Image: Trag       CEACH DEFICIENCY MUST BE PRECIDED BY TULL REOULTION OR USC DENTIFYING INFORMATION)       PREFIX TAG       CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT ON HEAPROPRIATE       COUNT UNITYIE       COUNTYIE       COUNTYIE <thcountyie< th=""> <thcountyie< th="">       COUNTYI</thcountyie<></thcountyie<>	DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES					M APPROVE
ND PLAN OF CORRECTION     IDENTIFICATION NUMBER     A BUILDING     COMMULTEE       346471     B. WING     C     C       MANE OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2PT CODE     STREET ADDRESS, CITY, STATE, 2PT CODE     STREET ADDRESS, CITY, STATE, 2PT CODE       MAIL OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2PT CODE     STREET RADRESS, CITY, STATE, 2PT CODE     STREET ADDRESS, CITY, STATE, 2PT CODE       MAIL OF CREATING REALTH & REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, 2PT CODE     STREET RADRESS, CITY, STATE, 2PT CODE       MAIL OF CREATING REALTH & REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, 2PT CODE     STREET ADDRESS, CITY, STATE, 2PT CODE       MAIL OF CREATING REALTH & REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, 2PT CODE     STREET ADDRESS, CITY, STATE, 2PT CODE       F 276     483.20(g)-(j) ASSESSMENT     F 276     POONE PROVIDERS PLAN OF CORRECTION OF THE APPROPRIATE       (j) Conditation     ACCURACY/COORDINATION/CERTIFIED     F 276     Z/8/17       (j) Conditation     A registered nurse must sign and certify that the assessment in sessessment in the appropriate     C       (j) Conditation     (j) Cartification     (j) Cartification     (j) Cartification       (j) Orable Medicare and Medicaid, an individual who willfully and knowingly.     C     C       (j) Concline assessment is subject to a civil money penalty of not more than \$1,000 for each assessment is subject to a civil money	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-039
345471         B_WING         01/11/201;           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS.CITY.STATE_ZIP CODE           XIST OF COLSPANE         STREET ADDRESS.CITY.STATE_ZIP CODE           VID COLSPANE"         STREET ADDRESS.CITY.STATE_ZIP CODE           VID COLSPANE"         STREET ADDRESS.CITY.STATE_ZIP CODE         CODE         VID CODE <th< th=""><th></th><th></th><th></th><th></th><th colspan="3"></th><th>PLETED</th></th<>								PLETED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, State, 2P CODE         MECKLENBURG HEALTH & REHABILITATION CENTER       STREET ADDRESS, CITY, State, 2P CODE         MEDIA       SUBMARY STREMENT OF DEPORTNER       D         ADD       SUBMARY STREMENT OF DEPORTNER       PROVIDERS FANCE OF DATA CORRECTION TAGE STREMENT WILL REGULATORY OR LISC IDENTIFYING INFORMATION,       PRECENT       PROVIDERS FANCE OF DATA CORRECTION THE APPROPRIATE DEFICIENCY       D         F 278       483.20(g)-(j) ASSESSMENT       F 278       F 278       483.20(g)-(j) ASSESSMENT (j) ACCURACY/COORDINATION/CERTIFIED       F 278       G       2/8/17         (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.       (i) Coordination       F 278       F 278       2/8/17         (i) Coordination       Accuracy of Assessment stagn and certify that the assessment is completed.       F 278       F 278       2/8/17         (i) Cartification       (i) Cartification       (i) Cartification       F 278       F 278       2/8/17         (i) Cartification of healt professionals.       (i) Cartification       F 278       F 278       2/8/17         (i) Cartification       (i) Cartification       (i) Cartification       F 278       F 278       2/8/17         (i) Cartification of the assessment is subject to a civil money penalty of not more than \$1,000 for each assessment is subject to a civ			345471	B WING			_	
MECKLENUES HEALTH & REHABILITATION CENTER         2115 SANDY PORTER ROAD CHARLOTTE, NO. 28273         2110           PRETX TAG         SUMMARY STATEMENT OF DEPICENCIES RECLARORY OR USCIDENTIFING INFORMATION         ID         IPRETX PRETX         ID         DOWNORTS IN USCIDENTIFING INFORMATION         ID         I			545471					/11/2017
MECKLENBURG HEALT & REHABLITATION CENTER     CHARLOTTE, NC 28273       (M) ID PRECK TAC     SUMMARY STREMENT OF DEFICIENCIES (2AC) DEFICIENCY USISTE IMEEDED BY FULL REGULTION VOIR 12 CIEDENTIFYNG INFORMATION     ID PRECK TAC     PROVIDENS FLAN OF CONNECTION BOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY ACCURACY/COORDINATION/CERTIFIED     ID PRECK (9) Accuracy of Assessments. The assessment must accurately reflect the resident's status.     F 278     F 278     2/8/17       (0) Cardination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.     F 278     Cardination (1) A registered nurse must sign and certify that the assessment is completed.     (2) Each individual who completes a portion of the assessment must sign and certify that the assessment is upper to a civil money penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-     (1) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or     The statements included are not an adminiation and eact when the subject to a civil money penalty or not more than \$5,000 for each assessment.       (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to code the minimum data set to     The statements included are not an administion and do not constitute		NONDER OR OUT LIER						
Image: Trag         CEACH DEFICIENCY MUST BE PRECIDED BY TULL REOULTION OR USC DENTIFYING INFORMATION)         PREFIX TAG         CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT ON HEAPROPRIATE         COUNT DEFICIENCY           F 278         483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED         F 278         2/8/17           (j) Accuracy of Assessments. The assessment must accurately reflect the resident's status.         (r) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.         (j) Certification         (j) A registered nurse must completes a portion of the assessment is completed.         (j) Certification         (j) Under Medicare and Medicaid, an individual who willfully and knowingly-         (j) Certifies a material and false statement in a resident assessment; or         (j) Certifies a material and false statement in a resident assessment.         (j) Certifies a material and false statement in a resident assessment.         (j) Certifies a material and false statement in a resident assessment.         (j) Causes another individual who willfully and knowingly-         (j) Causes another individual to certify a material and false statement.         The statements included are not an assessment.         (j) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to code the minimum data set to         The statements included are not an admission and do not constitute	MECKLEN	IBURG HEALTH & REHA	ABILITATION CENTER					
SS=D       ACCURÃCÝ/COORDINATION/CERTIFIED       Image: constraint of the sessessment must accurately reflect the resident's status.         (i)       Couracy of Assessments. The assessment must accurately reflect the resident's status.       Image: constraint of the assessment with the appropriate participation of health professionals.       Image: constraint of the assessment with the appropriate participation of health professionals.         (i)       Certification       (1) A registered nurse must sign and certify that the assessment is completed.       Image: constraint of the assessment.         (2)       Each individual who completes a portion of the assessment.       Image: constraint of the assessment.       Image: constraint of the assessment.         (i)       Penalty for Falsification       (1)       Under Medicare and Medicaid, an individual who willfully and knowingly.       Image: constraint of the assessment is a subject to a civil money penalty of not more than \$1,000 for each assessment; or       Image: constraint of the assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.       Image: constraint of the assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.       Image: constraint of the assessment is a subject to a civil money penalty or not more than \$5,000 for each assessment.       Image: constraint of the assessment.       Image: constraint of the assessment is a subject to a civil money penalty or not more than \$5,000 for each assessment.       Image: constraint of the assessment.       Image: constraint of the assessment.       Image: constraint of the assessment.       <	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
must accurately reflect the resident's status.         (h) Coordination         A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.         (i) Certification         (1) A registered nurse must sign and certify that the assessment is completed.         (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.         (ii) Penalty for Falsification         (1) Under Medicare and Medicaid, an individual who willfully and knowingly-         (ii) Certifies a material and false statement in a resident assessment.         (iii) Causes another individual to certify a material and false statement is subject to a civil money penalty of not more than \$1,000 for each assessment.         (ii) Causes another individual to certify a material and false statement.         (ii) Causes another individual to certify a material and false statement.         (iii) Causes another individual to certify a material and false statement.         (iii) Causes another individual to cortify a material and false statement.         (iii) Causes another individual to certify a material and false statement.         (iii) Causes another individual to certify a material and false statement.         (iii) Causes another individual to certify a material and false statement.         (iii) Causes another individual to certify a material and false statement.         (iiii) Causes another individual to certify the atterial				F 2	278			2/8/17
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.       (i) Certification         (i) Certification       (1) A registered nurse must sign and certify that the assessment is completed.       (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment must sign and certify the accuracy of that portion of the assessment.         (i) Penalty for Falsification       (1) Under Medicare and Medicaid, an individual who willfully and knowingly-         (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of nor more than \$1,000 for each assessment, or         (ii) Causes another individual to certify a material and false statement is subject to a civil money penalty or not more than \$5,000 for each assessment.         (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:         Based on record reviews and staff interviews the facility failed to code the minimum data set to								
(1) A registered nurse must sign and certify that the assessment is completed.         (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.         (i) Penalty for Falsification         (1) Under Medicare and Medicaid, an individual who willfully and knowingly-         (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or         (ii) Causes another individual to certify a material and false statement in a resident assessment.         (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to code the minimum data set to		A registered nurse must conduct or coordinate each assessment with the appropriate						
assessment must sign and certify the accuracy of that portion of the assessment.         (i) Penalty for Falsification         (1) Under Medicare and Medicaid, an individual who willfully and knowingly-         (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or         (ii) Causes another individual to certify a material and false statement in a resident assessment; or         (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.         (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to code the minimum data set to		(1) A registered nurse						
<ul> <li>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</li> <li>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</li> <li>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</li> <li>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to code the minimum data set to</li> </ul>		assessment must sig	n and certify the accuracy of					
resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to code the minimum data set to The statements included are not an admission and do not constitute		(1) Under Medicare a	and Medicaid, an individual					
<ul> <li>and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</li> <li>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:</li> <li>Based on record reviews and staff interviews the facility failed to code the minimum data set to</li> </ul>		resident assessment penalty of not more the second	is subject to a civil money					
material and false statement.This REQUIREMENT is not met as evidencedby:Based on record reviews and staff interviews the facility failed to code the minimum data set toThe statements included are not an admission and do not constitute		and false statement i subject to a civil mon	n a resident assessment is ey penalty or not more than					
facility failed to code the minimum data set to admission and do not constitute		material and false sta This REQUIREMENT by:	atement. F is not met as evidenced					
30RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								
Electronically Signed 01/27/2			SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE 01/27/201

**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.

PRINTED: 01/30/2017

GENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 093	38-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
			5.11/11/0	С		
		345471	B. WING		01/11/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD		
MECKLE	NBURG HEALTH & REHA	ABILITATION CENTER				
				CHARLOTTE, NC 28273	1	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CON	(X5) IPLETIO DATE
F 278	Continued From page	e 1	F 278	3		
Γ 218	Continued From page 1 accuratelty reflect a resident's bowel continence for 1 of 3 residents sampled for ostomy care (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/18/16 with diagnoses that included hemiplegia, multiple fractures of the tibia and cervical vertebra, carcinoma of the trachea, acute respiratory failure, and others. Resident #1 was discharged from the facility on 12/20/16. Review of Resident #1's medical record from 11/18/16 to 12/20/16 revealed no record of rectal tube or colostomy. Review of a nurse's note dated 11/23/16 at 5:03 PM read in part, large bowel movement (BM) noted. Signed by Nurse #1. Review of the most recent comprehensive Minimum Data Set (MDS) dated 11/25/16 revealed that Resident #1 was cognitively intact			<ul> <li>agreement with the alleged deficier herein. The plan of correction is completed in the compliance of star federal regulations as outlined. To in compliance with all federal and s regulations the center has taken or take the actions set forth in the following pl correction constitutes the center s allegation of compliance. All alleged deficiencies cited have been or will completed by the dates indicated.</li> <li>F278 How corrective action will be accomplished for each resident four have been affected by the deficient practice: Resident #1 was discharg from the facility 12/20/16 as Dischar Return Anticipated. To date, resider not been readmitted to the facility.</li> </ul>	te and remain tate will owing an of be nd to ed rge	
	member for toileting. continence was code reference period of th was noted. Interview with Nurse revealed that she ren clearly. Nurse #1 stat specifically recall the had on 11/23/16 but colostomy or rectal th when Resident #1 ha provide incontinent c on Resident #1. Nurs had a feeding tube at that required frequen direct care staff. Interview with the ME	ad as "not rated" during the me MDS and constipation #1 on 01/11/17 at 3:00 PM membered Resident #1 very ted that she did not large BM that Resident #1 stated he did not have a ube. Nurse #1 stated that ad a BM staff members would are and place a clean brief se #1 stated that Resident #1 nd had regular frequent BM's t incontinent care by the		<ul> <li>F278 How corrective action will be accomplished for those residents h the potential to be affected by the s deficient practice: All current reside MDS will be reviewed to ensure Se H, question H0400 Bowel Continen correctly coded according to the documentation from the residents□ medical records. Any issues identifibeing coded incorrectly, will be more by the MDSC. Completion date: February 8, 2017</li> <li>F278 Measures to be put in place of systemic changes made to ensure practice will not re-occur: Educating provided to MDSC by the MDSC reconsultant on January 17, 2017 on</li> </ul>	ame ents ction ce, is ied as dified or on was gional	

Facility ID: 955030

If continuation sheet Page 2 of 6

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/30/20 FORM APPROVE OMB NO. 0938-03
		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345471	B. WING		C 01/11/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MECKLENBURG HEALTH & REHABILITATION CENTER				2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	
(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 CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETIO
F 278	colostomy. MDS Coordinator did not complete Rest the MDS Coordinator she was fairly new to completing MDS's. M that it appeared there available during the r #1's bowel continence why MDS Coordinator Interview with the Dir 01/11/17 at 5:00 PM MDS Coordinator #2 record including nurs direct care staff to ha needed to code the M this was MDS Coordi with MDS's and she w inaccurate but she fe had done the best sh knowledge that she h that MDS Coordinator nurse had provided th coordinator #2 and th required for someone MDS. The DON furth expected the MDS's reflect the patient's st Interview with the Add 5:44 PM revealed tha MDS's to be coded a patient's status. Interview with the ME 01/11/17 at 6:00 PM to the position, she h September 2016. MD that the Corporate M	ant had a rectal tube or a bridinator #1 stated that she sident #1's MDS on 11/25/16 *#2 had completed it and the facility and was new to IDS Coordinator #1 did state e was no information eference period on Resident e and that may have been or #2 coded it as "not rated." ector of Nursing (DON) on revealed that she expected to review the entire medical e's notes and talk to the ve the accurate information ADS. The DON stated that nator's #2 first job working was not sure the MDS was It like MDS Coordinator #2 e could with limited had. The DON also stated r #1 and the corporate MDS he over sight that was e who was new to completing er stated that she fully to be coded accurately to tatus. ministrator on 01/11/17 at at he also fully expected ccurately to reflect the	F 278	<ul> <li>RAI requirements for coding H040 Continence in section H. All new employees will be educated on pr coding of Section H, question H04 according to the RAI Manual. The Consultant or designee will audit is residents  MDS to ensure Questi H0400 Bowel Continence is corre coded according to the document from the residents medical reco weekly for 4 weeks, twice a month month, and monthly x 10 months. coding issue identified on the aud be immediately corrected with coaching/discipline as needed to MDSC. Completion date: Febru 2017</li> <li>F278 How facility will monitor corr action(s) to ensure deficient pract not re-occur: Results of the week will be reviewed at Weekly Risk G Assurance Meeting and Quarterly Assurance meeting X 4 for further resolution if needed. Completion of February 8, 2017</li> </ul>	MDSC roper 400, e MDS 5 ion ectly ration rds once h for one Any lits will the uary 8, rective ice will cly audits Quality y Quality r

If continuation sheet Page 3 of 6

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/30/2017 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345471		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMF	E SURVEY PLETED	
		B. WING			C 01/11/2017		
	ROVIDER OR SUPPLIER	BILITATION CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 278 F 520 SS=D	not have a colostomy because there was no documentation to tell continent or incontine stated that she did re could not specifically large BM that was do also stated that the m Resident #1 was inco Coordinator #2 also s her notes she could r interviewed the direct status of Resident #1 483.75(g)(1)(i)-(iii)(2) COMMITTEE-MEMB QUARTERLY/PLANS (g) Quality assessme (1) A facility must ma and assurance comm minimum of: (i) The director of nur (ii) The Medical Direct (iii) At least three othe staff, at least one of v administrator, owner, individual in a leaders (g)(2) The quality ass committee must : (i) Meet at least quart coordinate and evalue	<ul> <li>so she coded "not rated"</li> <li>o Nursing Assistant (NA)</li> <li>her if Resident #1 was</li> <li>ent. MDS Coordinator #2</li> <li>view the progress notes but</li> <li>recall if she had seen the</li> <li>cumented on 11/23/16, she</li> <li>ote did not indicate if</li> <li>ontinent or continent. MDS</li> <li>stated that without reviewing</li> <li>not say if she had</li> <li>t care staff to find out the</li> <li>'s bowel continence.</li> <li>(i)(ii)(h)(i) QAA</li> <li>ERS/MEET</li> <li>ont and assurance.</li> <li>intain a quality assessment</li> <li>nittee consisting at a</li> <li>sing services;</li> <li>etor or his/her designee;</li> <li>et members of the facility's</li> <li>who must be the</li> <li>a board member or other</li> <li>ship role; and</li> <li>sessment and assurance</li> </ul>		520			2/8/17

Facility ID: 955030

If continuation sheet Page 4 of 6

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/30/2017 // APPROVED ). 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         345471         NAME OF PROVIDER OR SUPPLIER         MECKLENBURG HEALTH & REHABILITATION CENTER         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 520         Continued From page 4 assessment and assurance activities are necessary; and         (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;         (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.         (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.		· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345471	B. WING _				C 11/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	415 SANDY PORTER ROAD		
	IDURG HEALI H & REHA	BILITATION CENTER		С	HARLOTTE, NC 28273		
PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 520	assessment and assume cessary; and (ii) Develop and implet action to correct ident (h) Disclosure of infor Secretary may not recorrecords of such commission committee with the section. (i) Sanctions. Good fat committee to identify a deficiencies will not be sanctions. This REQUIREMENT by: Based on record revise facility's Quality Assess Committee failed to mean procedures and monit the committee put into was for one recited decited in August 2016 of and subsequently recomplaint investigation area of resident assess failure of the facility during a pattern sustain an effective Q. The Findings included the facility of the facility is the facility of the facility o	ement appropriate plans of ified quality deficiencies; mation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this ith attempts by the and correct quality e used as a basis for is not met as evidenced ews and staff interviews the sament and Assurance taintain implemented for these interventions that o place in August 2016. This efficiency that was originally on a recertification survey ited in January 2017 on a n. The deficiency was in the sament. They continued uring two federal surveys of o of the facility's inability to uality Assurance Program. t: enced to: sment: Based on staff al record review, the facility	F	520	<ul> <li>F520 How corrective action will be accomplished for each resident found thave been affected by the deficient practice: F 278 □ Resident #1 was discharged from the facility 12/20/16 as Discharge Return Anticipated. To date resident has not been readmitted to the facility.</li> <li>F520 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Individual actions denoted on said area for citation F-278 Completion date: February 8, 2017</li> <li>F520 Measures to be put in place or</li> </ul>	s , , , , , , , , , , , , , , , , , , ,	
	failed to accurately as pressure ulcer on an a	sess a stage 4 left heel admission Minimum Data ampled residents reviewed			systemic changes made to ensure practice will not re-occur: F278 □ Education was provided to MDSC by th	ie	

Facility ID: 955030

If continuation sheet Page 5 of 6

PRINTED: 01/30/2017

TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345471	B. WING	C 01/11	/2017	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 520	with pressure ulcers ( During the complaint facility was cited for fa data set to accurately continence for 1 of 3 ostomy care (Resider During an interview of the Administrator and DON stated the qualit committee met quarte Administrator, DON, I Practitioner, and all o DON reported that aff inaccurate MDS's in A MDS nurse performent training. The administ plan of correction was nurse and they believe caseload and the over assessments. The DO MDS nurse was resp the new MDS nurse a and if he found any is to correct the issue. The corporate MDS nurse a once a month but ma presence in the faciliti DON also stated that a better job of monito	(Resident #96). investigation of 01/11/17 the ailure to code the minimum / reflect a resident's bowel residents sampled for nt #1). on 01/11/17 at 5:44 PM with I the Director of Nursing, the	F 52(	<ul> <li>MDSC regional consultant on Jam 2017 on the RAI requirements for H0400 Bowel Continence in section new MDSC employees will be edu on proper coding of Section H, que H0400, according to the RAI Manu MDS Consultant or designee will a residents MDS to ensure Question H0400 Bowel Continence is correct coded according to the documenta from the residents medical recorn weekly for 4 weeks, twice a month month, and monthly x 10 months. coding issue identified on the audi be immediately corrected with coaching/discipline as needed to to MDSC. Completion date: Februar 2017</li> <li>F520 How facility will monitor correct action(s) to ensure deficient praction to re-occur: Results of the weekly will be reviewed at Weekly Risk M and Quarterly Quality Assurance m X 4 for further resolution if needed Completion date February 8, 2017</li> </ul>	coding on H. All located estion ual. The audit 5 on ctly ation ds once for one Any ts will he y 8, ective ce will y audits eeting neeting l.	

Facility ID: 955030

If continuation sheet Page 6 of 6