rective information to the				
		representative in accordance				
	with State Law.					
		relieved of its obligation to				
		on to the individual once he				
	or she is able to rece	s must be in place to provide				
		individual directly at the				
	appropriate time.					
	This REQUIREMENT	Γ is not met as evidenced				
	by:					
		ons, staff interviews, and		Resident #67 code status		
		cility failed to clarify and		A code status validation au	-	
		tatus for 1 of 3 sampled ospice services (Resident		residents, including those re hospice services, has been	-	
	#67).	ospice services (resident			conducted.	
				To help ensure the deficien	t practice does	
	The findings included	l:		not reoccur, the facility will		
	-			current Hospice Services to	discuss how	
		admitted to the facility on		communicating resident up		
	-	es that included acute		status changes will be conc	•	
		eart failure (CHF) and		the election of services, Ho	•	
	dementia.			facility'□s Interdisciplinary (Team, and when available,		
	A review of the signif	icant change Minimal Data		and the Resident⊡'s Family		
	Set (MDS) assessme			Party, will meet to review th		
		d that Resident #67 was		Thereafter, Hospice Service		
		and was receiving hospice		invited to attend all other Re		
	services.			Plan Meetings. For weekly		
	A roviou of the acres	alon initiated on 2/28/18		changes in resident status,	•	
		olan initiated on 2/28/18 37 was receiving hospice		communicate with the resid		
		nd of life care. Interventions		facility 's nurse or nurse in		
		patient and family wishes		changes will be discussed a		
		of any change in condition		at the facility'⊡s weekly Ris		
	or medication change	es.		facilities Licensed nursing s	staff will be	
			1	educated on in process.		1

Facility ID: 953418

If continuation sheet Page 2 of 46

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345008	B. WING	C		
NAME OF P	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP CODE	03/22/2018	
				300 PROVIDENCE ROAD		
COMPLET	TE CARE AT MYERS PAR	RK		CHARLOTTE, NC 28207		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETI	
F 578	Continued From page	- 2	F 57	8		
1 370	 578 Continued From page 2 documents. A MOST (Medical Order Standard of Treatment) form was updated on 2/3/18 to DNR (Do Not Resuscitate) in the front of the chart by hospice staff indicating Resident #67 was a DNR. The physician order dated 5/11/17 read, Full Code and was entered into the electronic health record for Resident # 67. The nurse report sheet with the assignment that included Resident #67 indicated Full Code status. The plan of care for nursing assistants (NA) read, Full Code. An interview on 3/21/18 at 2:26pm with NA #2 revealed she was aware that Resident # 67 was a DNR because she happened to be at the facility on the day the resident arrived back to the facility and the Hospice Nurse was speaking with a family member. She indicated NAs review the electronic plan of care for code status and during the interview she read Resident #67 had a Full Code status listed. 		F 57	 To help ensure this plan of correct effective, the facility will review all residents receiving Hospice Serv code status during its weekly Ris Meeting. The Director of Nursing will also conduct a weekly review minimum of 7 non-hospice reside status to ensure accuracy. This a be conducted weekly for 4 weeks Thereafter, the audit will be cond twice monthly for two months and once per month for 3 months. Results will be shared with Admir weekly, and the facility Quality As and Performance Improvement Committee Monthly until substan compliance is determined. 	I ices k Services of a ents code nudit will s; ucted d then nistrator ssurance	
	was conducted. She facility as needed and Resident #67 before interview she read or Resident # 67 was a the paper chart during MOST form updated 2/3/18. A review of the teleph Hospice records date Coordinator called Ho #67 was a DNR or a Nurse informed the M resident was a DNR a	18 at 4:56pm with Nurse #3 stated she worked in the d had not worked with this night. During the n her assignment form that Full Code. She looked in g the interview and saw a to DNR code status as of none encounter noted in the ed 3/21/18 read the MDS ospice to verify if Resident Full Code. The Hospice MDS Coordinator that the according to the MOST form ission with hospice services				

		ND HUMAN SERVICES			FOF	ED: 05/29/20 RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		TE SURVEY MPLETED
		345008			C 03/22/2018	
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
OMPLET	E CARE AT MYERS PAF	RK		300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(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 CON (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 578 F 584 SS=B	had not been aware of and an order had not An interview with the 4:30pm revealed she Hospice group caring the coordination and Hospice group and th An interview on 3/22/ Director of Nursing (ID DON stated she was group working with R aware they followed a communication on ne as the other hospice stated it was her expo status to be verbally so we could have cha updated the care plan An interview with the 2:36pm revealed he of communicate any cha the facility could upda care for the resident. Safe/Clean/Comforta CFR(s): 483.10(i) (1)- §483.10(i) Safe Envir The resident has a rig	bice nurse that the facility of the updated MOST form been written. Unit Manager on 3/21/18 at was unaware of the new of for Resident #67 and felt communication between the he staff had not happened. (18 at 12:02pm with the DON) was conducted. The aware of the new Hospice esident #67 but was not a different process for ew orders and assessments groups utilized. The DON ectation for a change to DNR communicated to the facility anged the orders and n. Administrator on 3/22/18 at expected hospice to anges to the MOST form so ate the records and better ble/Homelike Environment (7) ronment. ght to a safe, clean, ielike environment, including eiving treatment and	F 578			4/19/18
	The facility must prov §483.10(i)(1) A safe,	ride- clean, comfortable, and				

Facility ID: 953418

If continuation sheet Page 4 of 46

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345008	B. WING			03/22/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLETE CARE AT MYERS PARK					00 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG				(X5) COMPLETION DATE
F 584	use his or her person possible. (i) This includes ensu receive care and serv physical layout of the independence and do (ii) The facility shall en- the protection of the r or theft. §483.10(i)(2) Housek services necessary to and comfortable inter §483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private resident room, as spe §483.10(i)(5) Adequa levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observatio #53, a family member to maintain clean floo	t, allowing the resident to al belongings to the extent ring that the resident can rices safely and that the facility maximizes resident bes not pose a safety risk. xercise reasonable care for esident's property from loss eeping and maintenance o maintain a sanitary, orderly, ior; ed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); te and comfortable lighting table and safe temperature ly certified after October 1, temperature range of 71 to maintenance of comfortable is not met as evidenced ms, interviews with Resident r, and staff, the facility failed rs for 5 consecutive days in s (301, 305, 310, 311, 319	F	584	Rooms cited during the survey (301, 3 310, 311, 319, 321) have been cleaned All other facility rooms have been clean swept, and mopped. To help ensure the deficient practice do	d. ned,	

Facility ID: 953418

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP		STRUCTION		ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			1 Y /	OMPLETED
							С
		345008	B. WING			03/22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STATE, ZIP CODE		
	E CARE AT MYERS PAF	5K		300 PR	OVIDENCE ROAD		
				CHARLOTTE, NC 28207			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 584	Continued From page	e 5	F 58	4			
	The findings included		1 00		t reoccur, all facility housekeeping	staff	
					I be retrained on the facility s	otan	
	An observation occur	red on 3/18/18 from 11:45			ntracted cleaning service room an	d	
		perimeter of the floor in		flo	or cleaning process.		
		305, 310, 311, 319 and 321			monthly cleaning schedule will be		
		ection of dust and debris.			plemented to ensure each resider		
		hese resident rooms was a			om is deep cleaned monthly and u charge of existing residents. Com		
	large collection of due	si, debris and trasif.			eas will be addressed daily and as		
	Follow up observation	ns of the same rooms at the			eded. The facility administrator an		
	-	revealed the collection of			usekeeping manager will audit ea		
	-	n remained on the floor:			ily deep cleaned room and 3 rand		
	3/19/18 from 11:15 A				ily cleans 4 times weekly, for 4 we		
	3/20/18 from 1:30 PM				ereafter, the audit will be conducted		
	3/21/18 from 11:30 A 3/22/18 from 2:50 PM				ce weekly every week for two mo		
	3/22/18 If 0ff1 2:50 PW	1 - 3:00 PM			d then once per week every week onths.	TOP 3	
	During an interview w	vith Resident #53 (alert and			51013.		
		3 at 10:48 AM, he stated that		Re	sults will be shared the contracted	b	
	,	ve a little trash on the floor."		ho	usekeeping services Regional Dir ekly, and_the facility⊡s monthly 0	ector	
		mily member of a resident		As	sessment and Performance		
		rred on 03/20/18 at 1:20 PM			provement (QAPI)Committee mor	nthly	
		e visited the facility almost			til substantial compliance is		
	· ·	ns with the cleanliness of the		de	termined.		
		is. The family member sh and clutter" behind the					
		ent that had been "there for					
	An interview with Hou	usekeeping Staff (HKS) #1					
		at 2:50 PM. During the					
		305, 310, 311, 319, and 321					
		lust, debris and trash which					
		r with heavy accumulation of hehind resident doors.					
		as routinely assigned to					
	clean resident rooms						
		practice when providing					

If continuation sheet Page 6 of 46

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/22/2018	
		345008	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	E CARE AT MYERS PAI	RK		800 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 584	swept, moped, duste emptied trash and cle stated one room was per management dire she cleaned resident day, completed her a and had to leave bed here." An interview with the (HKM) and observati 305, 310, 311, 319 a PM revealed the floo debris and trash rem stated his routine pra house keeping servic after breakfast, after the day. The HKM s concern with the clear resident rooms on the expected HKS to ma would do a better job cleanliness. The Administrator sta 03/22/18 at 4:05 PM	es and stated that she d each resident room, eaned bathrooms. She d deep cleaned each week ection. HSK #1 stated that rooms on the 3rd floor that assignment as best she could ause she stated "my ride is Housekeeping Manager on of resident rooms 301, nd 321 on 03/22/18 at 3:00 rs in these rooms had dust, aining on the floors. HKM actice was to monitor the ces of his staff 3 times daily, lunch and before he left for stated he had not noticed a anliness of the floors in e 3rd floor, but that he intain floors clean and he of monitoring the floors for ated in an interview on that he expected HKS to ident rooms clean, daily. essments & Timing	F 584			4/19/18
-	§483.20 Resident As The facility must con a comprehensive, ac	sessment duct initially and periodically				
	§483.20(b) Compreh					

Facility ID: 953418

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345008	B. WING			C 03/22/2018	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	COMPLETE CARE AT MYERS PARK				300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG			ID PREFI TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 636	 §483.20(b)(1) Reside A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following: Identification and d Customary routine Cognitive patterns Communication. Voision. Mood and behavid Psychological wei Continence. Continence. Disease diagnosis Activity pursuit. Skin Conditions. Skin Conditions. Special treatmen Medications. Special treatmen Discharge planni Xvii) Documentation regarding the addition on the care areas trig the Minimum Data Sei Icviii) Documentation assessment. The assinclude direct observation assessment. The assinclude direct observation members on all shifts 	ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least demographic information br patterns. II-being. ing and structural problems. and health conditions. onal status. ts and procedures. ing. of summary information hal assessment performed gered by the completion of tt (MDS). of participation in sessment process must ation and communication well as communication with used direct care staff	F	636			

Facility ID: 953418

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CENTERS	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				M APPROVE <u> 0938-039</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
	345008		B. WING		C 03/22/2018	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	E CARE AT MYERS PAI	PK		300 PROVIDENCE ROAD		
				CHARLOTTE, NC 28207		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 636	Continued From page	e 8	F 63	36		
		in paragraphs (b)(2)(i)				
	•	ection. The timeframes				
	• • •	43(b) of this chapter do not				
	apply to CAHs.					
		r days after admission,				
	excluding readmissic	ons in which there is no				
		the resident's physical or				
		or purposes of this section,				
		a return to the facility				
		y absence for hospitalization				
	or therapeutic leave. (iii)Not less than once					
		T is not met as evidenced				
	by:					
	•	view, observations and staff		The CAA for residents #35,	#43. and	
		failed to complete Care Area		#245 were completed.	-,	
		that addressed and provided				
	an analysis of underl	ying causes and contributing		All other current residents w	ere audited to	
		areas of nutrition 2 of 3		ensure CAAs (Care Area As	sessments)	
		Resident #35, 43) and		were completed.		
	· ·	oled residents (Resident				
	#245).			To help ensure the deficient		
	Finding in aluded.			not reoccur, the facility MDS		
	Finding included:			and Director of Nursing Serv reeducated on proper compl		
	1 Resident #43 was	admitted on 01/08/2018 with		CAA (Care Area Assessmen		
		led protein malnutrition,		facility s Interdisciplinary Ca		
	diabetes, and Parkin	-		was also reeducated on pro		
				completion of resident CAAs		
	Review of the nutritic	on Care Area Assessment		Assessments).		
	. ,	018 documented there was				
		sis of the finding to support		The facility MDS Coordinato		
	proceeding to the car	re plan.		a weekly audit of all Admissi		
	D . (4 /			and Significant Change Asse		
	Review of the nutritic			ensure CAA (Care Area Ass		
		nted the resident with a 5%		complete. This audit will be		
	weight loss.			weekly for 4 weeks; Thereaf		
				will be conducted twice mon	thu for two	

Facility ID: 953418

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 05/29/2018 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345008	B. WING			C 03/22/2018	
NAME OF P	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	E CARE AT MYERS PAR	SK.		30	00 PROVIDENCE ROAD		
		u.		С	HARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 636	Continued From page	<u>-</u> 9	F	636			
		018 documented Resident		000	months.		
	#43 was on a therape						
	extensive assistance	with eating.			Results will be shared with Administra		
	Observation on 02/20)/2018 at 10:09 AM of the			weekly, and the facility Quality Assurate	ince	
	Resident # 43 reveale				and Performance Improvement Committee Monthly until substantial		
	breakfast by a nurse	u			compliance is determined.		
	Interview on 03/22/20)18 with the Registered					
) AM revealed she was					
		for Resident #43. She stated					
	does not complete the (CAA).	e Care Area Assessment					
	Dietary Manager (DM completed the Care A	Area Assessment (CAA) ne stated the analysis should					
	Interview on 03/22/20	018 at 10:08 AM with the					
	MDS coordinator stat doing the Care Area	ed is a collaborative effort Assessment (CAA). It is my					
	responsibility to see i	t's there and complete.					
		018 at 11:42 AM the Director					
	of Nursing (DON) sta						
		vas driven from all data for					
		lent. It was to be detailed their specific needs. She					
	stated it was her expe	•					
	complete with a good						
		s admitted on 01/17/2018 ncluded dementia, Lewey essure ulcers.					
	Review of the of prog 01/24/2018 for skin c	ress notes dated ondition documented in the					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD		/IB NO. 0938-0391 3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD		(X3) DATE SURVEY COMPLETED	
		C 03/22/2018	
	E		
COMPLETE CARE AT MYERS DARK 300 PROVIDENCE ROAD			
COMPLETE CARE AT MYERS PARK CHARLOTTE, NC 28207			
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF COPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTIONTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE DEFICIENCY)	ION SHOULD BECOMPLETTHE APPROPRIATEDATE		
F 636 Continued From page 10 F 636 weekly care management meeting that Resident #245 was seen by the wound care specialist on 01/24/2018 for her wounds which included a Stage 4 to her sacrum. Treatments were ordered for each of her wounds. It documented supplements, heels boots and an air mattress to aid in wound healing. F 636 Review of the admission MDS dated 1/30/2018 documented Stage 4 pressure ulcer. Review of the wound specialist note dated 03/14/2018 documented a Stage 4 pressure ulcer. Review of the CAA dated 01/30/2018 for pressure ulcer. Review of the CAA dated 01/30/2018 for pressure ulcer. Review of the CAA dated 01/30/2018 for pressure revealed no analysis of findings. Observation on 03/20/2018 at 10:45 AM of wound care provided by the Wound Nurse #1 revealed the resident with a Stage 4 wound on her sacrum. Interview on 03/20/2018 at 10:45 AM with Wound Nurse #1 revealed and and untiliple pressure wounds and currently has only one pressure wound being treated. She stated she does daily wound care. Interview on 03/22/2018 at 08:29 AM the MDS coordinator stated developing a CAA is a collaborative process and other disciplines put in their areas with information. She stated she was the facilitator. She requested information to put in the GAA before Cosing it. The CAA should be filled out by the respective disciplines, so the pressure CAA and there was room for improvement.			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345008	B. WING			C 03/22/2018	
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
COMPLET	E CARE AT MYERS PAR	ĸ			300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 636	Continued From page	e 11	F	636	5		
	Interview on 03/22/2018 at 09:56 AM Wound Nurse #1 stated she filled out Section M on the MDS but never Section V for the CAA.						
	MDS coordinator stat doing the Care Area	018 at 10:08 AM with the ed is a collaborative effort Assessment (CAA). It is my t's there and complete.					
	of Nursing (DON) sta Assessment (CAA) w that area for the resid	as driven from all data for lent. It was to be detailed their specific needs. She ectation the CAA was					
	03/04/13 with diagnos	admitted to the facility on ses which included and chronic obstructive					
	01/11/18 revealed Re received notification of	ed Dietician's note dated esident #35's physician of weight loss with approval e times daily and an appetite					
	Minimum Data Set (M revealed an assessm cognition. The MDS required the limited a eating and a loss of 5 last month or more th	ent of severely impaired indicated Resident #35 ssistance of one person with % percent or more in the					

Facility ID: 953418

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345008	B. WING				/22/2018
NAME OF P	ROVIDER OR SUPPLIER	L		ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
COMPLET	E CARE AT MYERS PAR	ĸ			300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)				(X5) COMPLETION DATE	
F 636	Area Assessment (C/ Review of Resident # 02/03/18 revealed no with a description of t factors and risk factor CAAs listed Resident 10% over the last 6 m documentation of an supporting the decision proceed to the care p Observation on 03/20 Resident #35 consum meal. Nurse Aide (N/ of the food location an Interview with NA #1 revealed Resident #3 from 0% to 50% for a Observation on 03/20 Resident #35 refused Interview with Nurse a revealed Resident #3 daily nutritional suppl 100%. Interview with the Reg 03/22/18 at 9:01 AM Resident #35's nutrition the facility did not incl CAA.	AA). 35's Nutritional CAA dated documentation of findings he problem, contributing related to nutrition. The #35 with "a weight loss of nonths." There was no analysis of findings on to proceed or not to lan. 118 at 8:58 AM revealed hed 50% of the breakfast A) #1 informed Resident #35 nd type with verbal cues. on 03/20/18 at 9:00 AM 5's intake varied and ranged Il meals. 118 at 12:51 PM revealed the lunch meal. #1 on 03/21/18 at 10:20 AM 5's acceptance of the thrice ement ranged from 0% to gistered Dietician on revealed she monitored onal status but her role in lude documentation in the	F	636			
	at 9:46 AM revealed s analysis of findings si	S Coordinator on 03/22/18 she did not document an upporting the decision to ceed to care plan. The MDS					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/29/20 FORM APPROVE OMB NO. 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345008	B. WING		C 03/22/2018		
NAME OF P	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP COD			
COMPLET	E CARE AT MYERS PAR	ĸ	300 PROVIDENCE ROAD CHARLOTTE, NC 28207				
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIO E APPROPRIATE DATE		
F 636	contain a comprehen Interview with the Dir at 9:48 AM revealed	the Nutritional CAA did not sive assessment. ector of Nursing on 03/22/18	F 636				
F 640 SS=B	analysis of findings. Encoding/Transmittin CFR(s): 483.20(f)(1)-	g Resident Assessments (4)	F 640		4/19/18		
	a facility completes a facility must encode t each resident in the f (i) Admission assess (ii) Annual assessme (iii) Significant chang (iv) Quarterly review a (v) A subset of items reentry, discharge, ar	ng data. Within 7 days after resident's assessment, a he following information for acility: ment. nt updates. e in status assessments. assessments. upon a resident's transfer, nd death. e-sheet) information, if there					
	after a facility comple a facility must be cap CMS System informa contained in the MDS standard record layou	itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident in a format that conforms to uts and data dictionaries, dardized edits defined by					
	14 days after a facility assessment, a facility	ittal requirements. Within y completes a resident's y must electronically transmit nd complete MDS data to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/29/2018 MAPPROVEE D. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345008	B. WING				/22/2018	
	ROVIDER OR SUPPLIER	ĸ		30	REET ADDRESS, CITY, STATE, ZIP CODE 10 PROVIDENCE ROAD HARLOTTE, NC 28207	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 640	 (iv) Significant correct (v) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, and (viii) Background (faction initial transmission of does not have an address of the second of the	luding the following: nent. nt. e in status assessment. tion of prior full assessment. ion of prior quarterly a upon a resident's transfer, nd death. re-sheet) information, for an MDS data on resident that mission assessment. rmat. The facility must ormat specified by CMS or, an alternate RAI approved t specified by the State and iews and record review, the mit discharge Minimum Data n for 3 of 6 sampled (Residents #1, #2 and #3). I: admitted to the facility on ged on 10/02/17. Data Set (MDS) transmittals on MDS dated 09/26/17 was ras no transmittal of a esident #1. DS Coordinator on 03/22/18 a discharge MDS was not	F	640	Discharge Assessments for Reside #1, #2, and #3 were completed. A discharge assessment was comp for all residents discharged June 5, to March 22, 2018. To help ensure the deficient practice not reoccur, the facility MDS Coord and Director of Nursing Services we reeducated on proper completion o MDS Discharge Assessment. The f MDS Coordinator will run a weekly Missing Resident Report to ensure discharged residents have a comple discharge Assessment. This audit w conducted weekly for 4 weeks; Thereafter, the audit will be conducted	leted 2017 e does inator ere f the acility all eted vill be		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/29/2018 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345008	B. WING				C / 22/2018
NAME OF PI	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	E CARE AT MYERS PAF	RK			00 PROVIDENCE ROAD HARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 640	Continued From page	e 15	F	640			
		the omission was an error.			twice monthly for two months and the once per month for 3 months.	n	
	at 2:52 PM revealed discharge MDS to be			Results will be shared with Admin and Director of Nursing Services and the facility Quality Assurance		kly,	
	12/20/16 and dischar	-			Performance Improvement Committee Monthly until substantial compliance h been determined.		
	revealed an admissic quarterly MDS dated 09/29/17 were transn	Data Set (MDS) transmittals on MDS dated 01/06/17, 04/04/17, 06/30/17 and nitted. There was no arge MDS for Resident #2.					
	at 2:49 PM revealed a transmitted for Reside	DS Coordinator on 03/22/18 a discharge MDS was not ent #2. The MDS the omission was an error.					
		ector of Nursing on 03/22/18 she expected Resident #2's transmitted.					
	3. Resident #3 was a 09/20/17 and dischar	admitted to the facility on ged on 10/19/17.					
	at 2:49 PM revealed transmitted for Resid	OS Coordinator on 03/22/18 a discharge MDS was not ent #3. The MDS the omission was an error.					
		ector of Nursing on 03/22/18 she expected Resident #3's					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			/		с
		345008	B. WING		03/22/2018
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			:	300 PROVIDENCE ROAD	
COMPLET	E CARE AT MYERS PAR	RK		CHARLOTTE, NC 28207	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTIO
F 640	Continued From page	e 16	F 640		
1 010	discharge MDS to be		1 040		
F 657	Care Plan Timing and		F 657	,	4/19/18
SS=D	CFR(s): 483.21(b)(2)		1 007		
	 be- (i) Developed within the comprehensive a (ii) Prepared by an inincludes but is not lining (A) The attending phy (B) A registered nursing resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and the resident and the resident region of practicable for the resident's care plan. (F) Other appropriated disciplines as determined and the resident and reviewed and r	terdisciplinary team, that nited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined e development of the e staff or professionals in nined by the resident's needs ne resident. vised by the interdisciplinary essment, including both the		Resident #245 care plan was updated help ensure interventions were identifi	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY	
and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		345008	B. WING		0.	C 3/22/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/22/2010	
COMPLET	E CARE AT MYERS PAR	RK		300 PROVIDENCE ROAD CHARLOTTE, NC 28207			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 657	Continued From page	Continued From page 17		7			
	diagnoses that includ disease and pressure Review of the of prog 01/24/2018 for skin of weekly care manage #245 was seen by th 01/24/2018 for her w Stage 4 to her sacrur for each of her wound	gress notes dated condition documented in the ment meeting that Resident e wound care specialist on ounds which included a m. Treatments were ordered		 conducted to ensure interventions identified to help ensure residents are addressed. To help ensure the deficient pract no reoccur, the facility s Interdisc Care Plan Team has been reeduc ensuring interventions are identifi address resident needs. The Director of Nursing Services Manager will review a minimum o residents' care plan during the fac weekly Risk Meeting to help ensurinterventions are identified and residents 	ice does ciplinary cated on ed to or Unit f 7 cility's ire		
	aid in wound healing. Review of the care pl documented a focus one intervention whic Scale per Living Cen Review of the admiss	lan dated 01/25/2018 area for pressure ulcer and ch was "complete Braden		 needs are addressed. This audit v conducted weekly for 4 weeks; Thereafter, the audit will be conducted weekly for two months and once per month for 3 months. Results will be shared with Admin weekly, and the facility Quality As and Performance Improvement Committee Monthly until substant 	ucted I then istrator surance		
	documented "resider			compliance is determined.			
	Observations of Resi						
	03/19/2018 at 09:19 air mattress	AM Resident #245 in bed on					
	03/21/2018 at 07:45 positioned on left side	AM Resident # 245 e in bed, on air mattress					
		AM Resident #245 received nt for wound healing via					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	
		345008	B. WING				22/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	E CARE AT MYERS PAR	ĸ			0 PROVIDENCE ROAD HARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 657	Continued From page	2 18	F6	657			
	03/21/2018 at 4:00 PI with wedge to right sig	M Resident # 245 positioned de, on air mattress					
	Nurse #1 revealed sh to Resident #245. Inter mattress, supplement were in place to prom prevent any new pres	18 at 10:45 AM with Wound e provided daily wound care ervention including an air t, and boots for her heels tote wound healing and soure areas. She stated the t made rounds weekly.					
	coordinator stated the responsibility to comp	18 at 05:55 PM the MDS care plans are her plete and the pressure ulcer nplete Braden Scale was					
F 695 SS=D	of Nursing (DON) stat to have interventions needs and for them to Respiratory/Tracheos	18 at 05:57 PM the Director ted she expected care plans to meet the residents' care b be complete. tomy Care and Suctioning	F6	395			4/19/18
	§ 483.25(i) Respirator tracheostomy care an The facility must ensu- needs respiratory care care and tracheal suc- care, consistent with p practice, the compreh care plan, the residen and 483.65 of this sul This REQUIREMENT by: Based on observation	d tracheal suctioning. Ire that a resident who e, including tracheostomy tioning, is provided such professional standards of hensive person-centered tts' goals and preferences,			The process leading to the cited deficiency was due to lapse in		

Facility ID: 953418

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						NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING	3		С
		345008	B. WING			3/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/22/2016
COMPLET	E CARE AT MYERS PAP	RK		300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 695	Continued From page	o 10	F 69	5		
1 000			F 09		cility and	
	Physician interviews, administer oxygen as	s care planned by hospice		communication between the fa the resident's hospice service	-	
		idents sampled for oxygen		Resident #67 Hospice Admissi		
	therapy (Resident #6			for oxygen intervention were n		
				implemented as prescribed. O		
	The findings included	1:		provided to resident #67 as or	dered on	
				3.21.18.		
		dmitted on 3/20/17 and				
	readmitted to the faci			An audit of all other residents i		
	-	led acute systolic congestive lementia, and anxiety		oxygen, including those on hose services, was conducted to en		
	disorder.	iementia, and anxiety		plans and orders were followed		
		icant change Minimal Data		To help ensure the deficient pr		
	Set (MDS) assessme			no reoccur, the facility Interdise		
		d that Resident #67 was had an anxiety disorder and		Care Plan Team met with Resi Hospice Provider, on 4.4.18 to		
		ing hospice services.		how communicating resident u		
		ing hospice services.		status changes will be conduct		
	A review of the Certif	ication of Terminal illness		facility has also met with all oth		
	Attestation Statemen	t dated 2/5/18 with a start		Hospice Service Providers to c		
		spice services revealed		communicating resident update	es and	
		esented to the emergency		status changes. On 4.18.18 th		
		18 with acute dyspnea		of Nursing Services will in-serv		
	,	related to an exacerbation		nursing staff on recognizing re		
		7 had signs of marked enough oxygen in the blood		and symptoms of respiratory d how to respond to residents in		
	•••	tions), pleural effusion (fluid		distress. In-servicing will also i		
		lungs and chest), and		reeducating the Nursing staff of		
	•	(enlarged heart). During		understanding Resident Care		
	this hospitalization sh			care plan purpose, location, ar		
		us (IV) diuretics with some		communication and implement		
	•	prognosis was slim due to		updates. Nursing staff not pres		
	-	ilure. Resident #67 was		be allowed to work until in-serv	vicing has	
		ne nursing facility after an		been completed.		
		amily to accept Hospice		Linon the election of convision	Hospics	
		a palliative approach to care ptions for hospitalizations.		Upon the election of services, the facility' Is Interdisciplinary		
				Team, and when available, the		

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		MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345008	B. WING		02/	
	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP		22/2018
				300 PROVIDENCE ROAD	OODE	
COMPLET	E CARE AT MYERS PAR	ĸĸ		CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 695	Continued From page	<u>></u> 20	F 60	15		
F 695	A review of the Hospi revealed Resident #6 respiratory function a assessing effectivene oxygen therapy. A review of the Hospi for Resident #67 reve orders were listed un interventions to admi when resident had dy demonstrate dyspnea by a nurse. Further of symptoms remained minutes, the clinician liters per minute (LPN uncontrolled after an clinician may increase flow of 4 LPM. A review of the facility dated 1/31/18 and ref focus or interventions cardiac functions. A review of the Hospi dated 3/19/18 revealed have periods of incre due to disease progre breathe on room air. continue to educate s needed for symptom A review of the Hospi Resident #67 dated 3	ice care plan dated 2/3/18 7 had an alteration in nd interventions included ass and compliance with fice care plan dated 2/3/18 ealed Hospice admission der problem and gave nister oxygen as ordered, vspnea, non-verbal indicators a, or dyspnea was assessed directions included if uncontrolled after 30 may increase oxygen to 3 <i>A</i>). If symptoms remained additional 30 minutes, the e oxygen up to a maximum <i>y</i> care plan for Resident #67 vised on 2/26/18 revealed no a related to respiratory or fice Nurse routine visit note ed Resident #67 continued to ased shortness of breath ession but continued to The Hospice Nurse wrote to staff on using oxygen as management. fice Service Narrative note for 8/19/18 read, the Hospice se #2 to use oxygen as	F 69	 and the Resident's Family Party, will meet to review Thereafter, Hospice Servi invited to attend all other f Plan Meetings. For weekly order changes. Hospice w to the resident s family/re and the facility' s nurse of charge. These changes w at the facility' s weekly R all other residents, order of communicated to the resident nurse in charge and addre facility's Licensed Nursing educated on this change if during the 4.18.18 in-serv To help ensure this plan of effective, the facility will re- residents receiving Hospic order changes during its w Meeting. The Director of N or Unit Manager will also of weekly review of a minimu non-hospice residents for This audit will be conducted for 4 weeks; Thereafter, th conducted twice monthly fand then once per month The Director of Nursing S Manager will also audit a nursing staff employees w recognizing resident signs of respiratory distress, and respond to residents in re- distress. Additionally, a m 	the plan of care. ces will be Resident Care y updates or vill communicate esponsible party, or nurse in vill be addressed isk Meeting. For changes will be dent nurse or essed during the ting. The y staff will be in process icing. f correction is eview all ce Services for veekly Risk Nursing Services conduct a um of 7 order changes. ed once weekly he audit will be for two months for 3 months. ervices or Unit minimum of 5 veekly on s and symptoms d how to spiratory	
	A review of the order	-		employees weekly will be knowledge of Care Plans,	audited on their	

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		MEDICAID SERVICES				NO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			ATE SURVEY OMPLETED	
		345008	B. WING			C 03/22/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
COMPLE	TE CARE AT MYERS PAR	ĸ		300 PROVIDENCE ROAD CHARLOTTE, NC 28207			
(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 AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 695	Resident #67 dated 2 revealed no orders to to administer oxygen breath or symptoms of A review of the oxyge Resident #67 reveale dated 1/25/18 prior to read 97% on room ain An observation on 3/7 Resident #67 was ea on 300 Hall. Residen accessory muscles po she ate approximately Resident #67 was not at this time. An interview on 3/19/ Hospice Nurse was c she was aware of Resident to use her ac and at times used put stated the floor staff v care plan located in Fibeen educated to adr (PRN) when the resid shortness of breath. stated that no PRN m over the past 24 hour Resident #67 was sitt dining room on 300 H uncomfortable, holdin	 1/2/18 through 3/20/18 check oxygen saturation or as needed for shortness of of dyspnea. an saturation summary for d the last assessment was other rehospitalization that r. 18/18 at 12:33pm revealed ting lunch in the dining room at #67 was noted to use eriodically through lunch as y 50% of her meal. t receiving portable oxygen 18 at 11:39am with the onducted. She indicated sident #67 having periods of nd had assessed the cressory muscles to breather sed breathing. The Nurse vere aware of the Hospice Resident #67's chart and had minister oxygen as needed lent had intermittent She revealed Nurse #2 hedications had been given s and no changes with 	F 69	5 include the care plan purpose, I and communication and implem of updates. This audit will be co once weekly for 4 weeks; There audit will be conducted twice m two months and then once per t three months. Results will be shared with Adm weekly, and the facility Quality / and Performance Improvement Committee Monthly until substa compliance is achieved.	nentation nducted eafter, the onthly for month for ninistrator Assurance		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345008	B. WING				U 22/2018
NAME OF PI	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
COMPLET	E CARE AT MYERS PAR	ĸ			300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	receiving portable oxy An observation on 3/2 Resident #67 sitting in dining room on 300 H be uncomfortable, sci breathing heavy. Res portable oxygen at thi An observation on 3/2 Nurse #2 walked up t pick up towels but did to be discomfort with muscles and pursed H An observation on 3/2 Resident #67 in the d served by staff. Resid her eyes closed, hold accessory muscles to Resident #67 was not at this time. An observation on 3/2 performing incontinent she laid flat on her bat was moaning and stat repeatedly. It was not using accessory muscles oxygen at this time. T observed in Resident An interview on 3/21/	ygen at this time. 21/18 at 9:59am revealed h her wheel chair in the Iall. She again appeared to ratching her back and sident #67 was not receiving is time. 21/18 at 10:02am revealed to Resident #67's table to I not address what appeared the use of accessory preathing. 21/18 at 12:31pm revealed ining room as lunch was dent #67 sat at the table with ing her neck, using b breathe, and fidgeting. t receiving portable oxygen 21/18 at 2:23pm of NA #2 nec care to Resident #67 as neck revealed the resident ted, "Oh Lord, oh Lord" ted that Resident #67 was cles and pursed breathing to i7 was not receiving portable here was no oxygen #67's room. 18 at 2:26pm with NA #2	F	695			
	67 received Hospice Resident # 67 had ne had no breathing prof	#2 revealed that Resident # services. NA #2 stated ver used oxygen before and olems that she was aware ared for Resident # 67					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/29/2018 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345008	B. WING		-		C 22/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
COMPLET	E CARE AT MYERS PAR	ĸ		00 PROVIDENCE ROAD			
(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 TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 695	An interview on 3/21/ indicated she was ver and the resident had concerns that she cou oxygen had never bee and explained she ha January and was sen came back on Hospic earlier in the week ha changes regarding Re no. Nurse # 2 explair always had a lot of ar "Oh Lord, oh Lord," w up and down, she wa #2 explained the resid saturation levels chec during the interview p Oxygen Saturation Su health records. Nurse was checked on 1/25, must have been an or orders off when Resid the hospital." Due to 67 was exhibiting, lyir accessory muscles, a surveyor requested N level for Resident # 6 An observation on 3/2 Resident #67 lying fla accessory muscles, a #2 asked Resident #6	and relationship with her. 18 at 3:10pm with Nurse #2 ry familiar with Resident #67 never had any respiratory uld remember. She stated en used for Resident # 67 d gotten really sick in t out to the hospital and te. Nurse #2 revealed a lady d asked me questions about esident #67 and she replied ned Resident #67 had exitely and when she states, hile moving her shoulders s expressing anxiety. Nurse dent got their oxygen sked on shower days and ulled up Resident #67's ummary on the electronic te #2 stated the last reading /18. Nurse #2 stated, "It versight and we left the dent #67 came back from the symptoms Resident # ng flat in bed, using nd pursed breathing, this urse #2 check the oxygen 7 during the interview. 21/18 at 3:25pm revealed t in her bed, using nd pursed breathing. Nurse 67 if she wanted her head he resident stated, "Yes, sesssment of the oxygen esident #67 recorded 85% 2 went to get another	F 695				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		345008	B. WING				C / 22/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
				3	300 PROVIDENCE ROAD		
COMPLET	E CARE AT MYERS PAR	(N		0	CHARLOTTE, NC 28207		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	revealed she also obs her accessory muscle She stated she felt ba- it was the resident's a the difficulty breathing stated she would call oxygen orders and tai (DON). An observation on 3/2 Resident #67 in bed we elevated while she re- cannula at 2 LPM. No or pursed breathing we An interview with Nur- revealed Resident #6 of 99% on oxygen at felt bad because she so much. She stated the Hospice services and did not know that chart. She stated Re- resident in the facility new Hospice group a education on what to orders and communic had not received any group regarding Reside An interview on 3/21/	m air on the second 18 at 3:33pm with Nurse #2 served Resident #67 using a abecause she had thought inxiety and had overlooked g signs and symptoms. She Hospice immediately for Ik to the Director of Nursing 21/18 at 4:26pm revealed with the head of the bed ceived oxygen via nasal o use of accessory muscles vere observed. se #2 on 3/21/18 at 4:26pm 7 had an oxygen saturation 2 LPM. Nurse #2 stated she cared about Resident #67 she was not familiar with Resident #67 was the first to receive services from the nd she had not received any expect as far as receiving ration. She indicated she education from the Hospice	F	695			
	group and did not kno	regarding the new Hospice ow anything about the he stated she expected to					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/29/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345008	B. WING				C 22/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	E CARE AT MYERS PAR	К		-	300 PROVIDENCE ROAD		
				Ľ	CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 695	see Hospice notes in Hospice groups utilize An interview on 3/21/ revealed she was uns assessed Resident ## #67 was receiving Ho know it was with a ne she would recognize extra effort to breathe an indicator. She exp started Roxanol and a signs and symptoms use of accessory mus reading 83-85%. She professional opinion F comfort status with th An interview on 3/21/ revealed oxygen wou the night due to the a afternoon.	the chart like the other ed in the facility. 18 at 4:44 pm with the NP sure of when she last 57. She knew that Resident spice services but did not w group. The NP indicated respiratory distress as using and pursed breathing was olained she would have administered oxygen with exhibiting pursed breathing, scles and oxygen saturations a revealed in her Resident #67 was not in e described symptoms. 18 at 4:56pm with Nurse #3 Id be administered through ssessment from the 18 at 5:02pm with NA #3	F	695			
	revealed she had wor months and had hear	ked in the facility for a few d Resident #67 state, "Oh o breathing problems that					
	aware of Resident #6 Hospice group and di facility. He added tha the Hospice care plar revealed when a resid and accessory muscle	ctor revealed he was not 7 receiving care from a new d not know they were in the it he nor his NP had seen h. The Medical Director dent used pursed breathing es with oxygen saturation 85% then he considered the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/29/2018 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345008	B. WING					C 22/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
COMPLET	E CARE AT MYERS PAR	ĸ			00 PROVIDENCE ROAD			
				С	HARLOTTE, NC 28207			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BI		(X5) COMPLETION DATE
F 695	Continued From page oxygen.	26	F	695				
	who had assisted Res 3/18/18, stated the res	18 at 10:50am with Nurse #4 sident #67 during lunch on sident's chest movements v extra since she had worked vare of any breathing						
	Hospice Supervisor re	18 at 11:09am with the evealed plans of care and eviewed every 14 days by Director.						
	Hospice Medical Diressaturation levels were the Hospice Nurses. admission notes and 2/3/18 to the facility M Hospice Medical Dirent not get a response, he to his medical office. Director stated he did # 67. He stated by th sounded like she was explained that if Reside better from applying of clinically better from the indicating Resident #6	e not routinely checked by He explained that the initial care plan were faxed on ledical Director. The ctor explained since he did e hand-delivered the forms The Hospice Medical not directly know Resident e description given it uncomfortable. He dent # 67 was suddenly oxygen then she was he oxygen administered 67's quality of life improved.						
	with the head of the b oxygen at 2 LPM. No pursed breathing obse An interview on 3/22/	ed her resting in bed quietly ed elevated and receiving accessory muscles or						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/29/2018 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345008	B. WING				C 22/2018
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				3	00 PROVIDENCE ROAD		
COMPLET	E CARE AT MYERS PAR	ĸ		c	CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 695 F 849 SS=D	She stated her oxyger 99% on 2 liters of oxy indicated Resident #6 cannula twice and had to 79% on room air. A had been fine ever sin An interview on 3/22/ ⁷ conducted with the D0 was aware of the new with Resident #67 but followed a different prinew orders and asses was her expectation for orders, flag the new of new orders to the floo all times. The DON si a change or decline fri we know. An interview on 3/22/ ⁷ Administrator revealed Hospice services was changes or addition to better care for the ress Hospice Services CFR(s): 483.70(o)(1)- §483.70(o)(1) A long- do either of the follow (i) Arrange for the pro through an agreemen Medicare-certified hos (ii) Not arrange for the	ay with the oxygen in place. In saturation level had been gen per minute. She 7 had taken off the nasal d decreased her saturation After the second time, she nce. 18 at 12:02pm was ON. The DON stated she 7 Hospice group working 2 was not aware they ocess for communication on asments. The DON stated it or Hospice to write new rders, and communicate the r nurse immediately and at tated that Resident # 67 had from her baseline and now 18 at 2:36pm with the d his expectation from to communicate any o services to the team to ident. (4) ervices. term care (LTC) facility may ing: vision of hospice services t with one or more spices. e provision of hospice through an agreement with		695 849			4/19/18
	services at the facility	through an agreement with					

Event ID: 6PFY11

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/29/2018 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345008	B. WING _			03/2	22/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
00000				30	00 PROVIDENCE ROAD		
COMPLE	E CARE AT MYERS PAR	ĸ		С	HARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 849	when a resident reque §483.70(o)(2) If hospi LTC facility through an paragraph (o)(1)(i) of the LTC facility must requirements: (i) Ensure that the hosp professional standard to individuals providin to the timeliness of the (ii) Have a written agret that is signed by an a the hospice and an authe LTC facility before any resident. The write at least the following: (A) The services the following: (A) The services the following: (A) The services the following: (C) The services the following (C) The services the following (D) A communication communication will be LTC facility and the hospice and that the needs of the following be and the hospice and (1) A significant changemental, social, or emo- (2) Clinical complication alter the plan of care.	g to a facility that will ion of hospice services ests a transfer. ce care is furnished in an in agreement as specified in this section with a hospice, meet the following spice services meet s and principles that apply g services in the facility, and e services. eement with the hospice uthorized representative of thorized representative of thospice care is furnished to tten agreement must set out hospice will provide. ponsibilities for determining ce plan of care as specified a chapter. 	F	349			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/29/2018 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345008	B. WING				(03/2	C 22/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				3	00 PROVIDENCE ROAD			
COMPLET	E CARE AT MYERS PAR	K		c	CHARLOTTE, NC 28207			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
F 849	responsibility for deter course of hospice can determination to chan provided. (G) An agreement tha responsibility to furnis care, meet the residen nursing needs in coor representative, and en provided is appropriat resident's needs. (H) A delineation of the including but not limited direction and manage counseling (including bereavement); social supplies, durable meet necessary for the pall associated with the ter conditions; and all othe necessary for the care illness and related cool (I) A provision that wh personnel are respon- of prescribed therapied determined appropriat delineated in the hosp facility personnel may where permitted by St the LTC facility. (J) A provision stating report all alleged violat mistreatment, neglect and physical abuse, in	th. g that the hospice assumes rmining the appropriate e, including the ge the level of services at it is the LTC facility's th 24-hour room and board nt's personal care and dination with the hospice nsure that the level of care rely based on the individual the hospice's responsibilities, ed to, providing medical ment of the patient; nursing; spiritual, dietary, and work; providing medical dical equipment, and drugs iation of pain and symptoms rminal illness and related ther hospice services that are e of the resident's terminal nditions. then the LTC facility sible for the administration tes, including those therapies te by the hospice and bice plan of care, the LTC r administer the therapies tate law and as specified by g that the LTC facility must ations involving f, or verbal, mental, sexual, hocluding injuries of unknown priation of patient property	F	849				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3	COMPLETED		
		345008	B. WING				C 22/2018	
NAME OF PF	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE			
COMPLET	E CARE AT MYERS PAR	ĸ			300 PROVIDENCE ROAD			
			1		CHARLOTTE, NC 28207			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 849	becomes aware of the (K) A delineation of the hospice and the LTC - bereavement services §483.70(o)(3) Each L provision of hospice of agreement must design facility's interdisciplinat for working with hospic coordinate care to the LTC facility staff and he interdisciplinary team clinical background, for scope of practice act, assess the resident of that has the skills and resident. The designated intercor responsible for the fold (i) Collaborating with and coordinating LTC the hospice care plan residents receiving th (ii) Communicating with and other healthcare provision of care for the provision of care for the conditions, and other of care for the patient (iii) Ensuring that the with the hospice medi- attending physician, a participating in the pro- as needed to coordina- medical care provided (iv) Obtaining the fold	ately when the LTC facility e alleged violation. The responsibilities of the facility to provide is to LTC facility staff. TC facility arranging for the care under a written gnate a member of the ary team who is responsible ice representatives to e resident provided by the hospice staff. The member must have a unction within their State and have the ability to r have access to someone I capabilities to assess the lisciplinary team member is lowing: hospice representatives facility staff participation in ning process for those ese services. th hospice representatives providers participating in the he terminal illness, related conditions, to ensure quality and family. LTC facility communicates ical director, the patient's and other practitioners povision of care to the patient ate the hospice care with the	F	84	,			
	-							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/29/2018 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345008	B. WING _				C 22/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
COMPLET	E CARE AT MYERS PAR	ĸ			00 PROVIDENCE ROAD HARLOTTE, NC 28207		
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 849	Continued From page	e 31	F	349			
	(A) The most recent to each patient.	hospice plan of care specific					
	(B) Hospice election						
		ation and recertification of becific to each patient.					
	(D) Names and conta	act information for hospice					
	personnel involved in patient.	hospice care of each					
		ow to access the hospice's					
	24-hour on-call system	m.					
	(F) Hospice medicati each patient.	on information specific to					
		in and attending physician (if					
	any) orders specific to	o each patient.					
		LTC facility staff provides cies and procedures of the					
		ent rights, appropriate forms,					
	and record keeping re	equirements, to hospice staff					
	furnishing care to LTC	C residents.					
		TC facility providing hospice					
		agreement must ensure that					
		n plan of care includes both ice plan of care and a					
		vices furnished by the LTC					
		intain the resident's highest					
	well-being, as require	mental, and psychosocial					
	•	is not met as evidenced					
	by:				The second of the second se		
		ns, record reviews, staff ictitioner (NP) interview, and			The process leading to the cited deficiency was due to lapse in		
	Physician interviews,	the facility failed to maintain			communication between the facility and		
		coordination of services			the resident's hospice service provider.		
		and facility personnel related dvanced directives, and			The facility did not communicate and follow the resident's plan of care as		
		1 of 3 sampled for hospice			outlined by Hospice. Resident #67 Car	е	
	services (Resident #6	67).			Plan was reviewed on 3.21.18.		

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·			MPLETED
			/			С
		345008	B. WING			3/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
				300 PROVIDENCE ROAD		
COMPLET	E CARE AT MYERS PAI	ĸĸ		CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 849	Continued From page	e 32	F 84	.9		
	The findings included			A review of all other res	idents receiving	
				hospice services, was o	•	
	Residents #67 was a	dmitted on 3/20/17 and		ensure the care plans a		
	readmitted to the fac			followed.		
		led acute systolic congestive				
		lementia, and anxiety		To help ensure the define		
	disorder.			no reoccur, the facility I Care Plan Team met wi		
	A review of the signif	icant change Minimum Data		Hospice Provider, on 4		
	Set (MDS) assessme			how communicating res		
	. ,	d that Resident #67 was		status changes will be		
	cognitively impaired,	had an anxiety disorder and		facility has also met wit	h all other facility	
	CHF, and was receiv	ring hospice services.		Hospice Service Provid		
	A			communicating residen	-	
	group and the facility	act between the Hospice		status changes. On 4.1 the facility'⊡s Hospice \$		
		ix 3, Hospice and Nursing		Agreements will be revi		
		onsibility, the hospice group		Administrator, Director	-	
		listed as the responsible		Services, and Medical I	-	
		Assessment Process,		4.18.17, The facility nu	rsing staff will be	
		essment, Plan of Care		educated on Hospice S		
	Development, Plan o			the communication of u		
	Coordination of Care			changes will be conduc	-	
	A review of the Cortif	ication of Terminal illness		Nursing staff will also b understanding Residen		
		it dated 2/5/18 with a start		which would include the		
		spice services revealed		purpose, location, and		
		esented to the emergency		and implementation of		
	-	18 with acute dyspnea		staff not present will no		
		related to an exacerbation		work until in-servicing h	las been	
		7 had signs of marked		completed.		
		enough oxygen in the blood		Upon the election of se		
		tions), pleural effusion (fluid lungs and chest), and		the facility'⊡s Interdisci Team, and when availa		
		y (enlarged heart). During		and the Resident 's Fa		
	this hospitalization sh			Party, will meet to revie		
		us (IV) diuretics with some		The facility'⊡s Nurse Pi		
		prognosis was slim due to		Medical Director will als		
	advancing cardiac fa	ilure. Resident #67 was		Thereafter, Hospice Se	rvices will be	

Facility ID: 953418

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		MEDICAID SERVICES	a		OMB NO. 09	
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
			A. BUILDING		с	
		345008	B. WING		03/22/2	2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				300 PROVIDENCE ROAD		
COMPLET	TE CARE AT MYERS PAR			CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE CC	(X5) DMPLETIC DATE
F 849	Continued From page	e 33	F 84	19		
		e nursing facility after an		invited to attend all other	Resident Care	
		amily to accept Hospice		Plan Meetings. For week		
		a palliative approach to care		order changes, Hospice		
	and abandon more of	ptions for hospitalizations.		to the resident s family/		
				and the facility' s nurse		
	-	ice care plan dated 2/3/18		charge. These changes		
		7 had an alteration in		and addressed at the fac Risk Meeting. The facility	-	
		nd interventions included ess and compliance with		communicate these upda		
	oxygen therapy.			Practitioner and Medical		
	-	ice care plan dated 2/3/18		To help ensure this plan		
		ealed Hospice admission		effective, the Director of Manager will review all re		
		der problem and gave nister oxygen as ordered,		Hospice Services for ord	-	
		/spnea, non-verbal indicators		updates, and changes in	-	
		a, or dyspnea was assessed		facility'⊡s weekly Risk M	-	
	by a nurse. Further c	directions included if		Director of Nursing Servi	ices or Unit	
	symptoms remained			Manager will also comm		
		may increase oxygen to 3		with resident' s Hospice	•	
		A). If symptoms remained		to help ensure effective of		
		additional 30 minutes, the		and orders are followed.		
	flow of 4 LPM.	e oxygen up to a maximum		weekly for 4 weeks; The		
				will be conducted twice r		
	A review of the facility	y care plan for Resident #67		months and then once p	-	
		vised on 2/26/18 revealed no		months. The Director of		
		s related to respiratory or		or Unit Manager will also		
	cardiac functions.			of 5 employees weekly c		
	A rouious of the	lon initiated on 2/22/42		of Hospice Services and		
		blan initiated on 2/28/18 7 was receiving hospice		audit will be conducted of weeks; Thereafter, the a		
		nd of life care. Interventions		conducted twice monthly		
		patient and family wishes		and then once per month		
		of any change in condition				
	or medication change			Results will be shared w	ith Administrator	
				weekly, and the facility G		
		ice Nurse routine visit note		and Performance Improv		
	dated 3/19/18 revealed	ed Resident #67 continued to		Committee Monthly until	substantial	

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		D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345008	B. WING				C 22/2018
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
COMPLET	E CARE AT MYERS PAR	K			300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 849	have periods of incread due to disease progree breathe on room air. continue to educate s needed for symptom in A review of the Hospin Resident #67 dated 3 Nurse instructed Nurse needed for symptom in A review of the order Resident #67 dated 2 revealed no orders to to administer oxygen breath or symptoms of A review of the oxygen breath or symptoms of a the symptoms of she ate approximately Resident #67 was not at this time. An interview on 3/19/ Hospice Nurse was of she was aware of Resishortness of breath a resident to use her act and at times used pur stated the floor staff w care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Resident and the staff we care plan located in Re	ased shortness of breath ession but continued to The Hospice Nurse wrote to taff on using oxygen as management. cc Service Narrative note for /19/18 read, the Hospice se #2 to use oxygen as management. summary report for /2/18 through 3/20/18 check oxygen saturation or as needed for shortness of of dyspnea. n saturation summary for d the last assessment was her rehospitalization that to last 12:33pm revealed ting lunch in the dining room t #67 was noted to use eriodically through lunch as y 50% of her meal. t receiving portable oxygen 18 at 11:39am with the onducted. She indicated sident #67 having periods of	F	849	compliance is achieved.		

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	: 05/29/2018 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345008	B. WING			03/2) 22/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATI	E, ZIP CODE		
COMPLE	E CARE AT MYERS PAR	ĸ	-	00 PROVIDENCE ROAD CHARLOTTE, NC 28207			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PL (EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)		(X5) COMPLETION DATE
F 849	stated that no PRN m over the past 24 hour Resident #67 had bee An observation on 3/2 Resident #67 was sitt dining room on 300 H uncomfortable, holdin accessory muscles to her face and clothes. receiving portable oxy An observation on 3/2 Resident #67 sitting in dining room on 300 H be uncomfortable, scr breathing heavy. Res portable oxygen at thi An observation on 3/2 Nurse #2 walked up to pick up towels but did to be discomfort with muscles and pursed to An observation on 3/2 Resident #67 in the d served by staff. Resid her eyes closed, hold accessory muscles to Resident #67 was not at this time. An observation on 3/2 performing incontinent she laid flat on her ba	ent had intermittent She revealed Nurse #2 edications had been given s and no changes with en assessed. 20/18 at 11:23am revealed ing in her wheel chair in the all. She appeared to be g her throat at times, using breathe, and fidgeting with Resident #67 was not ygen at this time. 21/18 at 9:59am revealed n her wheel chair in the all. She again appeared to ratching her back and sident #67 was not receiving is time. 21/18 at 10:02am revealed to Resident #67's table to not address what appeared the use of accessory preathing. 21/18 at 12:31pm revealed ining room as lunch was dent #67 sat at the table with	F 849				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 05/29/2018 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345008	B. WING		_	03/2	C 22/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
COMPLET	E CARE AT MYERS PAR	к		300 PROVIDENCE ROAD CHARLOTTE, NC 28207	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 849	using accessory muse breathe. Resident #6 oxygen at this time. T observed in Resident An interview on 3/21/ was conducted. NA # 67 received Hospice & Resident # 67 had ne had no breathing prot of. She stated she ca regularly and had a gu An interview on 3/21/ indicated she was ver and the resident had concerns that she cou oxygen had never bea and explained she ha January and was sen came back on Hospic Resident #67 had alw when she states, "Oh moving her shoulders expressing anxiety. N resident got their oxyg checked on shower d the nurse pulled up R Saturation Summary of records. Nurse #2 sta checked on 1/25/18. been an oversight and when she came back time, this surveyor reco	ted that Resident #67 was cles and pursed breathing to 7 was not receiving portable There was no oxygen #67's room. 18 at 2:26pm with NA #2 42 revealed that Resident # services. NA #2 stated ver used oxygen before and olems that she was aware ured for Resident # 67 bod relationship with her. 18 at 3:10pm with Nurse #2 by familiar with Resident #67 never had any respiratory uld remember. She stated en used for Resident # 67 d gotten really sick in t out to the hospital and e. Nurse # 2 explained vays had a lot of anxiety and Lord, oh Lord," while up and down, she was Jurse #2 explained the	F 849				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345008	B. WING				C 22/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
COMPLET	E CARE AT MYERS PAR	ĸ			300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 849	An observation on 3/2 Resident #67 lying fla accessory muscles, a #2 asked Resident #6 elevated a little and the please." The initial as saturation level for Re- on room air. Nurse # measuring tool and the recorded 83% on room An interview on 3/21/ revealed she also obs her accessory muscles She stated she felt ba- it was the resident's at the difficulty breathing stated she would call oxygen orders and ta- (DON). An observation on 3/2 Resident #67 in bed we elevated while she re cannula at 2 LPM. No- or pursed breathing we An interview with Nur revealed Resident #60 of 99% on oxygen at not familiar with the H- #67 was receiving an plan was in the chart. was the first resident services from the new had not received any as far as receiving or She indicated she had	21/18 at 3:25pm revealed it in her bed, using and pursed breathing. Nurse 57 if she wanted her head he resident stated, "Yes, assessment of the oxygen esident #67 recorded 85% 2 went to get another he oxygen saturation m air. 18 at 3:33pm with Nurse #2 served Resident #67 using es and pursed breathing. ad because she had thought unxiety and had overlooked g signs and symptoms. She Hospice immediately for lk to the Director of Nursing 21/18 at 4:26pm revealed with the head of the bed ceived oxygen via nasal o use of accessory muscles	F	849			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345008	B. WING				C /22/2018
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	E CARE AT MYERS PAR	ĸ			300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 849	Continued From page	2 38	F	849	1		
	Manager revealed sh received any training group and did not kno Hospice care plan. S see Hospice notes in Hospice groups utilize An interview on 3/21/ revealed she was uns assessed Resident # #67 was receiving Ho know it was with a ne she would recognize extra effort to breathe an indicator. She exp started Roxanol and a signs and symptoms use of accessory mus reading 83-85%. She professional opinion F comfort status with th An interview on 3/21/ revealed oxygen wou Resident #67 through assessment from the An interview on 3/21/ revealed she had won months and had hear Lord, Oh Lord," but th problems that she wa An interview on 3/22/ facility's Medical Dire- aware of Resident #67	 the stated she expected to the chart like the other ed in the facility. 18 at 4:44 pm with the NP sure of when she last 67. She knew that Resident ospice services but did not w group. The NP indicated respiratory distress as using and pursed breathing was blained she would have administered oxygen with exhibiting pursed breathing, soles and oxygen saturations e revealed in her Resident #67 was not in e described symptoms. 18 at 4:56pm with Nurse #3 ld be administered to the afternoon. 18 at 5:02pm with NA #3 rked in the facility for a few d Resident #67 state, "Oh here were no breathing is aware of. 					

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		ID HUMAN SERVICES MEDICAID SERVICES				INTED: 05/29/2018 FORM APPROVED IB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION) DATE SURVEY COMPLETED
		345008	B. WING			C 03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
			3	00 PROVIDENCE ROAD		
COMPLE	E CARE AT MYERS PAR	K	(CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 849	seen the Hospice can Director revealed whe breathing and access saturation levels reco considered the reside needing oxygen. An interview on 3/22/ who had assisted Res 3/18/18, stated the re had always been very with her but was unaw problems. An interview on 3/22/ Hospice Medical Dire saturation levels were the Hospice Nurses. admission notes and 2/3/18 to the facility M Hospice Medical Dire not get a response, he to his medical office. Director stated he did # 67. He stated by th sounded like she was explained that if Resid better from applying of clinically better from ti indicating Resident #67 Resident # 67 reveale with the head of the b oxygen at 2 LPM. No pursed breathing observation	th neither he nor his NP had e plan. The Medical en a resident used pursed ory muscles with oxygen rded at 83-85% then he int really uncomfortable and 18 at 10:50am with Nurse #4 sident #67 during lunch on sident's chest movements vextra since she had worked vare of any breathing 18 at 11:09am with the ctor revealed oxygen e not routinely checked by He explained that the initial care plan were faxed on ledical Director. The ctor explained since he did e hand-delivered the forms The Hospice Medical not directly know Resident e description given it ouncomfortable. He dent # 67 was suddenly poxygen then she was he oxygen administered 67's quality of life improved.	F 849			

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		ID HUMAN SERVICES MEDICAID SERVICES				INTED: 05/29/2018 FORM APPROVED IB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION) DATE SURVEY COMPLETED
		345008	B. WING			C 03/22/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO	DE	
		NZ	3	00 PROVIDENCE ROAD		
COMPLE	TE CARE AT MYERS PAR	(N	c	HARLOTTE, NC 28207		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 849	comfortable on this da She stated her oxyge 99% on 2 liters of oxy indicated Resident #6 cannula twice and har to 79% on room air. // had been fine ever sin 2. A review of the carr revealed Resident #6 services related to en- listed respecting the p and to notify hospice or medication change A review of the record documents. A MOST Treatment) form was (Do Not Resuscitate) hospice staff indicatin The physician order of Code and was enterer record for Resident # with the assignment ti indicated Full Code si nursing assistants (N/ An interview on 3/21/ revealed she was awa DNR because she ha on the day the residen and the Hospice Nurs family member. She electronic plan of care the interview she read Code status listed.	II Resident # 67 was more ay with the oxygen in place. In saturation level had been agen per minute. She of had taken off the nasal d decreased her saturation After the second time, she nce. e plan initiated on 2/28/18 7 was receiving hospice d of life care. Interventions batient and family wishes of any change in condition rs. ds revealed conflicting f (Medical Order Standard of updated on 2/3/18 to DNR in the front of the chart by rg Resident #67 was a DNR. lated 5/11/17 read, Full d into the electronic health 67. The nurse report sheet hat included Resident #67 tatus. The plan of care for	F 849			

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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 C 345008 B. WING 03/22/2018		MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
345008 B. WING 03/22/2018	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY LETED
			345008	B. WING				-
	NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLETE CARE AT MYERS PARK 300 PROVIDENCE ROAD COMPLETE CARE AT MYERS PARK CHARLOTTE, NC 28207	COMPLET	DMPLETE CARE AT MYERS PARK 300 PROVIDENCE ROAD CHARLOTTE, NC 28207						
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 849 Continued From page 41 F 849 was conducted. She stated she worked in the facility as needed and had not worked with Resident #67 before this night. During the interview she read on her assignment form that Resident #67 was a Full Code. She looked in the paper chart during the interview and saw a MOST form updated to DNR code status as of 2/3/18. A review of the telephone encounter noted in the Hospice records dated 32/1/18 read the MDS Codinator that the resident #67 was a DNR or a Full Code. The Hospice Rourse informed the MDS Coordinator called Hospica to very if Resident #67 was a DNR or a Full Code. The Hospice Rourse informed the MDS Coordinator that the resident was a DNR according to the MOST form completed upon admission with hospice services on 2/3/18. At this time the MDS Coordinator rate that the facility had not been aware of the updated MOST form and an order had not been aware of the new Hospice group carring for Resident #67 and felt the coordination and communication between the Hospice group carring for Resident #67 and felt the coordinations. A review of a verbal order for Resident #67 dated 26/18 recoiled from all not the papered. 3. A review of a verbal order for Resident #67 dated 26/18 receiled apprecision or 21/18 at 4:30pm revealed aphysician order dated 22/18 that read, LFT every 6 months for routine acetaminophen therapy in March and September. A review of the Order Summary Report for Resident #67 resident #67 review of the Order Summary Report for Resident #67 review of the row of aborderd 00.31/218 for a Hepate Panel	F 849	was conducted. She facility as needed and Resident #67 before f interview she read on Resident # 67 was a the paper chart during MOST form updated 2/3/18. A review of the teleph Hospice records date Coordinator called Ho #67 was a DNR or a Nurse informed the M resident was a DNR or a Nurse informed the M resident was a DNR a completed upon admi on 2/3/18. At this tim explained to the Hosp had not been aware of and an order had not An interview with the 4:30pm revealed she Hospice group caring the coordination and Hospice group and th 3. A review of a verba dated 2/6/18 received Director read, Discon Hospice recommenda A review of the Order Resident #67 reveale 2/2/18 that read, LFT acetaminophen thera	stated she worked in the d had not worked with this night. During the her assignment form that Full Code. She looked in g the interview and saw a to DNR code status as of one encounter noted in the d 3/21/18 read the MDS ospice to verify if Resident Full Code. The Hospice IDS Coordinator that the according to the MOST form ission with hospice services e the MDS Coordinator oice nurse that the facility of the updated MOST form been written. Unit Manager on 3/21/18 at was unaware of the new for Resident #67 and felt communication between the le staff had not happened. al order for Resident #67 d from the Hospice Medical tinue all routine lab work per ations. Summary Report for d a physician order dated every 6 months for routine py in March and September.	F	849			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/29/2018 APPROVED). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. /	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345008	B. WING		_		C 22/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
COMPLET	E CARE AT MYERS PAR	к		300 PROVIDENCE ROAD CHARLOTTE, NC 28207	,		
(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 849	No new orders were i received. An interview on 3/21/ Manager revealed the had not been disconti the order and routine The UM stated the or someone did not disc order. An interview on 3/22/ conducted with the Di The DON stated she Hospice group workin was not aware they for for communication on assessments. The D expectation for Hospit the new orders, and c to the floor nurse imm The DON stated that or decline from her ba The DON added that to discontinue routine believed it was overloo not recognize the Hos name. An interview on 3/22/ Administrator reveale Hospice services was	ed on 3/12/18 at 12:41pm. nitiated after the labs were 18 at 5:01pm with the Unit e routine lab order for March nued when Hospice wrote labs were drawn on 3/12/18. der was overlooked and ontinue the routine lab 18 at 12:02pm was rector of Nursing (DON). was aware of the new g with Resident #67 but ollowed a different process new orders and ON stated it was her ce to write new orders, flag communicate the new orders nediately and at all times. Resident # 67 had a change aseline and now we know. she had not seen the order labs for Resident #67 and oked because the staff did spice Medical Director's 18 at 2:36pm with the d his expectation from to communicate any o services to the team to	F 849				
F 867 SS=D	QAPI/QAA Improvem CFR(s): 483.75(g)(2)(ent Activities	F 867	,			4/19/18

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE	0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /			LETED
			A. DOILDING		с	
		345008	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
				300 PROVIDENCE ROAD		
COMPLET	E CARE AT MYERS PA	RK		CHARLOTTE, NC 28207		
(X4) ID			ID			(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED DEFIC		COMPLETIO DATE
F 867	Continued From pag	e 43	F 86	7		
	§483.75(g) Quality a	ssessment and assurance.				
		uality assessment and				
	assurance committee					
		ement appropriate plans of tified quality deficiencies;				
		Γ is not met as evidenced				
	by:					
		ons, resident, family and staff		Rooms cited during the	e survey (301, 305,	
		d review, the facility's Quality		310, 311, 319, 321) hav		
		surance (QAA) Committee		The CAA for residents #	#35, #43, and #245	
		plemented procedures and		were completed. Reside		
		that the committee put into		#245 Care Plans were r		
		and May 2017. This was for		updated to accurately re		
		ed during the facility's		CAA (Care Area Assess	sment).	
		mplaint investigation survey				
		7, F 584, F 636 and F 657		All resident rooms and		
		ecited during the facility's survey conducted on		floors have been swept other current residents		
		deficiencies were in the		Assessments) were au	•	
	areas of housekeepi			completion. Current res		
		sive assessments and care		were also reviewed and		
		ion. The continued failure of		accurately reflect reside	-	
		compliance, during three		Area Assessment).		
		cord shows a pattern of the		,		
	-	ustain an effective Quality		All facility housekeeping	g staff have been	
	Assurance Program.			retrained on the facility'		
	_			cleaning service room a	and floor cleaning	
	The findings included	1:		process. A monthly clea	•	
				been implemented to er		
	This tag is cross refe	rred to:		resident room is deep c	-	
				and upon discharge of e	-	
		ping and maintenance		Common areas will be a	-	
		bservations, interviews with		and as needed. The ME		
		ly member, and staff, the		and Director of Nursing		
	facility failed to main			been to recent training	sponsored by	
	consecutive days in l	a of 20 resident rooms (301	1	DHHS.		1
		6 of 20 resident rooms (301, nd 321) on 1 of 3 units.		DITIO.		

Facility ID: 953418

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	CONSTRUCTION	(X3) DAT	O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		CON	IPLETED
		345008	B. WING				C 3/22/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 0,	5/22/2010
				30	00 PROVIDENCE ROAD		
COMPLET	E CARE AT MYERS PAR	κ		CI	HARLOTTE, NC 28207		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 867	Continued From page	e 44	F 8	67			
1 001	The facility was recite	ed during this survey for F		01	not reoccur, a minimum of 5 resident		
		ntain clean floors in resident			surveys will be conducted weekly to h		
		as originally cited during a			ensure satisfaction. Bi- Monthly meetin	•	
		mplaint investigation survey to repair a commode, loose			will be held with housekeeping service review findings. The facility MDS	5 10	
		sinks, an over bed table,			Coordinator will conduct a weekly aud	it of	
	cracked window glas	s, resident wardrobes,			all Admission, Annual, and Significant		
	broken floor tiles and			Change Assessments to ensure CAA			
	F584 was also cited of	during a revisit and on survey on 4/10/17 for			(Care Area Assessments) are complet		
	failure to secure a loc			Bi-Monthly Meeting held by the Direct Nursing Services and MDS Coordinate			
	repair a resident's roo			will be conducted with Interdisciplinary			
	tiles.				Care Plan Team to review CAA (Care		
					Area Assessments) for acceptance.		
		nsive assessments. Based			Depute will be abared with Administra	tor	
		f interviews and record led to complete Care Area			Results will be shared with Administra twice monthly, and the facility Quality	lui	
	-	that addressed and provided			Assurance and Performance		
	an analysis of underly	ying causes and contributing			Improvement Committee Monthly until	I	
		areas of nutrition for 2 of 3			substantial compliance is achieved.		
		Residents #35 and 43) and					
	(Resident #245).	of 3 sampled residents					
	-	ed during this survey for F					
	636 for failure to com	•					
		to nutrition and pressure is originally cited during a					
		mplaint investigation survey					
	on 2/16/17 for failure						
		ssment related to cognition					
	and the use of psych	oactive medications.					
	1c. F 657 Care plan t	timing and revision. Based					
	on observations, staf	f interviews and record					
	-	led to develop a pressure					
	ulcer care plan to me for 1 of 3 sampled res	et the resident care needs					

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/29/2018 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345008	B. WING			C / 22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
COMPLET	E CARE AT MYERS PAR	ĸ		800 PROVIDENCE ROAD		
	-			CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 867	develop a pressure ul was originally cited du complaint investigatio failure to develop a di resident with active di Interview with the Adr Nursing (DON) on 03, that the repeat concer and maintenance serv regards to facility repa services, so the QAA focused on maintainin housekeeping services repeat concerns with assessments and car communication barrier responsible for the co	d for F 657 for failure to leer care plan. The F 657 uring a recertification and in survey of 2/16/17 for scharge care plan for a lischarge plans. ministrator and Director of /22/18 at 4:05 PM revealed rms related to housekeeping vices was originally cited in airs and not housekeeping monitoring would have ng facility repairs and not es. The DON stated that the comprehensive e plans was related to a r regarding which staff was mpletion of these tasks and clude. The Administrator also attributed repeat irnover in each of the	F 867			

Facility ID: 953418

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