PRINTED: 11/09/2018 FORM APPROVED OMB NO. 0938-0391

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING                                |   |           | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|--------------------|--|---|-----------|-------------------------------|--|
|                          |   | 345134   | B. WING _          |  | _   |           | C<br><b>04/2018</b>           |  |
|                          | ROVIDER OR SUPPLIER  CHARLOTTE TRANSITI   | ONAL CARE & REHAB CNTR   |                    | STREET ADDRESS, CITY, STA<br>4801 RANDOLPH ROAD<br>CHARLOTTE, NC 28211 |   | , , , , , |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | (EACH CORREC<br>CROSS-REFEREN  | PLAN OF CORRECTION<br>TIVE ACTION SHOULD B<br>ICED TO THE APPROPRIA<br>EFICIENCY) |           | (X5)<br>COMPLETION<br>DATE    |  |
| F 550<br>SS=D            | CFR(s): 483.10(a)(1)  §483.10(a) Resident The resident has a rig self-determination, ar access to persons an outside the facility, in this section.  §483.10(a)(1) A facility with respect and dign resident in a manner promotes maintenancher quality of life, receindividuality. The faci promote the rights of  §483.10(a)(2) The faci promote the rights of  §483.10(a)(2) The faci promote the rights of  §483.10(a)(b) The faci provision of services residents regarding tr provision of services residents regardless  §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit  §483.10(b)(1) The faci resident can exercise interference, coercion from the facility.  §483.10(b)(2) The res free of interference, or reprisal from the facil rights and to be supp | Rights. ght to a dignified existence, and communication with and dignitied and cluding those specified in  ty must treat each resident and in an environment that the or enhancement of his or ognizing each resident's lity must protect and the resident.  cility must provide equal the resident.  cility must provide equal the resident.  cility must provide equal the resident source. A facility the aintain identical policies and the state plan for all of payment source.  of Rights.  right to exercise his or her of the facility and as a citizen |                    | TITLE  |   |           | 11/1/18                       |  |

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

10/26/2018

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

**Electronically Signed** 

PRINTED: 11/09/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL |   |  |                     |  |  |                            |
|--|---|--|---------------------|--|--|----------------------------|
|  |   | 345134   | B. WING             |  | 10/0                                   | ;<br>)4/2018               |
| NAME OF P  | ROVIDER OR SUPPLIER   |  | <del>-1</del>       | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 10/0                                 | 14/2016                    |
|  | 101.52.1.01.00.1.2.2.1  |  |                     | 4801 RANDOLPH ROAD   |  |                            |
| CURIS AT   | CHARLOTTE TRANSIT   | IONAL CARE & REHAB CNTR  |                     | CHARLOTTE, NC 28211  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)   | JLD BE                                 | (X5)<br>COMPLETION<br>DATE |
| F 550  | Continued From pag  | e 1  | F 550               |  |  |                            |
|  | exercise of his or her<br>subpart.<br>This REQUIREMEN'<br>by:   | rights as required under this Γ is not met as evidenced on, record review resident,  |                     | Corrective action has been   |  |                            |
|  | and staff interviews t<br>resident's dignity by<br>not returning for an e<br>provide incontinent of   | turning off the call light and extended period of time to are as requested by the residents sampled for dignity  |                     | accomplished for the alleged defici practice regarding #35 which failed toileted in a timely manner resulting dignity issue. Resident #35 was to the Certified Nursing Assistant 10/1 at 3:19pm.   | I to be<br>g in a<br>ileted by         |                            |
|  | 09/09/18 with diagno<br>dysphagia, severe pr  | d: admitted to the facility on uses that included: weakness, rotein calorie malnutrition, ulmonary disease, and  |                     | 2. Current facility residents have the potential to be affected by the alleg deficient practice. All facility reside have the potential to be affected. The Director of Nursing/Nurse Manager initiated In-Service on 10/04/2018 Quality of Life: Dignity on all currents staff. New employees and agency  | ged<br>nts<br>he<br>ment<br>on         |                            |
|  | (MDS) dated 07/23/1 was cognitively intac   | nensive minimum data set<br>8 revealed that Resident #35<br>t and required limited<br>aff member with toileting. No<br>noted on the MDS.   |                     | personnel will be in-serviced on Qu<br>Life: Dignity, during orientation pro<br>3. Measures put in place to ensure<br>alleged deficient practice does not<br>include: Departmental Heads will  | cess.                                  |                            |
|  | #35 on 10/01/18 at 2<br>Resident #35 turned<br>Director of Housekee<br>entered her room and<br>#35 that she needed<br>DOH stated to Resid<br>to leave the call light<br>Nursing Assistants (Nexiting Resident #35)<br>Director of Nursing (I<br>the call light that was | ation was made of Resident :15 PM through 3:27 PM. the call light on and the eping (DOH) immediately d was informed by Resident some incontinent care. The ent #35 that she was going on and let one of the NAs) know. As the DOH was s room she ran into the DON), the DOH pointed at a still illuminated in the desident #35 "needs some |                     | complete Angel Care Round Communication Sheets which inclures idents three times per week for weeks than 2 times a week for 4 weeks to Dignity of residents.  4. The Director of Nursing will anal audits/review for patterns/trends are report in the Quality Assurance comeeting for 3 months to evaluate the effectiveness of the plan and will a the plan based on outcomes/trends | 4 eeks ensure  yze nd mmittee he djust |                            |

Facility ID: 922959

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X: |                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       | ` ′                 | MULTIPLE CONSTRUCTION JILDING                                     |            | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--------------------------|--|---------------------|---|------------|-------------------------------|--|
|   |                          | 345134   | B. WING             |   |            | C<br>10/04/2018               |  |
| NAME OF P   | ROVIDER OR SUPPLIER      |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODI                             |            | 10/04/2016                    |  |
|   | 101.02.1 01.1 00.1 2.2.1 |  |                     | 4801 RANDOLPH ROAD  | -          |                               |  |
| CURIS AT  | CHARLOTTE TRANSIT        | IONAL CARE & REHAB CNTR                                  |                     | CHARLOTTE, NC 28211   |            |                               |  |
| (VA) ID   | QUIMMADV Q               | TATEMENT OF DEFICIENCIES                                 | ID.                 | PROVIDER'S PLAN OF COI  | DDECTION . | (VE)                          |  |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENC          | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE  | (X5)<br>COMPLETION<br>DATE    |  |
| F 550   | Continued From page      | e 2  | F 55                | 50  |            |                               |  |
|   |                          | ne DON entered Resident                                  |                     | identified.   |            |                               |  |
|   |                          | ed the call light off without                            |                     |   |            |                               |  |
|   | providing incontinent    | care and stated he would                                 |                     | 5. The Administrator will be the                                  | e person   |                               |  |
|   |                          | to assist her. At 2:49 PM                                |                     | responsible for implementing                                      |            |                               |  |
|   |                          | ned that she was still waiting                           |                     | acceptable plan of correction.                                    |            |                               |  |
|   |                          | and the call light was again                             |                     |   | 6.01.1     |                               |  |
|   |                          | nt #35. At 3:15 PM the call<br>d Resident #35 again      |                     | 6. Preparation and/or execution plan of correction does not co    |            |                               |  |
|   |                          | as waiting for incontinent                               |                     | admission of agreement by th                                      |            |                               |  |
|   |                          | had come in and told her he                              |                     | truth of the facts alleged or co                                  | •          |                               |  |
|   |                          | ne never returned. At 3:19                               |                     | forth in the statement of defici                                  |            |                               |  |
|   | PM NA #1 entered R       | esident #35's room and                                   |                     | plan of correction is prepared                                    | and/or     |                               |  |
|   | •                        | care and exited Resident                                 |                     | executed solely because it is i                                   |            |                               |  |
|   | #35's room at 3:27 P     | M.   |                     | the provision of federal and st                                   | ate law.   |                               |  |
|   |                          | nducted with NA #1 on<br>. NA #1 stated that she had     |                     |   |            |                               |  |
|   |                          | to another resident and when                             |                     |   |            |                               |  |
|   |                          | she noted Resident #35's                                 |                     |   |            |                               |  |
|   |                          | see what she needed. NA #1                               |                     |   |            |                               |  |
|   | _                        | ent #35 needed incontinent                               |                     |   |            |                               |  |
|   | care and that she pro    | ovided the care. She added                               |                     |   |            |                               |  |
|   |                          | are that her call light had                              |                     |   |            |                               |  |
|   |                          | ne was working with another                              |                     |   |            |                               |  |
|   |                          | informed her that Resident                               |                     |   |            |                               |  |
|   | #35 needed some as       | ssistance.   |                     |   |            |                               |  |
|   | An interview was cor     | nducted with the DOH on                                  |                     |   |            |                               |  |
|   |                          | . The DOH stated that she                                |                     |   |            |                               |  |
|   |                          | 35's call light come on and                              |                     |   |            |                               |  |
|   |                          | what she needed. She stated                              |                     |   |            |                               |  |
|   |                          | formed her that she needed                               |                     |   |            |                               |  |
|   | _                        | ne DOH stated she informed<br>ould go and let someone    |                     |   |            |                               |  |
|   |                          | to leave the call light on. She                          |                     |   |            |                               |  |
|   |                          | nto the DON on the way out                               |                     |   |            |                               |  |
|   |                          | om and informed the DON                                  |                     |   |            |                               |  |
|   |                          | e changed and pointed to the                             |                     |   |            |                               |  |
|   |                          | . The DOH stated that the                                |                     |   |            |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED |   |             |                            |
|--|---|--|-------------------------------|---|-------------|----------------------------|
|  |   | 345134   | B. WING _                     |   |             | C                          |
|  | ROVIDER OR SUPPLIER  CHARLOTTE TRANSI   | TIONAL CARE & REHAB CNTR   |                               | STREET ADDRESS, CITY, STATE, ZIP COD 4801 RANDOLPH ROAD CHARLOTTE, NC 28211         |             | 10/04/2018                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 550  | the room.  An interview was co 10/03/18 at 9:54 AN NA #1 had finally pr on 10/01/18 and she added that she tried often but when she for the staff to come stated that turning ther "was just unnecembarrassing to sit Resident #35 stated independent persor could not do for her help her and was verifications."        | ge 3 Id take care of it and she left  and conducted with Resident #35 on  A. Resident #35 confirmed that covided incontinent care to her e was very grateful. She I not to use the call light very did it seemed to take a while e and help. Resident #35 he call light off without helping essary and was very in a wet brief" for a long time. If that she tried to be a very h, but this was one thing she self and relied on the staff to ery bothered and upset that over an hour for incontinent | F 5                           | 550   |             |                            |
| F 656<br>SS=D  | 10/04/18 at 11:25 A he had entered Res the call light off on 1 not recall if he told a or not. The DON sta turned the call light and that it was unac #35 wait for over an Develop/Implement CFR(s): 483.21(b)(1) \$483.21(b) Compre \$483.21(b)(1) The f implement a compre care plan for each r resident rights set for |  | F 6                           | 556   |             | 11/1/18                    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |                                |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|-----------------------|--|---|--------------------------------|--|-------------------------------|--|
|   |                       |  | D. MANO                                 |                                |  | С                             |  |
|   |                       | 345134   | B. WING _                               |                                | <u> </u>   | 10/04/2018                    |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |   | STREET ADDRESS, CITY, ST       | îATE, ZIP CODE   |                               |  |
| CURIS AT  | CHARLOTTE TRANS       | SITIONAL CARE & REHAB CNTR   |   | 4801 RANDOLPH ROAD             |  |                               |  |
| 001110711   |                       |  |   | CHARLOTTE, NC 2821             | 1  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE         | ' STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG                      | ( (EACH CORRECTED CROSS-REFERE | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BE<br>NCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE    |  |
| F 656   | Continued From p      | age 4  | F                                       | 656                            |  |                               |  |
|   |                       | eframes to meet a resident's   |   |                                |  |                               |  |
|   |                       | and mental and psychosocial  |   |                                |  |                               |  |
|   |                       | ntified in the comprehensive   |   |                                |  |                               |  |
|   |                       | comprehensive care plan must   |   |                                |  |                               |  |
|   | describe the follow   |  |   |                                |  |                               |  |
|   |                       | at are to be furnished to attain   |   |                                |  |                               |  |
|   | or maintain the res   | sident's highest practicable   |   |                                |  |                               |  |
|   | physical, mental, a   | and psychosocial well-being as   |   |                                |  |                               |  |
|   |                       | 33.24, §483.25 or §483.40; and   |   |                                |  |                               |  |
|   | ` ' · •               | at would otherwise be required   |   |                                |  |                               |  |
|   |                       | 83.25 or §483.40 but are not   |   |                                |  |                               |  |
|   | ·                     | e resident's exercise of rights  |   |                                |  |                               |  |
|   | _                     | cluding the right to refuse  |   |                                |  |                               |  |
|   | treatment under §4    |  |   |                                |  |                               |  |
|   |                       | d services or specialized<br>ces the nursing facility will                                     |   |                                |  |                               |  |
|   | provide as a result   |  |   |                                |  |                               |  |
|   | ·                     | If a facility disagrees with the   |   |                                |  |                               |  |
|   |                       | SARR, it must indicate its   |   |                                |  |                               |  |
|   | _                     | sident's medical record.   |   |                                |  |                               |  |
|   | (iv)In consultation   | with the resident and the  |   |                                |  |                               |  |
|   | resident's represei   | ntative(s)-  |   |                                |  |                               |  |
|   | (A) The resident's    | goals for admission and  |   |                                |  |                               |  |
|   | desired outcomes.     |  |   |                                |  |                               |  |
|   |                       | preference and potential for   |   |                                |  |                               |  |
|   | _                     | acilities must document  |   |                                |  |                               |  |
|   |                       | ent's desire to return to the  |   |                                |  |                               |  |
|   | · ·                   | sessed and any referrals to  |   |                                |  |                               |  |
|   |                       | cies and/or other appropriate  |   |                                |  |                               |  |
|   | entities, for this pu |  |   |                                |  |                               |  |
|   |                       | ns in the comprehensive care te, in accordance with the  |   |                                |  |                               |  |
|   |                       | orth in paragraph (c) of this  |   |                                |  |                               |  |
|   | section.              | orum in paragraph (c) or uns   |   |                                |  |                               |  |
|   |                       | :NT is not met as evidenced  |   |                                |  |                               |  |
|   | by:                   | IS HOT HIST AS CVIACHOCA   |   |                                |  |                               |  |
|   |                       | review and staff interviews the  |   | 1. The comprehen               | isive care plan for  |                               |  |
|   |                       | velop a comprehensive care   |   |                                | een updated to include   |                               |  |
|   |                       | ble goals and implement  |   |                                | resident centered and  |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | IPLE CONSTRUCTION  | (X3) DATE SURVE<br>COMPLETED             |                         |
|---|---------------------|---|---------------------|--|--|-------------------------|
|   |                     |   |                     |  | С  |                         |
|   |                     | 345134  | B. WING _           |  | 10/04/20                                 | 18                      |
| NAME OF P   | ROVIDER OR SUPPLIER | •   |                     | STREET ADDRESS, CITY, STATE, ZII   | P CODE                                   |                         |
|   |                     |   |                     | 4801 RANDOLPH ROAD   |  |                         |
| CURIS AT  | CHARLOTTE TRANS     | SITIONAL CARE & REHAB CNTR  |                     | CHARLOTTE, NC 28211  |  |                         |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI        | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN (<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED T<br>DEFICIE | CTION SHOULD BE COM<br>O THE APPROPRIATE | (X5)<br>PLETION<br>DATE |
| F 656   | Continued From p    | page 5  | F 6                 | 856  |  |                         |
|   | identified care pla | n interventions for 1 of 1  |                     | measurable goals. The o  |  |                         |
|   |                     | for hospice (Resident #76) and  |                     | care plan for resident #3  |  |                         |
|   |                     | eviewed for activities of daily<br>35 and Resident #68).  |                     | been updated to address status of the residents.                         | the current ADL                          |                         |
|   | The findings inclu  | ded:  |                     | All residents receiving have been reviewed to e                          |  |                         |
|   | 1. A review of the  | hospice benefit period indicated  |                     | plans are complete with  |  |                         |
|   |                     | certified for hospice care from   |                     | hospice services.  |  |                         |
|   | D:                  |   |                     | 3. All Comprehensive ca  |  |                         |
|   |                     | admitted to the facility on gnoses which included atrial  |                     | currently in review to ens   |  |                         |
|   |                     | ailure, hypertension, and renal   |                     | the individual care plans  |  |                         |
|   | insufficiency.      | andre, hypertendion, and renai  |                     | completed by 11/01/2018  |  |                         |
|   | A physician's orde  | er dated 06/08/18 indicated   |                     | 4. Staff education pertine   | ent to the                               |                         |
|   |                     | under services of a Local   |                     | management of all identi   |  |                         |
|   | Health Hospice ar   | nd Palliative Care.   |                     | residents has been provi 10/04/2018.                                     | ded on                                   |                         |
|   |                     | plan with an initiation date of   |                     |  |  |                         |
|   |                     | I there was no comprehensive  |                     | 5. Minimum Data Set Co   |  |                         |
|   |                     | asurable goals and identified   |                     | perform routine audits fo  | •  |                         |
|   | care plan interven  | itions implemented for hospice  |                     | care plans for both accur  | -  |                         |
|   | care for Resident   | #/6.  |                     | completion. This audit wi  |  |                         |
|   | Δ review of the ad  | Imission Minimum Data Set   |                     | weekly for one month. At audits will continue for a                      | _  |                         |
|   |                     | 5/18 indicated under Section  |                     | months under the superv  |  |                         |
|   | , ,                 | that Resident #76 had a   |                     | Director of Nursing.   | ision of the                             |                         |
|   |                     | nat indicated a life expectancy of  |                     |  |  |                         |
|   |                     | s and under Section O0100   |                     | Evaluation and Monitorin   | ıq                                       |                         |
|   |                     | ts, Procedures, and Programs  |                     |  |  |                         |
|   | as receiving hosp   | · · · · · · · · · · · · · · · · · · ·   |                     | 1. Minimum Data Set Co   | ordinators will                          |                         |
|   |                     |   |                     | audit residents receiving  | •  |                         |
|   |                     | :46 AM an interview was   |                     | monthly to ensure compr  | ehensive care                            |                         |
|   |                     | e Reginald Minimum Data Set   |                     | planning is complete.  |  |                         |
|   | · ·                 | t who stated she had completed  |                     |  |  |                         |
|   |                     | e residents in the facility on  |                     | 2. Minimum Data Set Co   |  |                         |
|   | 10/03/18 and dete   | ermined that Resident #76 did   |                     | audit care plans to ensur  | e Activities of                          | l                       |

|       | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '              |             | CONSTRUCTION   | (X3) DATE<br>COMP       | SURVEY<br>LETED            |
|-------|--|---|--------------------|-------------|--|-------------------------|----------------------------|
|       |  |   | A. BOILDI          | <b>'</b> '- |  | ,                       | C                          |
|       |  | 345134  | B. WING _          |             |  | 10/                     | 04/2018                    |
|       | SUMMARY S  | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | 48<br>CI    | REET ADDRESS, CITY, STATE, ZIP CODE  801 RANDOLPH ROAD  HARLOTTE, NC 28211  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  |                         | (X5)<br>COMPLETION<br>DATE |
| F 656 | place with measura plan interventions. It stated the prior MDS was responsible for care plan for Reside employed at the factors at the factor | chensive hospice care plan in ble goals and identified care The Reginald MDS Consultant S Reginald Consultant who creating a comprehensive ent #76 was no longer cility. The Reginald MDS e admission MDS of 15/16 indicated Resident ce care and a comprehensive and interventions should by 06/21/18 to reflect Resident ce care. The Reginald MDS the comprehensive care plan to reflect Resident #76 was are. The Reginald MDS a comprehensive plan of care ventions would be created ct Resident #76 was receiving standard to the comprehensive plan of care ventions would be created ct Resident #76 was receiving standard for Resident #76 by the MDS mpleted the admission MDS | F                  | 656         | Daily Living care interventions are personalized and accurate with each Minimum Data Set Coordinator completing audits of 5 residents each month for 2 months, then monthly for 2 months.  The Director of Nursing will analyze/review for patterns/trends and report in the Quality Assurance meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.  Preparation and/or execution of this plat of correction does not constitute admission for agreement by the provide of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becaut it is required by the provision of federal and state law. | g<br>t<br>an<br>er<br>: |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |                              | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---|--|------------------------------|-------------------------------|--|
|  |  | 345134   | B. WING                                 |  |                              | C                             |  |
|  | ROVIDER OR SUPPLIER  CHARLOTTE TRANSITI  | ONAL CARE & REHAB CNTR   |   | STREET ADDRESS, CITY, STATE, ZIP COD 4801 RANDOLPH ROAD CHARLOTTE, NC 28211                  |                              | 10/04/2018                    |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CO<br>( (EACH CORRECTIVE ACTIOI<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 656  | expectation was that for hospice would ha #76 by the MDS Coo admission MDS asse Administrator stated comprehensive care be created immediate On 10/04/18 at 10:03 conducted with the M stated she was response admission MDS The MDS Coordinate created a comprehen Resident #76 by 6/21 | a comprehensive care plan we been created for Resident rdinator who coded the ssment dated 06/15/18. The it was her expectation that a plan for hospice care would ely for Resident #76.  AM an interview was IDS Coordinator #1 who insible for coding Resident assessment dated 6/15/28. ir #1 stated she should have isive hospice care plan for /18 and she missed creating spice care plan with goals | Fé                                      | 356  |                              |                               |  |
|  | 09/09/18 with diagno<br>dysphagia, severe pr   | admitted to the facility on<br>ses that included: weakness,<br>otein calorie malnutrition,<br>ulmonary disease, and  |   |  |                              |                               |  |
|  | (MDS) dated 07/23/1 was cognitively intact   | ff member with toileting. No   |   |  |                              |                               |  |
|  | plan dated 08/29/18  | s of daily living (ADL) care<br>and revised 10/02/18 read in<br>ad an activity of daily living   |   |  |                              |                               |  |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |                            | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|--|---|----------------------------|-------------------------------|----------------------------|
|                          |   | 345134   | B. WING _                              |   |                            |                               | C<br><b>04/2018</b>        |
| NAME OF PI               | ROVIDER OR SUPPLIER   | 1  | <u> </u>                               | STREET ADDRESS, CITY, STATE, ZIP COD  | )E                         | 1.01                          | <u> </u>                   |
| CURIS AT                 | CHARLOTTE TRANSITI  | ONAL CARE & REHAB CNTR   |  | 4801 RANDOLPH ROAD<br>CHARLOTTE, NC 28211   |                            |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>LY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE<br>E APPROPRIA |                               | (X5)<br>COMPLETION<br>DATE |
| F 656                    | Continued From page   | e 8  | F 6                                    | 856   |                            |                               |                            |
|                          | the ADL care plan ha<br>measurable goals an<br>specific to Resident #<br>required.  |  |  |   |                            |                               |                            |
|                          | #35 on 10/01/18 at 2<br>Resident #35 turned<br>Director of Housekee<br>entered her room and<br>#35 that she needed<br>DOH stated to Resid<br>to leave the call light<br>Nursing Assistants (N<br>exiting Resident #35'<br>Director of Nursing (I<br>the call light that was | ation was made of Resident 15 PM through 3:27 PM. the call light on and the eping (DOH) immediately d was informed by Resident some incontinent care. The ent #35 that she was going on and let one of the NAs) know. As the DOH was s room she ran into the DON), the DOH pointed at still illuminated in the esident #35 "needs some |  |   |                            |                               |                            |
|                          | #35's room and turned providing incontinent send someone back Resident #35 confirm for incontinent care at turned on by Resider light remained on and confirmed that she will care. At 3:19 PM NA   | as waiting for incontinent<br>#1 entered Resident #35's<br>acontinent care and exited  |  |   |                            |                               |                            |
|                          | 10/01/18 at 3:27 PM. been providing care to she exited that room call light and went to confirmed that Residuals.   | NA #1 stated that she had to another resident and when she noted Resident #35's see what she needed. NA #1 ent #35 needed incontinent by ided the care. She added  |  |   |                            |                               |                            |

| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE   |        |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | I ` ′   | PLE CONSTRUCTION  G                              | ' '                           | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--------|--|--|---------|--|-------------------------------|-------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER  CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR    CARLOTTE TRANSITIONAL CARE & REHAB CNTR   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE)   PREPRIX REGULATORY OR LSC IDENTIFYING INFORMATION)   TAGE   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAGE)   PREPRIX TAGE   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAGE)   PREPRIX TAGE   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAGE)   PREPRIX TAGE   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAGE)   PREPRIX TAGE   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAGE)   PREPRIX TAGE   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE    F 656   CONTINUED TO THE APPROPRIATE   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE    F 656   CONTINUED TO THE APPROPRIATE   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE    F 656   CONTINUED TO THE APPROPRIATE   PROVIDER'S PLAN OF CORRECTION (EACH COMPLET TAGE   PROVIDER'S PLAN OF COMPLET TAGE    F 656   CONTINUED TO THE APPROPRIATE   PROVIDER'S PLAN OF COMPLET TAGE    F 656   PROVIDER'S PLAN OF CORRECTION (EACH COMPLET TAGE   PROVIDER'S PLAN OF COMPLET TAGE    F 656   PROVIDER'S PLAN OF CORRECTION (EACH COMPLET TAGE   PROVIDER'S PLAN OF COMPLET TAGE    F 656   PROVIDER'S PLAN OF COMPLET TAGE   PROVIDER'S PLAN OF COMPLET TAGE    T 656   PROVIDER'S PLAN OF COMPLET TAGE    F 656   PROVIDER'S PLAN OF CORRECTION (EACH COMPLET TAGE   PROVIDER'S PLAN OF COMPLET TAGE    F 656   PROVIDER'S PLAN OF COMPLET TAGE    T 656   PROVIDER'S PLAN OF COMPLET TAGE    T 656   PROVIDER'S PLAN OF COMPLET TAGE    F 656   PROVIDER'S PLAN OF COMPLET |        |  | 345134   | B. WING |  |                               | _                             |  |
| ### (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY)  F 656  Continued From page 9 that she was not aware that her call light had been on earlier as she was working with another resident and no one informed her that Resident #35 needed some assistance.  An interview was conducted with Resident #35 on 10/03/18 at 9:54 AM. Resident #35 confirmed that NA #1 had finally provided incontinent care to her on 10/01/18 and she was very grateful. She added that she tried not to use the call light very often but when she did it seemed to take a while for the staff to come and help.  An interview was conducted with MDS Regional Nurse Consultant who stated that the facility had gone a period with no MDS coordinator and that was the reason Resident #35's care plan had not been finalized and individualized to the needs of Resident #35. She stated that she expected all care plans to be completed and individualized with measurable goals and for the staff to implement the care plan daily.  3. Resident #68 was admitted to the facility on 07/31/17 with diagnoses that included atrial fibrillation and Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) dated 09/07/18 specified the resident's cognition was intact, he did not reject care and could make himself understood. The MDS also specified the resident required one-person assistance with  |        |  |  |         | 4801 RANDOLPH ROAD                               | •                             | 0/04/2018                     |  |
| that she was not aware that her call light had been on earlier as she was working with another resident and no one informed her that Resident #35 needed some assistance.  An interview was conducted with Resident #35 on 10/03/18 at 9:54 AM. Resident #35 confirmed that NA #1 had finally provided incontinent care to her on 10/01/18 and she was very grateful. She added that she tried not to use the call light very often but when she did it seemed to take a while for the staff to come and help.  An interview was conducted with MDS Regional Nurse Consultant who stated that the facility had gone a period with no MDS coordinator and that was the reason Resident #35's care plan had not been finalized and individualized to the needs of Resident #35. She stated that she expected all care plans to be completed and individualized with measurable goals and for the staff to implement the care plan daily.  3. Resident #68 was admitted to the facility on 07/31/17 with diagnoses that included atrial fibrillation and Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) dated 09/07/18 specified the resident's cognition was intact, he did not reject care and could make himself understood. The MDS also specified the resident required one-person assistance with  | PRÉFIX | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL  | PREFIX  | (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH | ON SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| intact, he did not reject care and could make himself understood. The MDS also specified the resident required one-person assistance with  | F 656  | that she was not aw been on earlier as s resident and no one #35 needed some a  An interview was co 10/03/18 at 9:54 AM NA #1 had finally pro on 10/01/18 and she added that she tried often but when she for the staff to come  An interview was co Nurse Consultant will gone a period with mas the reason Res been finalized and in Resident #35. She scare plans to be con with measurable god implement the care 3. Resident #68 wa 07/31/17 with diagnof fibrillation and Alzhe recent quarterly Min | are that her call light had he was working with another informed her that Resident ssistance.  Inducted with Resident #35 on I. Resident #35 confirmed that ovided incontinent care to her was very grateful. She not to use the call light very did it seemed to take a while and help.  Inducted with MDS Regional no stated that the facility had no MDS coordinator and that ident #35's care plan had not individualized to the needs of stated that she expected all inpleted and individualized als and for the staff to plan daily.  Is admitted to the facility on oses that included atrial imer's disease. The most imum Data Set (MDS) dated | F 6     |  |                               |                               |  |
| A care plan revised on 07/04/18 for activities of daily living specified the resident required assistance with personal hygiene.  On 10/01/18 at 10:10 AM Resident #68 was   |        | himself understood. resident required on personal hygiene.  A care plan revised daily living specified assistance with pers  | The MDS also specified the e-person assistance with on 07/04/18 for activities of the resident required conal hygiene.   |         |  |                               |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE A. BUILDING | CONSTRUCTION  | (X3) DATE SURVEY COMPLETED C |
|--------------------------|---|---|---------------------------|---|------------------------------|
|                          |   | 345134  | B. WING                   |   | 10/04/2018                   |
|                          | ROVIDER OR SUPPLIER  CHARLOTTE TRANSI   | TIONAL CARE & REHAB CNTR  | 48                        | TREET ADDRESS, CITY, STATE, ZIP CODE<br>801 RANDOLPH ROAD<br>HARLOTTE, NC 28211                                 | 10/01/2010                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETION                |
| F 656                    | waiting on his nurse shaving. During the a razor and shaving. Observations of Re facial stubble and the not been shaved for the shaved for the shaved for the shaved for the shaved.  On 10/01/18 at 10:10 notified by the State was requesting to be Resident #68 if he described to the nurtor for safety reason accommodated Resident was requesting to the explained to the nurtor for safety reason accommodated Resident was too busy performed to shave daily and representations. On 10/01/18 at 2:00 of Resident #68 in the receptionist desk. The assistance with shave the shaved.  On 10/01/18 at 3:00 observed with a shape the shave daily and design shaved. | oom and reported he was a aide to assist him with a interview, Resident #68 had a cream in his hand. Sident #68 revealed he had be resident reported he had ar three days.  12 AM nurse aide (NA) #2 was a Agency that Resident #68 a shaved. NA #2 asked could shave himself and he are aide he was not supposed | F 656                     |   |                              |
|                          |   | rviewed and reported care ed to meet the needs of   |                           |   |                              |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | PLE CONSTRUCTION  | (X  | 3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|---|---|-----------------------------|
|                          |  | 345134  | B. WING _           |   |   | C<br><b>10/04/2018</b>      |
|                          | ROVIDER OR SUPPLIER  CHARLOTTE TRANSIT   | IONAL CARE & REHAB CNTR   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 4801 RANDOLPH ROAD CHARLOTTE, NC 28211  |   |                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>ELSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)   | SHOULD BE   | (X5)<br>COMPLETION<br>DATE  |
| F 656<br>F 677<br>SS=D   | interventions. ADL Care Provided   | vere expected to follow the for Dependent Residents   | F 6                 |   |   | 11/1/18                     |
|                          | out activities of daily services to maintain personal and oral hy This REQUIREMEN by: Based on observation and staff interview the incontinent care when (Resident #35) and when request by the of 3 residents sample. The findings include Resident #35 was recognologies of the incontinent care when request by the of 3 residents sample. The findings include Resident #35 was recognologies of the incontinent care with the findings include Resident #35 was recognologies. Review of a comprece (MDS) dated 07/23/was cognitively interesting the incompression of | ons, record review, resident, the facility failed to provide the requested by the resident failed to shave a resident (Resident #68) for 2 and for activities of daily living.  d:  eadmitted to the facility on coses that included: weakness, rotein calorie malnutrition, bulmonary disease, and  thensive minimum data set 18 revealed that Resident #35 and required limited aff member with toileting. No |                     | 1. Corrective action has been accomplished for the alleged d practice in regard to Resident a failing to provide incontinent carequested. Resident #35 was pincontinent care on 10/1/2018 Resident #35 for failing to shave requested. Resident #68 for fail shave when requested. Resident shaved by the Unit Manager of at 2:01 pm.  2. Current facility residents have potential to be affected by the adeficient practice. All residents potential to be affected. Direct Nursing/Nurse Management in In-Service on 10/17/2018 to all Licensed Nursing Staff and Ce Nursing Assistants on Activities Living to include incontinent cas shaving of residents. All new L Nursing Staff, Certified Nurses and Agency Personnel will be induring orientation.  3. Measures put in place to ensemble of the service of the servic | #35 for are when provided at 3:19pm. we when illing to ent #68 was n 10/1/2018 we the alleged a have the or of nitiated I current ertified as of Daily are and icensed a Assistants in-serviced | s<br>8                      |

| NAME OF PROVIDER OR SUPPLIER  CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR  TAG  FREET ADMRESS. CITY, STATE, ZIP CODE 4801 RANDOLPH ROAD CHARLOTTE, NC. 28211  PROVIDER'S PLAN OF CONNECTION (PAGE OF PROVIDER'S PLAN OF CONNECTION (PAGE OF PROVIDER'S PLAN OF CONNECTION)  PREFIX (PAGE OF PROVIDER'S PLAN OF CONNECTION) (PAGE OF PROVIDER'S PLAN OF CONNECTION)  PREFIX (PAGE OF PROVIDER'S PLAN OF CONNECTION)  PROVIDER'S PLAN OF CONNECTION (PAGE OF PROVIDER'S PLAN OF CONNECTION)  PREFIX (PAGE OF PROVIDER'S PLAN OF CONNECTION)  PREFIX (PAGE OF PROVIDER'S PLAN OF CONNECTION)  PROVIDER'S PLAN OF CONNECTION (PAGE OF PROVIDER'S PLAN OF CONNECTION)  PROVIDER'S PLAN OF CONNECTION (PAGE OF PROVIDER'S PLAN OF CONNECTION)  PREFIX (PAGE OF PROVIDER'S PLAN OF CONNECTION (PAGE OF PROVIDER'S PLAN OF CONNECTION)  PREFIX (PAGE OF PROVIDER'S PLAN OF CONNECTION (PAGE OF PROVIDER'S PLAN OF CONNECTION)  PREFIX (PAGE OF PROVIDER'S PLAN OF CONNECTION (PAGE OF PRO | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | ` IDENTIFICATION NUMBED:      |             | (X2) MULTIPLE CONSTRUCTION  A. BUILDING    |                                | (X3) DATE SURVEY<br>COMPLETED |            |
|--|---|---|-------------------------------|-------------|--|--------------------------------|-------------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER  CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNT  PART RECHORDED STANDARD OF DEPCEMENCES REACH DEPCEMENCES (REACH DEPCEMENCES) AND RESERVENCE OF DEPCEMENCES (REACH DEPCEMENCES) WIS IDENTIFYED INFORMATION)  FORTY REGULATORY OR LSC IDENTIFYING INFORMATION)  FORTY Continued From page 12 and the care she required.  A continuous observation was made of Resident #35 on 10/01/18 at 2:15 PM through 3:27 PM. Resident #35 turned the call light on and the Director of Housekeeping (IOPH) immediately entered her room and was informed by Resident #35 that she needed some incontinent care. The DOH stated to Resident #35 has been seeded as one incontinent care. The DOH stated to Resident #35 has been seeded as exiting Resident #35 some and turned the call light that was still liminated in the hallway and stated Resident #35 heeds some incontinent care. The DOH entered Resident #35 some and turned on by Resident #35 forom and turned on by Resident #35 some and providing incontinent care and the call light that was still waiting for incontinent care and the call light that was again turned on by Resident #35 some and providing incontinent care and the call light that was again turned on by Resident #35 some and providing incontinent care and the call light that was again turned on by Resident #35 some and providing incontinent care and the call light that was again turned on by Resident #35 some and providing incontinent care and the care |   |   | 345134                        | B WING      |  |                                | _                             | 100.40     |
| CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR    MAJ 10   PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   PREF | NAME OF D   | DOVIDED OD SUDDUED                              | 343134                        | B: 11:110 _ | CTDEET ADDRESS CITY STATE ZID C            | <u> </u>                       | 10/04/                        | 2018       |
| CHARLOTTE TRANSITIONAL CARE & REHAB CNTR    (ASA) DEFINITION   CARE SAMMARY STATEMENT OF DEFICIENCIES  | NAIVIE OF F   | ROVIDER OR SUFFLIER                             |                               |             |  | ODE                            |                               |            |
| SUMMARY STATEMENT OF DEFICIENCIES   PRETIX   REACH CORRECTION   PRETIX   RECULATION ON LSC DENTIFYING WHOMANION)   PRETIX   PROVIDERS PLAN OF CORRECTION   COMMENTION   PRETIX   PROVIDERS PLAN OF CORRECTION   COMMENTION   PRETIX   PROVIDERS PLAN OF CORRECTION   COMMENTION   COMMENTA   COMMENTION   COMMENTION   COMMENTION   COMMENTION   COMM   | <b>CURIS AT</b>                                     | CHARLOTTE TRANS                                 | SITIONAL CARE & REHAB CNTR    |             |  |                                |                               |            |
| FRETIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 677  Continued From page 12 and the care she required.  A continuous observation was made of Resident #35 turned the call light on and the Director of Housekeeping (DOH) immediately entered her room and was informed by Resident #35 that she needed some incontinent care. The DOH stated to Resident #35 that she needed some incontinent care. The Nursing Assistants (NAs) know. As the DOH was exiting Resident #35's room she ran into the Director of Nursing (DON), the DOH pointed at the call light that was still illuminated in the hallway and stated Resident #35's needs some incontinent care. The DOH stated to Resident #35's room she ran into the Director of Nursing (DON), the DOH pointed at the call light the vas still waiting for incontinent care. The DOH stated to Resident #35's room and turned the call light off without providing incontinent care and the call light that sated he would send someone back to assist her. At 2:49 PM Resident #35's continend that she was still waiting for incontinent care and the call light that was still waiting for incontinent care and the care and the call light that sated he would send someone back to assist her. At 2:49 PM Resident #35's command turned the care and the call light that sated he would send someone back to assist her. At 2:49 PM Resident #35's command turned the care and the call light that sate was some one back to assist her. At 2:49 PM Resident #35's command turned the care and the call light that sate of the part of the par |   |   |                               |             | CHARLOTTE, NC 28211                        |                                |                               |            |
| and the care she required.  A continuous observation was made of Resident #35 on 10/01/18 at 2:15 PM through 3:27 PM. Resident #35 turned the call light on and the Director of Housekeeping (DOH) immediately entered her room and was informed by Resident #35 that she needed some incontinent care. The DOH stated to Resident #35 that she was going to leave the call light on and let one of the Nursing Assistants (NAs) know. As the DOH was exting Resident #35's room she ran into the Director of Nursing (DON), the DOH pointed at the call light that was still illuminated in the hallway and stated Resident #35's room she tran light that was still illuminated in the hallway and stated Resident #35's recome and turned the call light the part of the would send someone back to assist her. At 2:49 PM Resident #35 confirmed that she was still waiting for incontinent care and the call light was again turned on by Resident #35 at 3:15 PM the call light remained on and Resident #35 again confirmed that she was waiting for incontinent care and the call light was again turned on by Resident #35's room and provided incontinent care and the call gift was again turned on by Resident #35's room and provided incontinent care and the call sight and went to see what she needed. NA #1 on 10/01/18 at 3:27 PM. NA #1 stated that she had been providing care to another resident and when she exited that room she noted Resident #35's call light and went to see what she needed. NA #1 confirmed that Resident #35's call light and went to see what she needed. NA #1 confirmed that Resident #35's call light and went to see what she needed. NA #1 confirmed that Resident #35's call light and went to see what she needed. NA #1 confirmed that Resident #35's call light and went to see what she needed. NA #1 confirmed that Resident #35's call light and went to see what she needed. NA #1 confirmed that Resident #35's call light and went to see what she needed. NA #1 confirmed that Resident #35's call light was again to the provision of federal and state law. | PREFIX  | (EACH DEFICIE                                   | ENCY MUST BE PRECEDED BY FULL | PREFIX      | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T | ION SHOULD BE<br>HE APPROPRIAT |                               | COMPLETION |
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| call light and went to see what she needed. NA #1 confirmed that Resident #35 needed incontinent care and that she provided the care. She added  |   |   |                               |             |  |                                |                               |            |
| confirmed that Resident #35 needed incontinent care and that she provided the care. She added  |   |   |                               |             |  |                                |                               |            |
| care and that she provided the care. She added   |   |   |                               |             |  |                                |                               |            |
|  |   |   |                               |             |  |                                |                               |            |
| that she was not aware that her can high had   |   |   |                               |             |  |                                |                               |            |
| been on earlier as she was working with another  |   |   |                               |             |  |                                |                               |            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | I ` ′               | PLE CONSTRUCTION IG   |                              | (X3) DATE SURVEY COMPLETED  C |  |
|---|---|--|---------------------|---|------------------------------|-------------------------------|--|
|   |   | 345134   | B. WING             |   |                              |                               |  |
| NAME OF PROVIDER OR SUPPLIER  CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR |   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CO 4801 RANDOLPH ROAD CHARLOTTE, NC 28211                | •                            | 0/04/2018                     |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 677   | An interview was co 10/02/18 at 2:38 PM observed Resident as he went into to see that Resident #35 in her brief changed. The Resident #35 she we know and was going added that she ran in of Resident #35's round that she needed to be call light that was or DON stated he wound the room.  An interview was con 10/03/18 at 9:54 AM NA #1 had finally pron 10/01/18 and she had entered Resident was con 10/04/18 at 11:25 And he had entered Resident if he told a or not. The DON staturned the call light and that it was unactive was con 10/04/18 at 11:25 And he had entered Resident in the told a or not. The DON staturned the call light and that it was unactive. | informed her that Resident ssistance.  Inducted with the DOH on 1. The DOH stated that she #35's call light come on and what she needed. She stated formed her that she needed The DOH stated she informed ould go and let someone go to leave the call light on. She into the DON on the way out some and informed the DON one changed and pointed to the in. The DOH stated that the lid take care of it and she left inducted with Resident #35 on 1. Resident #35 confirmed that ovided incontinent care to her e was very grateful. She into to use the call light very did it seemed to take a while | F 6                 | 77  |                              |                               |  |
|   | I .   | s admitted to the facility on oses that included atrial  |                     |   |                              |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |             | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---------------------|---|-------------|-------------------------------|--|
|   |   | 345134   | B. WING _           |   |             | C<br>10/04/2018               |  |
| NAME OF PROVIDER OR SUPPLIER  CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR |   |  |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>4801 RANDOLPH ROAD<br>CHARLOTTE, NC 28211   | E           | 10/04/2010                    |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 677   | recent quarterly Mir 09/07/18 specified intact, he did not re himself understood resident required or personal hygiene.  A care plan revised daily living specified assistance with per On 10/01/18 at 10: interviewed in his rowaiting on his nurse shaving. During the a razor and shaving Observations of Refacial stubble and the not been shaved for On 10/01/18 at 10:  | eimer's disease. The most himum Data Set (MDS) dated the resident's cognition was ject care and could make. The MDS also specified the ne-person assistance with on 07/04/18 for activities of the resident required sonal hygiene.  10 AM Resident #68 was for and reported he was exaide to assist him with the interview, Resident #68 had go cream in his hand. It is ident #68 revealed he had the resident reported he had | Fé                  | 577   |             |                               |  |
|   | was requesting to be Resident #68 if he desident #68 if he desident #68 if he desident #68 if he desident #68 in the Resident | e shaved. NA #2 asked could shave himself and he rse aide he was not supposed  |                     |   |             |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | ` ,   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---|---|---|-------------------------------|--|
| 345134  |   | 345134   | B. WING                                 |   |   | C<br><b>10/04/2018</b>        |  |
| NAME OF PROVIDER OR SUPPLIER  CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR |   |  |   | STREET ADDRESS, CITY, STATE, Z<br>4801 RANDOLPH ROAD<br>CHARLOTTE, NC 28211 | •   | 10/04/2010                    |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | (EACH CORRECTIVE CROSS-REFERENCED   | N OF CORRECTION<br>ACTION SHOULD BE<br>TO THE APPROPRIATE<br>IENCY) | (X5)<br>COMPLETION<br>DATE    |  |
| F 677   | interviewed and reporshaved.  On 10/01/18 at 2:10 If shaved Resident #68  On 10/01/18 at 2:31 If interviewed and reported to be shaved at the shaving was part of mexpected to be provided to be shaved with a shave better and reported the shave daily and off being shaved.  On 10/01/18 at 3:00 If the shave daily and off being shaved.  On 10/01/18 at 3:04 If and stated she did not shaving in the morning getting residents out she did not honor Refer to be shaved at lunch lunch trays. The NA "slow" day and usually on 10/04/18 at 10:52 (DON) was interviewed expected staff to provupon request and shaved. | PM the Unit Supervisor was reed she was told Resident aved and she assisted the upervisor explained that norning ADL care and was ded upon request.  PM Resident #68 was red face and stated he felt hat it was his usually routine ten he went days without  PM NA # 2 was interviewed by assist Resident #68 with and because she was bust of bed. She reported that sident #68's second request a because she had to pass added that she was having a by worked faster.  AM the Director of Nursing red and explained he wide shaving assistance aving should be included le added that a request for | Fé                                      | 677   |   |                               |  |