STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. BUILDING _____ B. WING _____	C 05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION HEALTH CENTER AT BRIGHTMORE	10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey was conducted from 05/20/19 to 05/23/19. the facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID 7TWY11.	E 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Prognosis for a Hospice resident that was terminally ill for 1 of 4 residents (Resident #46) and receiving Hospices services while at the facility for 2 of 4 residents (Resident #46 and Resident #49) reviewed for Hospice. Findings included: 1. Resident #46 admitted to the facility on 10/1/2016. Her diagnoses included senile degeneration of the brain, and dementia. A Hospice contract dated 1/11/2019 certified that Resident #46 was admitted under the care and services of Hospice for end of life. The quarterly Minimum Data Set (MDS) dated 4/11/2019 specified the resident's cognition was severely impaired. Review of Section J1400 (Prognosis-Does the resident have a condition or	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 641 ACCURACY OF ASSESSMENTS Corrective Action: Resident #46. Resident Minimum Data Set (MDS) assessment (Quarterly) with Assessment Reference Date (ARD) 4/11/2019) was modified with a Corrective Attestation Date of 5/22/2019. The assessment was submitted to the state QIES system on 5/24/2019 and was accepted on 5/24/2019. Submission ID: 16827887 Resident #49. Resident Minimum Data	6/7/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/10/2019

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F 641	Continued From page 1 chronic disease that may result in a life expectancy of less than 6 months?) was coded as Resident #46 not having less than 6 months to live. Review of Section O (Special Programs/ Treatments) was coded as Resident #46 not receiving Hospice services. An interview was completed on 5/22/2019 at 1:45 PM with the MDS Coordinator. She stated she was aware Resident #46 was receiving Hospice services. The MDS Coordinator explained Section J1400 (Prognosis-Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) was coded No in error for Resident #46. The MDS Nurse stated any resident receiving hospice services should be coded Yes for Section J1400. On 5/22/2019 during the same interview with the MDS Coordinator, she also stated Section O (Special Programs/ Treatments) - Hospice was coded No in error. The MDS Coordinator verbalized Resident #46 currently received Hospice services and should have been coded Yes. The MDS Nurse further explained the assessment needed to be modified to reflect the correct prognosis and services being received by Resident #46. An interview was completed on 5/23/2019 at 10:57 AM with the Administrator. The Administrator stated he expected the MDS to be coded accurately according to the Resident Assessment Instrument (RAI) and the regulation.	F 641	Set (MDS) assessment (Quarterly) with Assessment Reference Date (ARD) 4/4/2019) was modified with a Corrective Attestation Date of 5/22/2019. The assessment was submitted to the state QIES system on 5/24/2019 and was accepted on 5/24/2019. Submission ID: 16827887 Identification of other residents who may be involved with this practice: All current residents with documented terminal illness or receiving hospice care and services with Quarterly Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 6/5/2019 through 6/7/2019 an audit was completed by the MDS Nurse Consultant to review the most recent Minimum Data Set (MDS) in the last 6 months to ensure that all residents with a current Hospice contract and under the care and services of Hospice for end of life were coded accurately in Section J1400 (Prognosis) as Yes , and Section O0100K Hospice Care as Yes and to ensure that residents with conditions or chronic disease that may result in a life expectancy of less than six months or have terminal illness were coded accurately in section J1400(Prognosis) as Yes. 10 current residents with documented terminal illness or receiving hospice care and services, all their assessments that is Comprehensive/ Quarterly / PPS Mini Data Set (Assessments) have been coded accurately for Section J1400: Prognosis and Section O0100K: Hospice Care. This audit was completed on 6/7/2019.	

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F 641	Continued From page 2 2. Resident #49 admitted to the facility on 7/3/2018. Her diagnoses included adult failure to thrive and hypertension. A Hospice contract dated 8/6/2018 certified that Resident #49 was admitted under the care and services of Hospice for end of life. The Quarterly MDS dated 4/4/2019 specified the resident's cognition was severely cognitively impaired. Review of Section O (Special Programs/ Treatments) was coded as Resident #46 not receiving Hospice services. An interview was completed on 5/22/2019 at 1:45 PM with the MDS Coordinator. She stated she was aware of Resident #49 receiving Hospice services. The MDS Coordinator explained Section O (Special Programs/ Treatments) - Hospice was coded No in error. The MDS Coordinator verbalized Resident #49 currently received Hospice services and should have been coded Yes. The MDS Nurse further explained the assessment needed to be modified to reflect the correct services being received by Resident #49. An interview was completed on 5/23/2019 at 10:57 AM with the Administrator. The Administrator stated he expected the MDS to be coded accurately according to the Resident Assessment Instrument (RAI) and the regulation.	F 641	Systemic Changes: On 5/30/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must ensure that each assessment accurately reflects the resident□s status. Section J1400: Prognosis (Does the resident have a condition or chronic disease that may result in a lift expectancy of less than 6months? Requires physician documentation.) Review the electronic medical record for documentation by the physician that the resident□s condition or chronic disease may result in a lift expectancy of less than 6months or that they have a terminal illness. If the physician states that the resident□s life expectancy may be less than 6months, request that he or she document this in the medical record. Do not code until there is documentation in the medical record. Review the medical record to determine whether the resident is receiving hospice services. Code 0, No: if the medical record does not contain physician documentation: that the resident is terminally ill; or the resident is receiving hospice services. Section O0100K: Hospice Care (during the last 14days). Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as	

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F 641	Continued From page 3	F 641	a hospice provider and/or certified under the Medicare program as a hospice provider. This in service was completed by 5/31/2019. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and /or MDS Nurse Consultant will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments that is Comprehensive/ Quarterly / PPS Mini Data Set (Assessments) per week to ensure that Section J1400: Prognosis was coded accurately for residents with a condition or chronic disease that may result in a life expectancy of less than 6months or have terminal illness or are receiving hospice services and Section O0100K: Hospice Care was coded accurately for resident receiving hospice services. This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate	

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F 641	Continued From page 4	F 641	concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM(Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 6/7/2019	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645		6/10/19

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F 645	Continued From page 5	F 645		

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an

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F 645	Continued From page 6 intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to refer a resident with newly diagnosed bipolar disorder and unspecified psychosis for a Level II Preadmission Screening and Resident Review (PASARR) for 1 of 3 residents reviewed for PASARR (Resident #40). Findings included: Resident #40 was readmitted to the facility on 3/5/18. Resident #40's medical diagnoses were inclusive of dementia, unspecified psychosis and bipolar disorder. Resident #40's annual Minimum Data Set (MDS) dated 9/19/18 identified active diagnosis of manic depression (bipolar disease) and psychotic disorder. Resident #40 was not evaluated for Level II Preadmission Screening and Resident Review (PASARR). Review of the most recent quarterly Minimum Data Set (MDS) dated 4/3/19 revealed Resident #40 was moderately cognitively impaired. During an interview with the Social Worker (SW) on 5/21/19 at 2:00 PM, she reported having the responsibility for resubmitting for Level II PASARR. The SW stated she received notification of residents with new diagnosis and behavioral concerns during the daily clinical staff meetings but she had not been informed of Resident #40's mental health diagnoses after her readmission from the hospital on 3/5/18.	F 645	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 645 PASARR SCREENING FOR MD & ID Corrective Action: Resident #40. Resident does not require to be referred for a Level 11 preadmission Screening and Resident review because resident does not have a current diagnosis of bipolar disorder and unspecified psychosis. Resident was assessed by the medical director on 5/13/2019 and the resident□s current active diagnosis are diabetes mellitus type 2, hyperlipidemia, hypertension, chronic atrial fibrillation, trigeminal neuralgia since 3/20/2015,spinal stenosis, glaucoma, gastroesophageal reflux disease, peripheral vascular disease, diabetic polyneuropathy, moderate dementia without behavioral disturbance. Identification of other residents who may be involved with this practice: All current residents with newly diagnosed	

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F 645	Continued From page 7 During an interview with the MDS Coordinator on 5/21/19 at 2:25 PM, she reported she had completed the identification information for Resident #40 on the annual MDS. The MDS Coordinator stated she had not informed the SW of the identified mental health diagnosis for Resident #40 on readmission nor during the annual MDS assessment. On 5/23/19 at 11:32 AM, an interview with the Medical Director, he stated Resident #40 was readmitted from the hospital with a diagnosis of bipolar disorder and unspecified psychosis that may have been identified during the hospitalization. The Medical Director reported Resident #40 had not displayed signs of psychosis prior to the hospitalization, however, she had an infection which may have exacerbated her psychosis. The Medical Director reported Resident #40's family member had identified a history of bipolar disorder. On 5/21/19 at 2:17 PM, during an interview with the Administrator, he stated his expectation was for residents identified with a mental health diagnosis, to be screened and referred for an evaluation for Level II PASARR. The Administrator reported he expected the SW to complete the screening and make the referral.	F 645	bipolar disorder, newly diagnosed unspecified psychosis and new diagnosed serious mental disorder and or newly diagnosed intellectual disability have the potential to be affected by the alleged practice. On 6/5/2019 through 6/7/2019 an audit was completed by the social services director and or Director of Nursing to review the most recent physician assessment and ensure that a resident with newly diagnosed serious mental disorder , intellectual disability are reviewed for referral for PASARR(Preadmission Screening and Resident Review) level II screening. No current residents have any newly diagnosed serious mental disorder, intellectual disability that would require referral for PASARR Level II screening. This audit was completed on 6/7/2019. Systemic Changes: On 5/30/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators, Social worker and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant on PASSRR screening. The education focused on: Preadmission screening for individuals with a mental disorder and individuals with intellectual disability. A nursing facility must not admit, on or after January 1, 1989, any new residents with:(i) Mental disorder, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health	

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F 645	Continued From page 8	F 645	authority, prior to admission, That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and If the individual requires such level of services, whether the individual requires specialized services; or(ii) Intellectual disability, unless the State intellectual disability or developmental disability authority has determined prior to admission- That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. Exceptions. i) The preadmission screening program need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. The State may choose not to apply the preadmission screening program to the admission to a nursing facility of an individual; Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, Who requires nursing facility services for the condition for which the individual received care in the hospital, and Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. Referral for Level II resident review evaluation is required for individuals	

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F 645	Continued From page 9	F 645	previously identified by PASARR to have a mental disorder, intellectual disability, or a related condition who experience a significant change. This in service was completed by 5/31/2019. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and /or Social worker will review 5 residents most recent physician assessment to include but not limited to discharge summary and ensure that a resident with newly diagnosed serious mental disorder , intellectual disability are reviewed for referral for PASARR(Preadmission Screening and Resident Review) level II screening. This will be done on weekly basis for 4 weeks then monthly for 3 months starting on 6/10/2019. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly	

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F 645	Continued From page 10	F 645	QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM(Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 6/7/2019	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to monitor fruit (strawberries, grapes, and limes) and produce (lettuce and onions) with signs of spoilage in 1 of 1 walk in refrigerators. Findings included:	F 812	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of	6/7/19

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F 812	Continued From page 11 An initial tour of the kitchen was completed on 5/20/2019 at 7:30 AM with the Dietary Manager (DM). The initial tour revealed the following problems: 1 container of strawberries with signs of spoilage (white/ bluish fuzzy matter) 5 out of 6 limes with signs of spoilage (brown, mushy spots) 1 box of lettuce with signs of spoilage (dark brown/ black mushy spots and brown liquid) 3 individual bags of grapes with signs of spoilage (white/ bluish fuzzy matter) 1 out of 10 onions with signs of spoilage (dark brown/ gray mushy spots) An interview was completed on 5/20/2019 at 7:55 AM with the DM. She stated that she, as well as the dietary aides, checked the refrigerator daily for proper storage and signs of spoilage. The DM stated the dietary aide that worked in the mornings were responsible for checking produce and fruits for signs of spoilage. The DM explained the refrigerator was last checked on 5/19/2019. The DM continued to explain there was no log in place that verified the refrigerator had been checked by staff. The DM verbalized her expectation of staff was to follow the policy regarding food storage and throw away items identified with signs of spoilage. An interview was completed on 5/22/2019 at 1:39 PM with the Administrator. The Administrator stated his expectation was for the Dietary Manager to follow the guidelines in regards to	F 812	Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F Tag- 812-Food Procurement, Store/Prepare/Serve Sanitary-the facility failed to Store, Prepare, distribute and serve food in accordance with professional standards for food service safety . Corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 5/20/2019 the Dietary Manager removed the produce that had the appearance of spoilage from the walk in refrigerator and placed them into the trash. This included 1 container of strawberries with signs of spoilage (white/ bluish fuzzy matter) 5 out of 6 limes with signs of spoilage (brown, mushy spots) 1 box of lettuce with signs of spoilage (dark brown/ black mushy spots and brown liquid) 3 individual bags of grapes with signs of spoilage (white/ bluish fuzzy matter) 1 out of 10 onions with signs of spoilage. There were no other food noted with signs of spoilage. Address how the facility will identify other residents having the potential to be affected by the same deficient practice On 5/20/2019 date the Dietary manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. BUILDING _____ B. WING _____	C 05/23/2019

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F 812	Continued From page 12 food storage.	F 812	evaluated 100% of other refrigerators and food storage areas for food sources that had the appearance of spoilage. There were no other food that appeared spoiled noted. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 5/24/2019 the Administrator in-serviced 100% of facility dietary staff on Food Store/Prepare/Serve Sanitary policy. The education included the implementation of a daily checklist for the Dietary Manager and designee to check all refrigerators and food storage areas daily to monitor and remove food that appears to show signs of spoilage. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 5/31/2019 the dietary manager began quality assurance audits of kitchen refrigerators and other food storage areas in the facility to monitor for food spoilage and that food meets professional safety standards. The quality assurance audits will be completed by the dietary manager weekly x4 then monthly x 3 . The findings from the audits will be reviewed in the facility weekly quality assurance meeting. The weekly quality assurance meeting is attended by the Administrator, Director of	

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F 812	Continued From page 13	F 812	Nursing, Unit Managers, Dietary Manager, Minimum Data Set Registered Nurse, Environmental/Housekeeping Director, and Health information Manager. Date of compliance will be June 7, 2018.	