PRINTED: 11/18/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
		345405	B. WING_			C 10/23/2015
	ROVIDER OR SUPPLIER	LITATION CENTER	1	STREET ADDRESS, CITY, STATE, 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	.0.20.20	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 201 SS=D	The facility must perr the facility, and not tr resident from the facilischarge is necessary and the resident's net facility; The transfer or dische the resident no longer provided by the facility. The safety of individual endangered; The health of individual endangered; The resident has failed appropriate notice, to under Medicare or Medicare or Medicare or Medicare admission to a resident who be after admission to a resident who be a supplementation of the facility reases to the facility failed to attempt interventions issuance of a 30 day sampled residents we discharge notice (Residual contents).	mit each resident to remain in ransfer or discharge the ility unless the transfer or ary for the resident's welfare reds cannot be met in the range is appropriate because has improved sufficiently so er needs the services ty; uals in the facility is uals in the facility would rered; ed, after reasonable and o pay for (or to have paid edicaid) a stay at the facility. ecomes eligible for Medicaid nursing facility, the nursing resident only allowable reaid; or o operate. It is not met as evidenced determine the cause and of or a behavior which caused discharge notice for 1 of 1 ho received a 30 day	F2	The statements includ admission and do not congreement with the alle herein. The plan of cocompleted in the comp federal regulations as contact.	constitute eged deficiencies orrection is liance of state and	11/18/15

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

11/16/2015 **Electronically Signed**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						С	
		345405	B. WING _		•	10/23/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
CHARLO	TE HEALTH & REHABI	I ITATION CENTER		1735 TODDVILLE ROAD			
CHARLO	TE REALIN & RENADI	LITATION CENTER		CHARLOTTE, NC 28214			
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F 201	Continued From pag	ge 1	F 20	01			
	The findings include	d:		in compliance with all federal	and state		
				regulations the center has tal			
	Resident #112 was a	admitted to the facility on		take the actions set forth in the	ne following		
	02/04/11 with diagno	ses which included		plan of correction. The follow	• .		
	unspecified psychos	is.		correction constitutes the cer			
				allegation of compliance. All			
		#112's face sheet revealed a		deficiencies cited have been			
	family member listed	d as legal guardian.		completed by the dates indic	ated.		
	Review of Resident:	#112's quarterly Minimum		F201 Reasons for transfer/di	scharge of		
		9/15 revealed an assessment		resident	scharge of		
	of intact cognition with no behavior problems.			1. Resident # 112 was tran	sferred to a		
		, , , , , , , , , , , , , , , , , , ,		skilled nursing facility and he	is stable at		
	Review of a nursing	note, written by Nurse #1		this time.			
	dated 10/04/15 reve	aled Resident #112 urinated		2. All other residents with b	ehaviors		
		and received redirection.		have the potential to be affect	ted by this		
		ed Resident #112 continued		same deficient practice.			
	1	nd did not want to use the		An audit of residents with a h	•		
	toilet.			behaviors will be completed I			
	Davious of a disabore	re notice dated 10/05/15		Discharge Planner (Social W 11/18/15.Residents behavior			
	1	ge notice dated 10/05/15 112 was to be discharged by		reported to the attending phy			
		e did not contain a reason for		indicated.	Siciali as		
		notice contained a hand		3. All Nursing staff will be r	e-educated by		
	_	dicated Resident #112		the Staff Development Coord	•		
	received verbal notif	ication of the discharge and		regarding the importance of			
	I .	e to contact Resident #112's		behaviors and documentation			
	guardian.			behaviors as of 11/18/15. All	Nursing staff		
				will be re-educated by the SI	C regarding		
		#112's mental health nurse		the importance of notification			
		note dated 10/05/15		resident⊡s physician regardi	ng behaviors		
		112 received a routine visit		as of 11/18/15.			
	,	The MHNP documented "no		Newly hired nursing staff will			
		osis. Staff has not reported orsening of behavioral		on the importance of reporting	-		
	symptoms."	orseming or benavioral		and notification of physician in behaviors at the time of hire.			
	aymptoma.			4. The Unit Managers will a			
	Review of a nursing	note dated 10/13/15 revealed		reports for behaviors daily to			
	_	esident #112's discharge to a		the physician has been notific			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCT G		(X3) DATE :	
		345405	B. WING			40%	
NAME OF P	ROVIDER OR SUPPLIER	343403	B: Willo	STREET ADDRE	ESS, CITY, STATE, ZIP CODE	10/2	23/2015
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CHARLO1	TTE HEALTH & REHABIL	LITATION CENTER		CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E OSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 201	Resident #112 's guareceive the discharge #112's 10/13/15's dis because she was out guardian reported the informed her the reasurination. Interview on 10/22/15 Aide #1 revealed Resident #1 problems on the nurs Interview on 10/22/15 revealed Resident #1 problems on the nurs Interview with the fact 10/22/15 at 3:30 PM received a discharge urination. The social with Resident #112 to inappropriate and a c given if he continued outside. The social we Resident #112 a bed facility. The social was	on 10/22/15 at 10:24 AM with ardian revealed she did not e notice until after Resident charge to another facility to fown. Resident #112 's e facility's administrator son for discharge was public at 11:19 AM with Nurse sident #112 did not exhibit in the nursing unit. 5 at 11:23 AM with Nurse #2 in 11:23 AM with Nurse #2 in 12 did not exhibit behavior sing unit. 5 at 11:30 AM with Nurse #3 in 12 did not exhibit behavior sing unit. 6 at 11:30 AM with Nurse #3 in 12 did not exhibit behavior sing unit. 6 at 11:30 AM with Nurse #3 in 12 did not exhibit behavior sing unit. 6 at 11:30 AM with Nurse #3 in 12 did not exhibit behavior sing unit.	F 2	worsening report to during me Supervise behavior has been behavior report to findings of The DON the QA& effective The QA& results of effective findings of the pool of the po	ng behaviors as indicated and of the Interdisciplinary team dail norning meeting. The Weeker sor will audit 24 hour reports for and ensure that the physician notified of new or worsening rs. The weekend supervisor worthe DON the results of her	ly nd or an ill	
	Interview on 10/22/18 revealed Resident #1 problems on the nurs Interview with the fact 10/22/15 at 3:30 PM received a discharge urination. The social with Resident #112 to inappropriate and a city given if he continued outside. The social with Resident #112 a bed facility. The social with 112 agreed to be disreported she was not interdisciplinary team.	5 at 11:30 AM with Nurse #3 112 did not exhibit behavior sing unit. cility's social worker on revealed Resident #112 notice due to public worker explained she met be explain his behavior was discharge notice would be to urinate in the lobby and worker reported she informed was available at another orker reported Resident scharged. The social worker					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345405	B. WING_			C 10/23/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		10/23/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 250 SS=D	in the lobby and outs discharge notice. The attempt was made to guardian by phone. The mailed to Resident # Interview with the Dir 10/22/15 at 4:10 PM received a discharge urination. The DON of any interventions to Interview with Nurse revealed she spoke with 10/04/15 when urinated lobby. Nurse #1 expany interventions to put than to redirect Resident #1 of a discharge notice explained he would he staff regarding Resident 10/05/15. 483.15(g)(1) PROVIS RELATED SOCIAL STATED	at 3:50 PM with the ed Resident #112 s urination ide of the facility caused the e administrator reported an notify Resident #112's The discharge notice was 112's guardian. The discharge notice was 112's notice due to the public reported she was not aware of alter the behavior. The discharge notice was 112's public urination occurred in the facility's lained she was not aware of the dent #112 to a bathroom. The discharge notice was 112's public urination, receipt and discharge. The MHNP have addressed and met with ent #112's behavior on The discharge notice was 112's public urination, receipt and discharge. The MHNP have addressed and met with ent #112's behavior on The discharge notice was 112's public urination, receipt and discharge of the MHNP have addressed and met with ent #112's behavior on The discharge notice was 112's public urination, receipt and discharge of the MHNP have addressed and met with ent #112's behavior on		250		11/18/15

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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NAME OF D		343403	5	C-	TREET ADDRESS CITY STATE ZID CODE	10/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			735 TODDVILLE ROAD		
				С	CHARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROI DEFICIENCY)			(X5) COMPLETION DATE
F 250	Continued From page	e 4	F	250			
	This REQUIREMENT by:	is not met as evidenced					
	The facility failed to p social services regard interventions for resid	lent behavior for 1 of 1 no exhibited inappropriate			F250 Provision of Medically Related Social Services DOC 11/18/15		
	The findings included	:			Resident 112 was admitted to a skilled nursing facility and he is stable this time.	at	
	Resident #112 was admitted to the facility on 02/04/11 with diagnoses which included unspecified psychosis.				All residents have the potential to be affected by this same deficient practice 2 An audit of residents with a history behaviors will be completed by the		
	Data Set dated 09/09	112's quarterly Minimum /15 revealed an assessment h no behavior problems.			Discharge Planner (Social Worker) as 11/18/15. Residents behaviors will be reported to the attending physician as indicated.	of	
	dated 10/04/15 revealin a public place and #1 documented Resid	eview of a nursing note, written by Nurse #1 ated 10/04/15 revealed Resident #112 urinated a public place and received redirection. Nurse I documented Resident #112 continued to reinate in a public place.		3 All Nursing staff will be re-educated by the SDC regarding the importance of reporting behaviors and documentation regarding behaviors as of 11/18/15. All Nursing staff will be re-educated by the SDC regarding the importance of			
	practitioner (MHNP) revealed Resident #1 that day (10/05/15).	12 received a routine visit The MHNP documented "no sis. Staff has not reported			notification of resident □s physician regarding behaviors as of 11/18/15. The Discharge Planner (Social Worker was reeducated by the NHA on 10/22/regarding the responsibility to provide medically necessary social services to residents.	15 the	
	10/22/15 at 3:30 PM received a discharge urination. The social with Resident #112 to inappropriate and a discharge to the social with the soci	ility's social worker on revealed Resident #112 notice due to public worker explained she met explain his behavior was ischarge notice would be ker reported she was not			All newly hired Discharge Planners (So Workers) will be educated during orientation regarding the responsibility provide medically necessary social services to the residents. 4 The Unit Managers will audit 24 horeports for behaviors to ensure that the physician has been notified of new or	to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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		345405	B. WING _		1	0/23/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE	
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CHARLOT	TE HEALTH & REHAB	SILITATION CENTER		CHARLOTTE, NC 28214		
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F 250	regarding Resident discharge notice. The she did not interact or the nursing staff behavior problems responsibilities. Interview with the Discretized a discharge urination. The DON met with Resident facease. The DON reany interventions to social worker and into coordinate behavioral interventions to shape the social worker and into the social worker and the social worker and the social worker and the social worker and into the social worker and the social worke	#112's behavior to prevent a The social worker explained with Resident #112's MHNP regarding interventions for due to other job Director of Nursing (DON) on Marevealed Resident #112 are notice due to the public Nexplained the social worker #112 to request public urination exported she was not aware of alter the behavior but the ursing staff were responsible vioral interventions. The DON reason Resident #112's all worker were not involved in tions.	F2	worsening behaviors a report to the Interdisci during morning meetin Supervisor will audit 2 behaviors and ensure has been notified of n behaviors. The weeke report to the DON the findings weekly. The Discharge Planne behavior managemen with new or worsening with the Interdisciplina includes: DON, NHA, Activity Director. The effectiveness of the in plan to determine the individual Behavior M. The Discharge Planne will audit the effective management plans w	plinary team daily ng. The Weekend 14 hour reports for that the physician ew or worsening and supervisor will results of her er will develop at plans for residents g behaviors along ary Team which DP (SW), MDSC, IDT will evaluate the dividual residents effectiveness of the anagement Plan. er (Social Worker) ness of behavior eekly and report the	
F 272 SS=D	10/04/15 when urin lobby. Nurse #1 ex any interventions to than to redirect the Telephone interview on 10/22/15 at 5:05 aware of Resident # of a discharge notice explained he would	with Resident #112 on ation occurred in the facility's plained she was not aware of prevent the behavior other Resident to a bathroom. with Resident #112's MHNP PM revealed he was not #112's public urination, receipt the and discharge. The MHNP have addressed and met with ident #112's behavior on PREHENSIVE	F 2	results of audits to the monthly as of x one you have results of these audits effectiveness of the plant changes as needed.	ear. will evaluate the to determine the	11/18/15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	DDE	10/23/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 272	The facility must con a comprehensive, and reproducible assessifunctional capacity. A facility must make assessment of a respecial respective patterns; Communication; Vision; Mood and behavior; Psychosocial well-bet Physical functioning Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sutthe additional assessment of a comprehensive patterns; Communication; Vision; Mood and behavior; Psychosocial well-bet Physical functioning Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sutthe additional assessment of a responsible pata Set (MDS); and	duct initially and periodically ccurate, standardized ment of each resident's a comprehensive ident's needs, using the stanstrument (RAI) specified instrument include at mographic information; catterns; sing; and structural problems; and health conditions; all status; and procedures; ammary information regarding sment performed on the care the completion of the Minimum	F2	272		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345405	B. WING			10/	23/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CHARLOT	TE HEALTH & REHABII	LITATION CENTER			735 TODDVILLE ROAD		
				C	HARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	by: Based on staff interviacility failed to condition assessment to identificated function and risk for falls, psychological activities of daily living residents (Residents). The findings included 1. Resident #10 was 11/22/14 with diagnost and chronic obstruction. Review of Resident #2 Set (MDS) dated 09/assessment of short problems with verbal directed toward other Resident #10 receives medication. The MD had two falls without assessment. Review of Resident #4 Assessment (CAA) of documentation of find the problem, descript contributing factors a fall risk. There was ranalysis of the finding proceed or not to proceed.	riews and record review, the act a comprehensive fy and analyze how condition I quality of life related to the active medication, and ag for 2 of 23 sampled #3 and #73). d: s admitted to the facility on ses which included dementia five pulmonary disease. #10's annual Minimum Data 03/15 revealed an and long term memory behavioral problems rs. The MDS indicated ed anti-depressant PS indicated Resident #10 injury since the prior #10's Fall Care Area lated 09/07/15 revealed no dings with a description of tion of fall history, causes, and risk factors related to a no documentation of an gs supporting the decision to occeed to the care plan.	F	272	F272 Comprehensive Assessments DOC 11/18/15 1 Resident #10 and Resident # 73 Resident #10s Fall CAA from his 9/03/7 MDS was revised to include a description of the problem, a description of his fall history, causes and contributing factors related to fall risk and risk factors. An analysis was documented of the reason proceed to care plan as of 11/16/15. Resident #10s Psychotropic Drug Use CAA dated 9/03/15 was revised to includocumentation of findings and a description of the problem. The CAA not reflects the name and dosage of the medication. Contributing factors and rist factors related to psychotropic drug use have been added to the CAA. An analy was documented of the reason to proceed to care plan as of 11/16/15. Resident #73s ADL/Rehabilitation CAA from his 5/28/15 MDS was revised to include a description of the physical limitations, the impact of his mood, causes and contributing factors related ADLs and risk factors as of 11/16/15. Resident was interviewed to garner his input on 11/16/15. An analysis was documented of the reason to proceed to care plan as of 11/16/15. As of 11/18/15 all comprehensive MDS with an ARD of 10/24/15 or after were audited by the MDSCs and the MDS Consultant to determine if the Fall CAA	on to de by sis seed to	
	revealed no docume	ntation of findings with a bblem, name and dose of			included documentation of findings with description of the problem, description	na	

SAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH & REHABILITATION CENTER DISCRIPTION OF LISCIDENTIFYING INFORMATION OF DEPCEMBENT		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
INVESTMENT OF PROVIDER OR SUPPLIER CHARLOTE HEALTH & REHABILITATION CENTER CHARLOTE HEALTH & REHABILITATION CENTER CHARLOTE, NC. 28214 SUMMANY STAFFMENT OF DEPICIENCES (FACH DEPICIENCES) (FACH DEPICIENCY MUST ARE PROCEDED BY PULL PROVIDER PROPERTIES (FACH DEPICIENCY MUST ARE PROCEDED BY PULL PROVIDER PROVIDER PLAND OF CORSE-PREMENTED TO THE APPROPRIATE DEPICIENCY OR LSC IDENTIFY IN PROVIDER PLAND OF CORSE-PREMENTED TO THE APPROPRIATE DEPICE OF THE APPROPRIATE DEPACE OF THE APPROPRIATE DEPACEMENT DEPICE OF THE APPROPRIATE DEPACE OF THE APPROPRIATE DEPACEMENT DEP				A. BOILDI	_		,	_
STREET LADDRESS. CITY. STATE, JP CODE 1735 TODDVILLE ROAD CHARLOTTE, MC 28214 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) F 272 Continued From page 8 medications, contributing factors and risk factors related to psychotropic drug use. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Interview with MDS Coordinator #1 on 10/23/15 at 12:31 PM revealed Resident #10's fall and psychotropic drug use CAAs dien dot contain documentation of an analysis of the findings. 2. Resident #73 was admitted to the facility on 06/28/14 with diagnoses which included cerebral vascular disease. Review of Resident #73's annual Minimum Data Set (MDS) dated 05/28/15 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #73's required the extensive assistance of one person with dressing and hygiene. Review of Resident #73's Activities of Daily Living Functional/Rehabilitation Care Area Assessment (CAA) dated 05/28/15 revealed no documentation of findings with a description of Resident #73's aphysical limitations, impact of mood, input from Resident #73', acuses, contributing factors and risk factors related to Three was no documentation of an analysis of the findings supporting the decision to proceed to rare plan. Interview with MDS Coordinator #1 on 10/23/15 at 12:31 PM revealed Resident #73's activities of Daily Living Functional/Rehabilitation CAA in country and the description of the problem, causes, contributing factors and risk factors related to Three was no documentation of an analysis of the findings supporting the decision to proceed to roa to proceed to the care plan. Interview with MDS Coordinator #1 on 10/23/15 at 12:31 PM revealed Resident #73's Activities of Daily Living Functional/Rehabilitation CAA include the decision to proceed to the care plan. Interview with MDS Coordinator #1 on 10/23/15 at 12:31 PM revealed Resident #73's			345405	B. WING_				-
CHARLOTTE NC 28214 MAILOR SUMMARY STATEMENT OF DEFIDENCISE PRECEDUATION	NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	107	20/2010
MAILOTTE, NC 28214 PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FILL PREFIX TAG					17	735 TODDVILLE ROAD		
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contain documentation of an analysis of findings. month, then twice monthly for one month and then monthly x 10 months to ensure								
and then monthly x 10 months to ensure						T		
		contain documenta	ition of an analysis of findings.			-		
the Fall CAA Psychotronic Drug Use CAA								

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345405	B. WING		C 10/23/2015
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	10/25/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 272 F 333 SS=D	Continued From page 483.25(m)(2) RESIDE SIGNIFICANT MED E The facility must ensuany significant medica	ENTS FREE OF ERRORS ure that residents are free of	F 27	and ADL Function/Rehabilitation CAAs applicable include documentation of findings with a description of the problecauses, and contributing factors and rifactors related to the risk associated with the problem as well as an analysis of the need to proceed to care plan. MDS Consultant will also audit those CAAs ensure that an interview is documente indicated. The MDSC will report findings of audit the QA&A committee monthly x one years. The QA&A committee will evaluate the findings from those audits to determine the effectiveness of the plan and make changes as necessary.	em, isk vith the to d as s to ear.
	by: Based on observation interviews the facility medication to 1of 6 sat #185) on 6 days for a medications. Findings included: Resident #185 had discussed in the resident medication order 6/10 200 mg twice a day be was scheduled for 9:00.	ris not met as evidenced ns, record review and staff failed to administer seizure ampled residents (Resident total of 8 missed doses of agnoses that included ns. nt's record indicated that the 0/2015 was for Lacosamide y mouth for seizures and 00 AM and 5:00 PM. As a the Lacosamide had to be		F333 Residents Free of Significant Med Erro 1 Resident # 185s physician was notified on 10/24/15 with no new order given. Resident # 185 has received his medication per physician □s order. 2 All other residents have the poten to be affected by this same deficient practice. An audit of Medication Administration Records (MARs) will be completed as 11/18/15 to ensure that medications ar given per physicians orders.	rs s itial

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(>	K3) DATE SURVEY COMPLETED
		345405	B. WING _			C 10/23/2015
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	DDE	16/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 333	Review of the contregarding Residen revealed there were 10/11, 10/12, 10/10 medication had not The eight occasion should have signed Lacosamide 200 m. An interview with the at 9:30 AM on 10/20 on the documental logbook, the medications were "Especially seizure was called last niggoing to see Residinformed of any see At 2:29 PM on 10/20 (DON) was interview DON identified the the medication who and Nurse #4 stated Residing on so I pulled modification on 10/16 to get his medication.	ntrolled substance logbook ven. rolled substance logbook t #185's Lacosamide 200 mg re eight occasions (9/26, 10/5, 6, and 10/18/2015) when the t been signed out and given. as involved three nurses who d out and given the ng to Resident #185. the unit manager (UM) occurred 22/2015.She verified that based cion in the controlled substance reation was not given and she th the nurse. 1/23/2015 the nurse practitioner pectation was that all to be given and the NP added, e medications." She stated she th about this. The NP was lent #185 and had not been	F3	3 All nurses were reeduce SDC regarding the importar providing medications per porders as of 11/18/15. All newly hired nurses will be during orientation regarding importance of providing medications orders. 4 The Director of Nurses MARs one time monthly to emedications are being given physician or of these audits to the QA&A monthly x one year effective The QA&A committee will ever effectiveness of the plan and changes as needed.	nce of ohysician see educated the dications per will audit ensure that a per e 11/18/15 report findings a committee e 12/16/15 valuate the	S

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345405	B. WING		10	C 0/23/2015
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		
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F 333	Continued From page	e 11	F 3	33		
	logbook as having giv	on the control substance ven it to Resident #185. All				
F 371 SS=D	the survey. At 3:23 PM on 10/23/expected the nurses ordered by the physic omitted the DON's experience to the unDuring an interview and nurse #6 stated she was 10/12/2015 9:00 AM signed off. After review controlled substance.	2015 the DON stated she to administer medications as cian. If a medication is spectation was that it would it manager or DON. t 3:40 PM on 10/23/2015 was not aware that the dose of Lacosamide was not awing the log for the Nurse #6 concluded that wen Resident #185 the osamide 200 mg on	F 3	71		11/18/15
	considered satisfacto authorities; and (2) Store, prepare, di under sanitary condit					
	by: Based on observatio	is not met as evidenced ns and staff interviews the ain sanitary conditions for 2		F371 Food Procure/Store/Prepare/Serve-Sar	nitary	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			` ′	E SURVEY PLETED
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		345405	B. WING			1	/23/2015
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1	00
CHARLOT	TE HEALTH & REHABI	I ITATION CENTER		17	735 TODDVILLE ROAD		
CHARLO	TE HEALTH & KEHADI	LITATION CENTER		С	HARLOTTE, NC 28214		
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F 371	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 of 2 nourishment rooms on the 100 and 200 hallway. The findings included: 1. An observation was made of the refrigerator in the nourishment room on the 100 hallway on 10/20/15 at 9:20 AM. The observation revealed inside the refrigerator on the top and bottom shelf there was dark brown and red sticky substance on the shelves. Interview with housekeeper #1 on 10/20/15 at 9:38 AM stated she was responsible for cleaning the nourishment room on 100 hallway. She stated the refrigerators was to be cleaned in the mornings and the evenings. During the interview, she acknowledge the refrigerator had a lot of dark brown and red sticky substance on the top and bottom shelf. 2. An observation was made of the refrigerator in the nourishment room on the 200 hall on 10/20/15 at 9:25 AM revealed on the top and bottom shelf there was dark brown and red sticky substance. Interview with housekeeper #2 on 10/20/15 at 9:35 AM accompanied to the nourishment room revealed she was responsible for cleaning common areas and the nourishment room on the 200 hallway. During the interview, she acknowledge the nourishment room had not been cleaned and had a lot of dark brown and red sticky substance on the top and bottom shelf. Interview conducted with the Director of			PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO		BBE COMPLETION DATE S of Ses ors nonth thly x ses ses ses ses ses ses ses ses ses s	
	Interview conducted with the Director of Housekeeping on 10/20/15 at 9:42 AM stated staff is trained to clean nourishment rooms. The Director of housekeeping was accompanied to the nourishment room and revealed it had a lot of dark brown and red sticky substance on the top						

and bottom shelf. During the interview, he stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345405	B. WING _			10/	23/2015		
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STAT 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	FE, ZIP CODE	1 10//	20/2010		
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F 371	nourishment rooms in evenings. He further for staff to round before	responsible for cleaning the note the mornings and the stated his expectation was one the end of the shift and to	F	371					
F 520 SS=D	make sure the nouris daily. 483.75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS		F S	520			11/18/15		
	assurance committee nursing services; a p	ain a quality assessment and e consisting of the director of hysician designated by the B other members of the							
	issues with respect to and assurance activi develops and implem	ent and assurance east quarterly to identify by which quality assessment ties are necessary; and nents appropriate plans of tified quality deficiencies.							
		ords of such committee ch disclosure is related to the committee with the							
		by the committee to identify eficiencies will not be used as .							
	by:	T is not met as evidenced		F520					
	_ 3000 0.1 00001 7000			. 5=5					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345405	B. WING			C 10/23/2015	
NAME OF PROVIDER OR SUPPLIER					EET ADDRESS, CITY, STATE, ZIP CODE	<u> 107.</u>	23/2015
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER		1735 TODDVILLE ROAD CHARLOTTE, NC 28214			
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F 520	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F		QAA Committee-Members/Meet Quarterly/Plans See F371 for corrective action for the associated deficiency. Reeducation was given to all Department managers by the NHA on 11/13/15 regarding the policy and intent of QA& program. All newly hired Department Managers was be educated at the time of hire regarding QA&A processes. Administrator will ensure completion of audits for F371 monthly x one year. The Dietary Manager will report on the findings of these audits monthly to the QA&A committee x one year. The QA&A committee x one year. The QA&A committee will evaluate the findings from these audits in order to ensure that the plan is effective and machanges as necessary.	A will ng	