PRINTED: 06/14/2018 FORM APPROVED OMB NO. 0938-0391

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED		
		345097	B. WING _			05	/10/2018	
	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1411 DOVE STREET MONROE, NC 28111				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD R-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656 SS=D	CFR(s): 483.21(b)(1) §483.21(b) Comprel §483.21(b)(1) The faimplement a compre care plan for each re resident rights set fo §483.10(c)(3), that is objectives and timef medical, nursing, an needs that are ident assessment. The co describe the followir (i) The services that or maintain the resic physical, mental, an required under §483 (ii) Any services that under §483.24, §483 provided due to the under §483.10, inclu treatment under §48 (iii) Any specialized rehabilitative service provide as a result of recommendations. I findings of the PASA rationale in the resic (iv)In consultation w resident's represent (A) The resident's go desired outcomes. (B) The resident's pr future discharge. Fa whether the residen community was assolocal contact agenci entities, for this purp (C) Discharge plans	nensive Care Plans acility must develop and chensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable rames to meet a resident's id mental and psychosocial iffied in the comprehensive imprehensive care plan must ing - are to be furnished to attain itent's highest practicable d psychosocial well-being as is 24, §483.25 or §483.40; and it would otherwise be required is 25 or §483.40 but are not resident's exercise of rights iding the right to refuse is 3.10(c)(6). services or specialized es the nursing facility will if PASARR if a facility disagrees with the int's medical record. ith the resident and the active(s)- coals for admission and reference and potential for cilities must document it's desire to return to the essed and any referrals to es and/or other appropriate	F	956	TITLE		(X6) DATE	

06/01/2018

Electronically Signed

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					05/10/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2010
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JESSE HE	LMS NURSING CENTER	{		MONROE, NC 28111	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 656	Continued From page	e 1	F 656	8	
	requirements set forth section. This REQUIREMENT by:	in accordance with the in in paragraph (c) of this is not met as evidenced		Preparation and/or execution of thi	s Plan
	Based on observations, record review, resident interview, hospice representative interview and staff interviews, the facility failed to collaborate with hospice to develop and implement an interdisciplinary care plan for one of one resident reviewed for hospice (Resident #12).			Preparation and/or execution of thi of Correction (POC) does not const admission or agreement by the protect the truth of the facts alleged or conclusions set forth in this statemed deficiencies. The Plan of Correction prepared and/or executed solely be	vider of ent of n is ecause
		: t between the facility and tive date 8/26/13 revealed		it is required by the provisions of Fe and State law.	ederai
	plan jointly established modified as necessar	Plan of Care. A written care ed, maintained, reviewed and y, at regular intervals, by the ctor, Attending Physician		1)The facility interdisciplinary team immediately conduct a record audit Resident #12 and all other hospice residents to ensure that careplans f each resident are accurate, integral and applicable to meet the needs o	for ted,
	and hospice Interdisc participation of Skilled the extent practical, v assessment of each I	iplinary Group, and with the d Nursing Facility (SNF), to		resident. An updated careplan note reflecting these changes will be incl on the resident electronic medical red A roster of all residents included in update will be maintained as part of	e luded ecord. this
	needed to manage an Patient's terminal illne needs of the hospice details concerning the	omfort and symptom relief, and palliate the hospice less and to meet the related Patient's family; and (c) le scope and frequency of		Plan of Correction. Date Certain: 6 2)The facility interdisciplinary team immediately review and update all tresident careplans to ensure that the careplan includes 1) an assessment	will nospice ne nt of
	with diagnoses which disease, dementia, cl disease, and protein	mitted to the facility 1/29/16 included: Alzheimer's nronic obstructive pulmonary calorie malnutrition.		needs. 2) an identification of hospic services, including management of discomfort and symptoms of relief r to manage and palliate the hospice patient's terminal illness and to meer related needs of the hospice patien family. 3) Details concerning the scand frequency of hospice services.	needed et the t's ope

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		345097	B. WING		05		
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	710/2010	
				1411 DOVE STREET			
JESSE HE	LMS NURSING CENTER			MONROE, NC 28111			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 656	Continued From page	e 2	F 656	5			
F 656	(MDS) revealed the massessment was a quassessment Reference The MDS assessment was unable to complete Mental Status due to understood which indimpairment. The resile had a condition or chresulted in a life experiments. The resident received hospice care the facility. Review of Resident #Record revealed the Consent/Election of Ending 11/30/17. A review completed of which had been docureviewed on 3/27/18 plan. The only discover care in the care plant addressing activities of the session of the session of the care plant addressing activities of the session of the session of the session of the session of the care plant addressing activities of the session of t	nost recent completed parterly assessment with an one Date (ARD) of 3/7/18. It indicated Resident #50 of the the Brief Interview for thaving been rarely or never icated severe cognitive dent was coded as having ronic disease that may have cotancy of less than 6 of the was coded as having had be while she was a resident at the second at	F 656	roster of residents included in this will be maintained as part of this Correction. Date Certain 6/6/18 3)The facility will conduct regular meetings concerning all hospice during regularly scheduled carep updates, as needed, but quarterly minimum. Hospice services will bi-weekly careplan update meeting facility to discuss hospice patient applicable changes in patient condition/care. Those updates wereflected on the facility careplan, applicable. These meetings will (at a minimum) a representative hospice team, a social worker, and MDS coordinator. The meeting will discuss updates to both the facility careplan and the hospice careplate ensure that both careplans are in and complimentary to ensure the practicable quality of care for each resident. A portion of the meetin include a quality review, to include a quality Quality Assurance program	Plan of careplan residents lan y at a attend ngs at the s and vill be when include of the nd the vill ty an to attegrative highest ch g will le risk part of the		
		s were discontinued on		is overseen by the Administrator careplan update will be included resident's chart after the first initia	A in the		
	Worker (SW) on 5/10 stated Resident #12 v hospice services and on 11/30/17 due to th disease with early on not think she had inviplan meeting and she	ducted with the Social /18 at 9:25 AM. The SW was determined to qualify for was readmitted to hospice e diagnosis of Alzheimer's set. The SW stated she did ted hospice for the last care usually just sent invitations		meeting, and when applicable ch have been made thereafter. A ro attendees at each meeting will be maintained as part of this POC. of hospice residents discussed w maintained as part of this Plan of Correction. Date Certain 6/9/18 4)The facility will immediately con	anges oster of e A roster vill be :		
		to family members. The an meeting was 3/27/18 and		family/patient careplan meeting v hospice patients and their familie			

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		345097	B. WING _			05/10/2018	
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F 656	dietitian, the day shir The SW explained the invited but did not at services had not par meetings since their to hospice. The SW hospice care plan for the second interview on 5/10/18 at 10:06 received input from addressed it. The Supply a care plan for stated there was not hospice care plan arintegrated. An interview was coon 5/10/18 at 10:19 she did not know if heare plan meetings a have to ask the SW. A phone interview w Worker from the hospical to ask the SW. A phone interview w worker from the hospical to ask the SW. A phone interview w worker from the hospical to ask the SW. The Case collaborated with the care plan and she has care plan sfor the recase Worker stated care plan weekly. The was not a process from the care plan are resident. The Case familiar with the conagency and the faciliplan which was writted.	ed the MDS nurse, the ft floor nurse, and herself. The resident's family was tend. The SW stated hospice ticipated in the care plan esident had been readmitted stated she did not have a rethe resident. Was conducted with the SW AM. The SW stated if she mospice or a concern, they W stated hospice did not for the resident. The SW a care plan where the find the facility care plans were and the facility care stated mospice participated in the fact the facility and she would	F 6	meeting will include, at a mi representative of the hospic group, the facility social wor coordinator, a member of th services team, a registered the activity coordinator. At residents, dates, and times will be maintained as part of Correction. Date Certain 6/5)The facility will coordinate patient careplan meetings we services as appropriate, but minimum. The facility social communicate meeting times services. Written document family/patient careplan meetincluded in the patient's elect record. The facility will mai to monitor dates and coording meetings for compliance of Date Certain 6/9/18 6)Hospice services will prove the hospice services care plinclusion into the patient's facility electronic medical record, a updated copies as needed, quarterly. Date Certain 6/9 7)The Administrator will mai records and monitoring met Plan of Correction.	te services ker, the MDS e nursing dietician, and roster of of meetings if this Plan of 8/18 family and with hospice quarterly at a I worker will s with hospice tation of the ting will be ctronic medical intain a roster nation of these attendance. ride a copy of lan for acility nd will provide but at least /18 intain all		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345097	B. WING		05/10/2018	
	ROVIDER OR SUPPLIER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5475	
F 684 SS=D	to front line facility state assistants (NAs) through assistant and the facility preparation of a confacility and there was the software system to stated there was not a compared to the software system to stated there was not a compared to the software system to stated there was not a compared to the software system to the software system to stated there was not a compared to the software system to stated there was not a compared to the software system to state the facility set. The software system to sate the software system to sate system to sate system to sate system to sate system. The system is a substant to sate system to sate syste	and would be communicated aff such as nursing ugh a verbal report. Bed with the DON was at 10:51 AM. The DON coares their care plans with The DON stated hospice inputer system than the not a hospice care plan in the facility used. The DON as set care plan meeting with urther stated hospice itsed between the hospice staff when the hospice staff when the hospice staff weral times per week. The staff received information into through verbal reports. The provided to deep the comprehensive dent, the facility must ensure it treatment and care in dessional standards of the staff person-centered.	F 684		e er of of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345097	B. WING			05/10/2018	
	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CO 1411 DOVE STREET MONROE, NC 28111	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From pag	ge 5	F 68	84			
		d: act between the facility and ctive date 8/26/13 revealed		prepared and/or executed so it is required by the provision and State law.	s of Federal		
	plan jointly establish modified as necessare hospice Medical Direct and hospice Interdist participation of Skillet the extent practical, assessment of each an identification of the management of disconnected to manage a Patient's terminal illurneeds of the hospice	Plan of Care. A written care ed, maintained, reviewed and ary, at regular intervals, by the ector, Attending Physician ciplinary Group, and with the ed Nursing Facility (SNF), to which includes: (a) an hospice Patient's needs; (b) he hospice Services, including comfort and symptom relief, and palliate the hospice hess and to meet the related e Patient's family; and (c) he scope and frequency of		1)The facility interdisciplinary immediately conduct a recor Resident #12 and all other h residents to ensure that care each resident are accurate, i and applicable to meet the n resident. An updated carepl reflecting these changes will on the resident electronic me A roster of all residents inclu update will be maintained as Plan of Correction. Date Ce 2)The facility interdisciplinary immediately review and update resident careplans to ensure careplan includes 1) an asseneeds. 2) an identification of	d audit on ospice eplans for integrated, eeds of each an note be included edical record. ded in this part of this rtain: 6/6/18 y team will ate all hospice that the essment of		
	required under State have individualized of concurrence on each admission, and to reneeded based upon As SNF has care plas SNF agrees to notify the dates and regular meetings. hospice winterdisciplinary care quality review and consistent with, and regulations, the samplans meet the higher and state licensure in each consumer in the samplans meet the higher and state licensure in the samplans meet the samplans meet the higher and state licensure in the samplans meet meet meeting	recognizes that SNF is and Federal regulations to care plans with physician heresident soon after exise said care plans as the condition of the Resident. In meetings at least quarterly, whospice in writing or verbally arrly scheduled times of the will participate in the explan process to include cooperate with SNF so as to ms for hospice Patients are allowed by laws and the as SNF's; that the care east professional standards requirements for Long Term and the second		services, including managen discomfort and symptoms of to manage and palliate the h patient's terminal illness and related needs of the hospice family. 3) Details concerning and frequency of hospice se roster of residents included i will be maintained as part of Correction. Date Certain 6/6, 3)The facility will conduct regmeetings concerning all hospiduring regularly scheduled cupdates, as needed, but quaminimum. Hospice services bi-weekly careplan update m facility to discuss hospice pa applicable changes in patien	nent of relief needed ospice to meet the patient's the scope rvices. A n this review this Plan of /18 gular careplan pice residents areplan arterly at a will attend neetings at the tients and		

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		345097	B. WING			05/10/2018	
NAME OF PI	ROVIDER OR SUPPLIER	l	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
				14	411 DOVE STREET		
JESSE HE	LMS NURSING CENTER	ł		M	IONROE, NC 28111		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 6	F	684			
	· -	Term Care Facilities and			condition/care. Those updates will be		
	hospices.	Term Gare Fasinties and			reflected on the facility careplan, when		
					applicable. These meetings will include		
	Section 3.7 SNF reco	gnizes that hospice is			(at a minimum) a representative of the		
	required under State	and Federal regulations to			hospice team, a social worker, and the		
		are plans with physician			MDS coordinator. The meeting will		
	concurrence on each	•			discuss updates to both the facility		
		rise said care plans as			careplan and the hospice careplan to		
		he condition of the patient.			ensure that both careplans are integral		
	Hospice will discuss each patient every fifteen (15) days and notify SNF of any updated care				and complimentary to ensure the higher	est	
	plans. SNF will participated in the				practicable quality of care for each resident. A portion of the meeting will		
	-	plan process to include			include a quality review, to include risk		
		operate with hospice so as			areas, which will be included as part of		
		ans for hospice Patients are			facility Quality Assurance program, wh		
	,	o the extent allowed by laws			is overseen by the Administrator. A		
		same as SNF's; that the care			careplan update will be included in the		
	plans meet the higher	st professional standards			resident's chart after the first initial		
	and state licensure re	equirements for hospices as			meeting, and when applicable changes	3	
		iditions of Participation for			have been made thereafter. A roster of	of	
		erm Care Facilities and Joint			attendees at each meeting will be		
		editation of Healthcare			maintained as part of this POC. A rost	er	
		nent for hospices; and that			of hospice residents discussed will be		
	•	participation of hospice,			maintained as part of this Plan of		
	SINF, and the patient/	family to the extent possible.			Correction. Date Certain 6/9/18 4)Hospice services will discuss patient		
	Resident #12 was ad	mitted to the facility 1/29/16			care at least every fifteen (15) days an		
		included: Alzheimer's			notify the facility of any careplan updat		
		rronic obstructive pulmonary			that occur outside of regularly coordina		
	disease, and protein				meetings between the facility and hosp		
					services noted in section one (1) of this		
	A review of Resident	#50's Minimum Data Set			plan of correction. Date Certain 6/9/18		
	(MDS) revealed the n	nost recent completed			5)The facility will immediately conduct	а	
		uarterly assessment with an			family/patient careplan meeting with all		
		ce Date (ARD) of 3/7/18.			hospice patients and their families. Th	is	
		t indicated Resident #50			meeting will include, at a minimum, a		
	,	ete the Brief Interview for			representative of the hospice services		
		having been rarely or never			group, the facility social worker, the MI	os Os	
	understood which ind	icated severe cognitive	1		coordinator, a member of the nursing		

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F 684	had a condition or chresulted in a life experiments. The resident received hospice care the facility. Review of Resident #Record revealed the Consent/Election of E11/30/17. Review of Resident #sheet revealed the property was hospice. A review completed to which had been docureviewed on 3/27/18/3:47 PM. The review plan. The only discovered in the care plan addressing Activities rehabilitation care plan related to hospice service were discontinued on on 11/30/17. An interview was conworker (SW) on 5/10 stated Resident #12 first was admitted to a condition then stabilized longer met hospice of from hospice serviced determined to qualify was readmitted to hospice serviced determined to hospice serviced d	dent was coded as having ronic disease that may have ectancy of less than 6 it was coded as having had e while she was a resident at the facility. The resident's resident was completed on 5/8/18 at revealed no hospice care except for the care plan of Daily Living function in. The information listed roices were hospice services in 9/21/17 and were reinitiated ducted with the Social was on hospice when she the facility. The resident no riteria and was discharged is. The resident was then for hospice services and spice. The SW stated the ponsive due to cognitive loss.	F 68	services team, a registered direction the activity coordinator. A ros residents, dates, and times of will be maintained as part of the Correction. Date Certain 6/8/6) The facility will coordinate fa patient careplan meetings with services as appropriate, but quantinimum. The facility social was communicate meeting times was ervices. Written documentate family/patient careplan meeting included in the patient's electrorecord. The facility will maint to monitor dates and coordinate meetings for compliance of atto Date Certain 6/9/18 7) Hospice services will provide the hospice services care plar inclusion into the patient's facile electronic medical record, and updated copies as needed, but quarterly. Date Certain 6/9/18) The Administrator will maint records and monitoring method Plan of Correction.	ster of meetings nis Plan of 18 amily and n hospice uarterly at a vorker will with hospice ion of the ng will be conic medical ain a roster ation of these tendance. e a copy of n for ility d will provide ut at least 8 ain all		

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F 684	stated she did not thi for the last care plan she usually just send meetings to family meeting waincluded the MDS nushift floor nurse, and resident's family was The SW stated she of plan for the resident. facility only did care pertain problems, for a combative behavior for the resident being there would not be a second interview won 5/10/18 at 10:06 A received input from his staff. The SW stated in the care plan about there was not a care hospice in the care preceived input from haddress it. The SW stated in the system in the system in the system in the system of the resident, and she was entered into the system. An interview was corron 5/10/18 at 10:19 A she did not know if R care plan and she were integrated.	re plan meetings. The SW nk she had invited hospice meeting. The SW stated invitations to care plan embers. The resident's last as 3/27/18 and the attendees ree, the dietitian, the day herself. The SW stated the invited but did not attend. id not have a hospice care. The SW further stated the plans on certain parts or for example, if the resident had recombative. The SW stated care plan for hospice. The SW stated with the SW attended to the second care plan for hospice. The SW stated she had ospice from the care plan is she did not enter anything thospice. The SW stated plan, or intervention for lan. The SW stated if she ospice or a concern, they stated hospice did not supply sident. The SW stated she is unable to identify if a note em or a handwritten note. It was not a care plan where in and the facility care plans. The MDS nurse stated she will be supply sident and the facility care plans.	F 68					

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F 684	Continued From pag		F6	84				
		ice participated in the care facility and she would have						
	Records Manager (N AM. The MAM state assessment plan of handwritten hospice enters into the facilit stated there were se	nducted with the Medical MAM) on 5/10/18 at 10:22 ed there was a hospice care in addition to notes which she scans and y's EMR system. The MAM everal recertification notes ection of Resident #12's						
	Worker from the hos 10:30 AM. The Cas collaborated with the care plan. The Casibeen invited to atter at the facility. The Collaborate plan for hospice was and she reviewed the The Case Worker sthave access to the hospice care plan, there was not a proof the hospice care plan the resident. The Collaboration with the agency and the facilithere was not a care jointly by hospice and Worker stated there kept at the hospice cated information in	as conducted with the Case spice agency on 5/10/18 at e Worker stated she had not e facility for Resident #12's e Worker stated she had not did care plans for the resident case Worker stated the care is reviewed twice per week e hospice care plan weekly, ated the facility staff would nospice care plan but she did by staff had reviewed the The Case Worker stated bees from hospice to integrate in and the facility care plan for asse Worker stated she was contract between the hospice ity. The Case Worker stated in plan which was written did the facility. The Case was not a separate care plan office. The Case Worker in regards to the resident						
	would be communic	ated to front line facility staff sistants (NAs) through a						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345097	B. WING			05/10/2018		
	ROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP CODE 1411 DOVE STREET MONROE, NC 28111				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 684	plan after each visit of Worker stated there of Group which consisted hospice staff and the hospice Care Plan. An interview conduct conducted on 5/10/18 stated the facility prethe resident's family, reviewed the hospice staff. The DON state computer system that stated there was not software system the stated there was not hospice. The DON's discussed between the facility staff when the facility several times he would have to refed discuss interventions the hospice care plan staff received informationally werbal report were notes which we hospice which had be computer system. A copy of the hospice Resident #12, dated 5/10/18 at approximatincluded information address, diagnoses,	ase Worker stated the care was handwritten. The Case was an Interdisciplinary ed of members of only the	F 68	4				
	established that mee	a nursing plan of care will be ts the patient's needs. The is were listed. The orders						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		345097	B. WING			05/1	0/2018	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1411 DOVE STREET MONROE, NC 28111					
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 684	Nurse was to coordin facility staff. The POO physician on 12/1/17. revealed no associate	ocumented the hospice ate the plan of care with the C was signed by the hospice Further review of the POC ed measurable goals or to identified diagnoses,	F 6	84				