	-	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	E SURVEY PLETED
		345304	B. WING				C / 06/2018
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/S	знам		:	2727 SHAMROCK DRIVE		
					CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550 SS=D	Resident Rights/Exer 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, ind this section. §483.10(a)(1) A facilit with respect and dign resident in a manner promotes maintenanch her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, must establish and m practices regarding tr provision of services of residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise	cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, ad communication with and d services inside and cluding those specified in by must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. clility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen		550	DEFICIENCY)		1/3/19
	free of interference, c reprisal from the facili rights and to be supp	sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

12/27/2018

TATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING			<u>NO. 0938-039</u> TE SURVEY MPLETED
		345304	B. WING				C 2/06/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 1	2/00/2010
				27	27 SHAMROCK DRIVE		
BRIAN CE	NTER NURSING CARE	SHAM			HARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 550	Continued From page	o 1					
F 550			F	550			
		rights as required under this					
	subpart.						
		Γ is not met as evidenced					
	by:	and regident and staff			Brian Center, Shamrock		
		ons, resident and staff			POC		
		d review the facility failed to					
		resident with a urinary			Deficiency Statement:	ia Dlan	
		ollection bag was visible from			Preparation and/or execution of the of Correction does not constitute	is Plan	
	•	residents with urinary				ovidor of	
	catheters (Resident #	+47).			admission or agreement by the pr the truth of the facts alleged or		
	The findings included	4.			conclusions set forth in this staten	oont of	
	The findings included	1.					
	Booidopt #47 was ad	mitted to the facility on			deficiencies. The Plan of Correction prepared and/or executed solely b		
	02/16/09 with diagnos	Imitted to the facility on			it is required by the provisions of F		
		nction of the bladder. The			and State Law.	euerai	
		n Data Set (MDS) dated			and State Law.		
					F550		
		e resident's cognition was			F550		
	Intact and he had an	indwelling urinary catheter.			Based on observations, resident a	and atoff	
	On 12/02/19 at 2:44 1	PM observations made of			-		
					interviews and record review, the failed to maintain dignity for a resi		
		oom revealed his urine			0,1		
	hallway. The urine bag	d to the bed visible from the			with a urinary catheter; the urine c bag was visible from the hallway f		
	nanway. The unite D				residents with urinary catheters (F		
	On 12/02/18 at 4.30 i	PM a second observation			#47).	Concent	
		nt #47 and his urine catheter					
		from the hallway with urine			Address how corrective action will	he	
	in it.	nom the nanway with time			accomplished for those residents		
					have been affected by the deficier		
	0n 12/05/18 at 10·00) AM the Director of Nursing			practice;		
		ed and reported staff were			 Resident #47 identified during 	the	
		ry catheters covered. She			survey, the urine collection cathet		
	· ·	bags should be placed in a			was secured in a privacy bag on 1		
		revent a resident's urine			The nurse and Nursing Assis		
	from being visible.				received a one-on-one in-service		
					receive one prior to working a shift		
	On 12/05/18 at 1:00 I	PM Resident #47 was			DON or RN designee on securing	-	
		om about his urinary catheter.			collection bag in a privacy bag.		

Facility ID: 953008

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/31/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345304	B. WING		C 12/06/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1
BRIAN CE	ENTER NURSING CARE/S	SHAM		727 SHAMROCK DRIVE CHARLOTTE, NC 28205	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 550	He explained that he visible from the hallwa to see when it needed resident explained he long that he didn't thir of urine. He added th	knew the bag was at times ay because staff were able d to be emptied. The had the urinary catheter so hk anything about the sight hat the bag should be sight of urine might make	F 550	 Completion by 01/3/19. Address how corrective action will be accomplished for those residents has potential to be affected by the same deficient practice; All residents with a urine collectibag were identified. An audit was completed by the DON and/or RN designee to determine if all urine collection bags were secured by a probag to prevent urine from being visib (Completion by 01/3/19). All residents with a urine collectibag upon admission and/or change of condition will have a privacy bag sect to prevent urine from being visible. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will occur; An in-service will be completed furtile securing urine collection bag privacy bags. Any member of the nustaff who is unable to attend the mandatory in-service by 1/3/19 will rethe in-service prior to working a shift. Assistant Director of Nursing or designee will report any new urine collection bag in the morning clinical up meeting daily (Monday – Friday) areported to the weekend Charge nuring and will also be taken to daily clinical start-up meeting (Monday - Friday) 	ving a on ivacy le. on of oured not for all by o s in ursing eceive RN stand and/or se. ected o the

Event ID: S2D211

Facility ID: 953008

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VEFICIENCIES VIDER OR SUPPLIER ER NURSING CARE/S SUMMARY STA (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE 2727 SHAMROCK DRIVE CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) Friday) and/or reported to the wee Charge nurse and QAPI (Complet 1/3/19)	OULD BE COMPLETION ROPRIATE DATE
ER NURSING CARE/S SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) 50 Friday) and/or reported to the wee Charge nurse and QAPI (Complet	CTION DULD BE ROPRIATE (X5) COMPLETION DATE Ekend
ER NURSING CARE/S SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) 50 Friday) and/or reported to the wee Charge nurse and QAPI (Complet	CTION (X5) DULD BE COMPLETION ROPRIATE DATE
SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY) Friday) and/or reported to the wee Charge nurse and QAPI (Completed)	OULD BE COMPLETION ROPRIATE DATE
(EACH DEFICIENC) REGULATORY OR L	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) 50 Friday) and/or reported to the wee Charge nurse and QAPI (Complet	OULD BE COMPLETION ROPRIATE DATE
ontinued From page	3	F 55	Friday) and/or reported to the wee Charge nurse and QAPI (Completed to the section of the sectio	
FR(s): 483.15(c)(3)- 483.15(c)(3) Notice I	(6)(8) before transfer.	F 62	 Indicate how the facility plans to mits performance to make sure that solutions are sustained. The facilid evelop a plan for ensuring that can is achieved and sustained. The plus implemented and the corrective evaluated for its effectiveness. The integrated into the quality assurant system of the facility. Facility will change over to the Leaf Lite Bag which has a built in for urine collection bags as of 1/3/ Auditing and monitoring will remain place as outlined, adhering to the timeframe and guidelines. Director of Nursing and/or RN designee will audit 100% of reside urine collection bags secured with bag daily x 1 month, then weekly months to ensure compliance. An identified will be corrected at that Results of the monitoring will be swith the Administrator and/or Dire Nursing on a weekly basis and witmonthly for a period of 90 days at time frequency of monitoring will the administrator and/or Dire Nursing on a weekly basis and witmonthly for a period of 90 days at time frequency of monitoring will the administrator and/or Dire Nursing on a weekly basis and witmonthly for a period of 90 days at time frequency of monitoring will be swith the Administrator and/or Dire Nursing on a weekly basis and witmonthly for a period of 90 days at time frequency of monitoring will be swith the Administrator and/or Dire Nursing on a weekly basis and with the frequency of monitoring will be swith the Administrator and/or Dire Nursing on a weekly basis and with the frequency of monitoring will be swith the Administrator and/or Dire Nursing on a weekly basis and with the frequency of monitoring will be swith the Administrator and/or Dire Nursing on a weekly basis and with the frequency of monitoring will be swith the Administrator and/or Dire Nursing on a weekly basis and with the frequency of monitoring will be swith the Administrator and/or Dire Nursing on a weekly basis and with the Administrator and by the QAPI Committer and by the QAPI Committer and by the QAPI Committer and by the QAPI committer	t lity must correction lan must e action he PoC is hoce e Fig covering /19. in in N ents with h privacy x 2 ly issues time. shared for of th QAPI t which be
FF 48	R(s): 483.15(c)(3)- 3.15(c)(3) Notice b	ice Requirements Before Transfer/Discharge R(s): 483.15(c)(3)-(6)(8) 3.15(c)(3) Notice before transfer. ore a facility transfers or discharges a	R(s): 483.15(c)(3)-(6)(8) 3.15(c)(3) Notice before transfer.	 Facility will change over to th Leaf Lite Bag which has a built in for urine collection bags as of 1/3/ Auditing and monitoring will remain place as outlined, adhering to the timeframe and guidelines. Director of Nursing and/or RN designee will audit 100% of reside urine collection bags secured with bag daily x 1 month, then weekly months to ensure compliance. An identified will be corrected at that Results of the monitoring will be s with the Administrator and/or Dire Nursing on a weekly basis and wi monthly for a period of 90 days at time frequency of monitoring will be determined by the QAPI Committee (s): 483.15(c)(3)-(6)(8) 3.15(c)(3) Notice before transfer.

Facility ID: 953008

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345304	B. WING				06/2018
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/S	SHAM			2727 SHAMROCK DRIVE CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and manner facility must send a cor representative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility ar resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (C) The resident's her allow a more immediat under paragraph (c)(f (D) An immediate tran required by the resider under paragraph (c)(f)	and the resident's he transfer or discharge and ove in writing and in a r they understand. The boy of the notice to a Office of the State budsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or her this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section;	F	623			

Facility ID: 953008

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	S FOR MEDICARE &		0.00			IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY
			A. BUILDIN	G		С
		345304	B. WING			
	ROVIDER OR SUPPLIER	040004		STREET ADDRESS, CITY, STATE, ZIP CC		2/06/2018
	NOVIDEIN ON SUIT EIEN			2727 SHAMROCK DRIVE		
BRIAN CE	NTER NURSING CARE/	SHAM		CHARLOTTE, NC 28205		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE	COMPLETIO
F 623	Continued From page	e 5	F 6	23		
		its of the notice. The written				
		ragraph (c)(3) of this section				
	must include the follo	S I ()()				
	(i) The reason for tra					
		of transfer or discharge;				
	(iii) The location to wh					
	transferred or dischar	•				
		e resident's appeal rights, address (mailing and email),				
	and telephone number					
	-	its; and information on how				
		orm and assistance in				
		and submitting the appeal				
	hearing request;					
		ss (mailing and email) and				
		the Office of the State				
	Long-Term Care Om					
		y residents with intellectual				
	and developmental d	ig and email address and				
		the agency responsible for				
		vocacy of individuals with				
		lities established under Part				
		tal Disabilities Assistance				
	-	of 2000 (Pub. L. 106-402,				
	codified at 42 U.S.C.					
	•	ty residents with a mental				
		sabilities, the mailing and				
	agency responsible for	lephone number of the				
		als with a mental disorder				
		e Protection and Advocacy				
	for Mentally III Individ	-				
	§483.15(c)(6) Change	es to the notice.				
		ne notice changes prior to				
		or discharge, the facility				
	must update the recip		1			1

Facility ID: 953008

If continuation sheet Page 6 of 41

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345304	B. WING				C 06/2018	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER NURSING CARE/S	SHAM			727 SHAMROCK DRIVE CHARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	becomes available. §483.15(c)(8) Notice if In the case of facility of the administrator of the written notification privi- to the State Survey Ag State Long-Term Care the facility, and the re- well as the plan for the relocation of the residential 483.70(I). This REQUIREMENT by: Based on record revi- Social Worker, Ombu- the facility failed to pro- transfer/discharge for- to the hospital for 1 of and failed to notify the transfers for 5 of 7 res- #316, #318, #48 and and hospitalizations. Findings included: 1. Resident #317 adm 3/25/2018. Resident- included hemiplegia and cerebral infarction affer and unspecified symp- cognitive functions followed and and and and and and and and and an	in advance of facility closure closure, the individual who is be facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate ents, as required at § T is not met as evidenced ew, Emergency Department dsman and staff interviews, ovide a written notice of a facility initiated discharge f 1 resident (Resident #317) e Ombudsman of hospital sidents (Resident #317, #25) reviewed for	F	623	 F623 Based on record review, Emergency Department Social Worker, Ombudsma and staff interviews, the facility failed to provide a written notice of transfer/discharge for a facility initiated discharge to the hospital for 1 of 1 resident (Resident #317) and failed to notify the Ombudsman of hospital transfers for 5 of 7 residents (Resident #316, #317, #318, #48 and #25) review for hospitalizations. The plan for correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Facility failed to notify resident #317 wi written notice of discharge for a facility initiated discharge. Facility failed to notify the Ombudsman hospital transfers for residents #316, 3 #318, #48 and #25. 	ved che th a of 17,		
	Review of quarterly M dated 6/25/18 reveale	linimum Data Set (MDS) ed that resident was			 #318, #48 and #25. The procedure for implementing the acceptable plan of correction for the 	ie		

Facility ID: 953008

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	• •		COMPLETED		
					С		
		345304	B. WING		12/06/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER NURSING CARE	SHAM		2727 SHAMROCK DRIVE CHARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET		
F 623	Continued From page	e 7	F 62	3			
	cognitively intact. Re assistance with bed r use and personal hyg impairment on one si for ambulation. No b Review of Resident # revealed that he was on 6/25/2018 due to written notice of disch being provided to the party (RP) or the Om A telephone interview on 12/4/2018 with the hospital Emergency I at the ED stated he ro Resident #317. Resi committed to the ED initiated by the facility Resident #317 was in stabilization. The SV he contacted the faci ready for discharge a that Resident #317 h facility due to aggress be allowed to return. continued to explain #317's notice of trans facility was unable to	esident required extensive mobility and transfers, toilet giene. Resident had de and utilized a wheelchair ehavioral symptoms coded. 4317's medical record discharged to the hospital aggressive behaviors. No harge was documented as resident, the responsible budsman. 4 was completed at 8:58 AM e Social Worker (SW) at the Department (ED). The SW emembered the case with dent #317 was involuntarily for aggressive behaviors 7. The SW at the ED stated in the ED for several days for V at the ED further explained lity once Resident #317 was and the facility informed him ad been discharged from the sive behaviors and would not The SW at the ED he requested Resident offer/ discharge and the produce required transfer/		 specific deficiency cited; The Administrator that was identified during the survey as not notifying the resident with a 30 day written noticed discharge from the facility is no longemployee as of 10/01/18. The Social Worker identified during survey as not notifying the Ombuds transfer/discharge resigned as of 12/06/18. The Administrator is currently in the process of recruiting a new Social Services Manager and will have an extended by 1/11/19. A one on one in-service was received will be completed prior to the next with shift by the Administrator for the Social Services Manager or Social Services Designee, to include notifying the reand/or representative and to other of in accordance with state law of a 30 written notice of discharge initiated facility. A one on one in-service was received will be completed prior to the next with the completed prior to the next with the state law of a 30 written notice of discharge initiated facility. A one on one in-service was received will be completed prior to the next with the completed prior to the nex	ee e of ger an the man of offer ed or vorking cial es esident officials 0 day by the ed or vorking cial es esident officials 0 day by the ed or vorking cial es esident officials 0 or vorking cial es esident officials 0 or vorking cial es estimates officials 0 or vorking cial es estimates or ed to daily		
	facility was unable to discharge notice. Th Resident #317 receiv with locating alternati	produce required transfer/ e SW at the ED verbalized ved assistance from ED staff ive placement. Resident I home with family and			to daily y) nsure re and		

Facility ID: 953008

		MEDICAID SERVICES		PLE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	OMPLETED
						С
		345304	B. WING			12/06/2018
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
	NTER NURSING CARE	SHAM		2727 SHAMROCK DRIVE		
				CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE	(X5) COMPLETIO DATE
F 623	Continued From page	e 8	F 6	23		
		npleted on 12/4/2018 at 3:22		corrected and/or in comp	iance with the	
	PM with the Assistant	•		regulatory requirements;		
		stated that Resident #317		person responsible for im		
	was involuntarily com	mitted to the hospital due to		acceptable plan of correc		
		5. The ADON explained that		corrective action will be c		
		notice was not issued due to		corrective action dates m	ust be	
	•	upset Resident #317. The		acceptable to the State.	(<u>4000</u> / (II	
		that Resident #317 was not		In-service education		
	behaviors.	acility due to aggressive		licensed nurses will be co and/or designee to compl	•	
	benaviors.			Home to Hospital Transfe	-	
				will be completed by 1/3/		
	An interview was con	npleted with the prior		Currently, the Admin		
		5/18 at 8:11 AM. The prior		100% of 30 day written no		
		he recalled the incident		discharges and transfer/h		
	regarding Resident #	317. The prior Administrator		discharges to ensure resi	dent and/or	
	verbalized Resident #	U		resident representative a		
		d to be hospitalized. The		are notified, and if the alle		
		plained he was in contact		verified appropriate corre		
	· ·	informed the hospital that		be taken weekly x 3 mont	hs to ensure	
		not be allowed to return to		compliance.	imaa will alaa	
		Administrator further stated		Medical Records des	•	
		lischarge was not issued due everity of the situation. The		verify that medical record reflect the discharges and	-	
		ated he would expect for the		transfer/hospital discharg		
	· ·	and the Administrator to		months to ensure complia		
	work together to issue			identified issues will be co		
		of the situation as quickly as		time and disciplinary action		
	possible to the reside	ent and/ or the responsible		provided to the staff mem	ber.	
	party (RP), and notify	the Ombudsman.		Results of the monito	-	
				shared with QAPI monthly		
				90 days at which time free		
		npleted with the facility		monitoring will be determ	ined by the QAPI	
		on 12/5/2018 at 8:56 AM. as not certain if a notice of		Committee. Completion 01/3/19		
		as completed for Resident				
	-	er stated that she did not				
		transfer/ discharge for				
	-	SW also verbalized she was				

Facility ID: 953008

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE	ECONSTRUCTION	(X3) DATE	
AND FLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG _			C
		345304	B. WING				06/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/S	SHAM			2727 SHAMROCK DRIVE CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 623	 she has not been info any transfers or disch that she did not notify Ombudsman in writing discharge. An interview was com Administrator on 12/5 current Administrator would be for the Socia with the Administrator or the RP in writing of transfer/discharge and Ombudsman in writing and/ or discharge. A telephone interview Ombudsman on 12/6 Ombudsman stated th notifications of transfer the facility. 2. Resident #316 was 8/14/2015. Resident hemiplegia, vascular and dysphagia. Revia 	Ald be responsible for the Ombudsman of es. The SW explained that rming the Ombudsman of arges. The SW confirmed Resident #317 or the g of the notice of transfer/ Appleted with the current /2018 at 3:08 PM. The stated that his expectation al Worker, in conjunction the notice of d also notify the resident and/ the notice of d also notify the g regarding any transfer was completed with the /2018 at 8:55 AM. The hat she has not received any ers and/ or discharges from a admitted to the facility on had diagnoses that included dementia without behaviors, ew of the quarterly Minimum	F	623			
	Data Set (MDS) dated Resident #316 was se for decision making. Review of Resident #	d 9/5/2018 revealed that everely cognitively impaired					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE	E SURVEY PLETED
		345304	B. WING				C / 06/2018
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	ENTER NURSING CARE/S	SHAM			2727 SHAMROCK DRIVE CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 623	9/21/2018 due to criti	cal lab values and No written notice of transfer being provided to the	F	62:	3		
	Social Worker (SW) of The SW verbalized sh would be responsible the Ombudsman of tr SW explained that sh the Ombudsman of an The SW confirmed th	or the Ombudsman in writing					
	Administrator on 12/5 current Administrator would be for the Socia with the Administrator or the RP in writing of discharge and also no	npleted with the current 5/2018 at 3:08 PM. The stated that his expectation al Worker, in conjunction r, to notify the resident and/ f the notice of transfer/ otify the Ombudsman in transfer and/ or discharge.					
	Ombudsman on 12/6 Ombudsman stated th	was completed with the /2018 at 8:55 AM. The hat she has not received any ers and/ or discharges from					
	8/7/2017. Resident # included neuromuscu	admitted to the facility on 318 had diagnoses that lar dysfunction of bladder omplete. Review of the					

Facility ID: 953008

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345304	B. WING			1:	C 2/06/2018
NAME OF P	ROVIDER OR SUPPLIER	L	I	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	.	
BRIAN CE	ENTER NURSING CARE/S	SHAM			2727 SHAMROCK DRIVE CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 623	discharge Minimum E		F	623	3		
	6/15/2018 due to sho written notice of trans	318's medical record hsferred to the hospital on ulder and hip pain. No fer was documented as resident, the RP or the					
	Social Worker (SW) of The SW verbalized sl would be responsible the Ombudsman of tr SW explained that sh the Ombudsman of a The SW confirmed th	Ombudsman in writing of					
	Administrator on 12/5 current Administrator would be for the Soci with the Administrator or the RP in writing of discharge and also no	npleted with the current /2018 at 3:08 PM. The stated that his expectation al Worker, in conjunction r, to notify the resident and/ f the notice of transfer/ otify the Ombudsman in transfer and/ or discharge.					
	Ombudsman on 12/6 Ombudsman stated t	was completed with the /2018 at 8:55 AM. The hat she has not received any ers and/ or discharges from					

Facility ID: 953008

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345304	B. WING				C 06/2018
NAME OF PROVID	DER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CENTE	R NURSING CARE/S	HAM			2727 SHAMROCK DRIVE CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
the 4. F 1/1 incl A re (MI cog A re rev 2/1 No bei Om An Wo sta res Om exp of a cor the trar An Adu cur be Adu in v An At	9/18. Resident #44 lusive of unspecifie eview of the quarte DS) dated 10/22/18 gnitively intact. eview of Resident # ealed he was trans 9/18 and returned f written notice of trans provided to the budsman. interview was com wrker (SW) on 12/5/ ted she was not aw ponsible for making budsman of transfe blained she had not any transfers or dis offirmed she had not Ombudsman in wr nsfer/discharge. interview was com ministrator on 12/5/ rent Administrator s for the Social Work ministrator, to notify writing of the notice ify the Ombudsman elephone interview	eadmitted to the facility on 8's medical diagnoses were ed joint contracture. rly Minimum Data Set 8 revealed Resident#48 was #48's medical record offerred to the hospital on to the facility on 2/20/18. ansfer was documented as resident or the pleted with the Social 2018 at 8:56 AM. The SW vare of who would be g notifications to the ers or discharges. The SW t informed the Ombudsman charges. The SW t notified Resident #48 or riting of the notice of pleted with the current /2018 at 3:08 PM. The stated his expectation would ter, in conjunction with the y the resident and/or the RP of transfer/discharge and in in writing regarding any	F	623			

Facility ID: 953008

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMF	E SURVEY PLETED
		345304	B. WING				C /06/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/S	SHAM		2727 SHAMROCK DRIVE CHARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE C			(X5) COMPLETION DATE
F 623	Ombudsman stated s written notifications of discharges from the fa 5. Resident #25 was n 10/24/18. Resident#2 inclusive of type 2 dia stage renal disease. Review of the quarter dated 10/9/18 reveale cognitively intact. Review of Resident # revealed multiple disc 4/27/18, 5/22/18, 6/18 8/19/18, 9/17/18, 10/1 from the facility with h written notice of disch being provided to the Ombudsman. An interview was com Worker (SW) on 12/5 stated she was not av responsible for makin Ombudsman of transf explained she had no Ombudsman of any tr SW confirmed she had or the Ombudsman in transfer/discharge. An interview was com Administrator on 12/5 current Administrator be for the Social Worl Administrator, to notif	he had not received any f transfers and/ or acility. readmitted to the facility on 25's medical diagnoses were betes mellitus and end ly Minimum Data Set (MDS) ed Resident #25 was 25's medical record charges (12/13/18, 3/13/18, 3/18, 7/16/18, 8/10/18, 1/18, 10/6/18, and 10/11/18) nospital admissions. No harge was documented as resident or the pleted with the Social /2018 at 8:56 AM. The SW vare of who would be g notification to the fers or discharges. The SW	F	62:	3		

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	-	ND HUMAN SERVICES			FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345304	B. WING		C 12/06/2018
	ROVIDER OR SUPPLIER	SHAM		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 SHAMROCK DRIVE CHARLOTTE, NC 28205	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 623	transfer and/ or disch A telephone interview Ombudsman on 12/6 Ombudsman stated s written notifications o	an in writing regarding any arge. / was completed with the /2018 at 8:55 AM. The she had not received any f transfers and/ or	F 62	23	
F 641 SS=D	resident's status.	of Assessments. st accurately reflect the	F 64	11	1/3/19
	by: Based on record rev facility failed to code terminally ill and rece at the facility for 1 of 2	is not met as evidenced iew and staff interview the that a Hospice resident was iving Hospice services while 2 sampled residents rvices (Resident #54).		F641 Based on record review and staff interview the facility failed to code Hospice resident was terminally receiving Hospice services while facility for 1 of 2 sampled residen receiving Hospice services (Resi • Address how corrective action	e that a ill and at the nts ident #54)
	Resident #54 was ad 6/6/2016. Diagnoses disease, epilepsy and Hospice contract date	mitted to the facility on s included Alzheimer's d cerebral infarction. A ed 2/3/2018 certified that mitted under the care and or end of life.		accomplished for those residents have been affected by the deficie practice; Facility failed to accurately code Hospice resident was terminally receiving Hospice services, ident MDS Section J1400 and MDS Se Resident #54 MDS was modified coded accurately as receiving Ho	s found to ent that a ill and tified in ection O. I and
	11/2/2018 specified th severely impaired. R	Im Data Set (MDS) dated he resident's cognition was deview of Section J1400 resident have a condition or		services on 12/4/18. The MDS nurse identified during survey as not coding accurately #54 received one-on-one in-serv education by the District Director	resident ice

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/31/201 FORM APPROVE OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345304	B. WING		C 12/06/2018
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	
	NTER NURSING CARE	CHAM		2727 SHAMROCK DRIVE	
BRIAN CL	INTER NORSING CAREA			CHARLOTTE, NC 28205	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 641	as Resident #54 not I live. Review of Section Treatments) was coold receiving Hospice services On 12/4/2018 at 12:4 completed with the M stated Section J1400 resident have a cond may result in a life ex months?) was coded #54. The MDS Nurse receiving hospice services for Section J1400. On 12/4/2018 during MDS Nurse, she also Programs/ Treatment in error. The MDS Nurse should have been cool further explained the modified to reflect the services being receive On 12/4/2018 at 5:07 completed with the Ar Administrator stated I coded as accurately at	may result in a life an 6 months?) was coded having less than 6 months to on O (Special Programs/ ed as Resident #54 not rvices. 5 PM an interview was IDS Nurse. The MDS Nurse (Prognosis-Does the ition or chronic disease that pectancy of less than 6 No in error for Resident e stated any resident vices should be coded Yes the same interview with the o stated Section O (Special its) - Hospice was coded No urse verbalized Resident d Hospice services and ded Yes. The MDS Nurse assessment needed to be a correct prognosis and ed by Resident #54.	F 64		ervices per on will be s having a ime ervices as g and/or he as MD orders by the b ensure ices are anual. I be put nade to e will not vices will isk" IDT coding ected en to eported is to s ure that

Event ID: S2D211

Facility ID: 953008

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/31/2018 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345304	B. WING				C / 06/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/S	SHAM			27 SHAMROCK DRIVE HARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 641 F 685 SS=E	F 685 Treatment/Devices to Maintain Hearing/Vision		evaluated for its effect integrated into the qu system of the facility. The MDS Coordinato will randomly audit fiv weekly for 12 weeks a MDS's monthly for an to verify accurate cod and O of the MDS. Results of the monito with Administrator and weekly basis and with period at which time f		The MDS Coordinator and/or designee will randomly audit five completed MDS weekly for 12 weeks and then five rand MDS's monthly for an additional 3 mon to verify accurate coding of Sections J	ctiveness. The PoC is uality assurance or and/or designee ve completed MDS's and then five random n additional 3 months ding of Sections J oring will be shared nd/or designee on a h QAPI monthly for a frequency will be	
	and assistive devices hearing abilities, the f assist the resident- §483.25(a)(1) In making §483.25(a)(2) By array and from the office of the treatment of vision the office of a profess provision of vision or This REQUIREMENT by: Based on observation interviews and review facility failed to provid hearing abilities for a	d hearing ints receive proper treatment to maintain vision and facility must, if necessary, ing appointments, and anging for transportation to a practitioner specializing in n or hearing impairment or sional specializing in the hearing assistive devices. T is not met as evidenced ins, resident and staff of the medical record, the le services to maintain sampled resident (#17) who g loss, for 1 of 1 sampled			Based on observations, resident and s interviews and review of the medical record, the facility failed to provide services to maintain hearing abilities fo sampled resident (#17) who complaine	ra	

Event ID: S2D211

Facility ID: 953008

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12 FORM APP OMB NO. 09	PROVED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE SURV COMPLETEI	
		345304	B. WING		C 12/06/2	018
NAME OF PI	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP COD		
		CUAM	:	2727 SHAMROCK DRIVE		
	NTER NURSING CARE/	STAM		CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COM	(X5) MPLETION DATE
F 685	Continued From page	e 17	F 685	5		
	resident reviewed.		1 000		nled	
	resident reviewed.			of hearing loss, for 1 of 1 sam resident reviewed.	ipieu	
	The findings included	1:		F685		
	5			Address how corrective action	n will be	
		mitted to the facility on		accomplished for those reside		
		ncluded mild intellectual		have been affected by the det	ficient	
		najor depressive disorder,		practice;		
	and mood disorder.			Resident #17 identified d	-	
	Medical record review	v for Resident #17 revealed		survey as not having an Audio appointment had an Audiolog		
		on dated 4/4/18. The consult		appointment on 12/17/18	y	
		nt #17 reported hearing loss		The nurse identified durin	na the survey	
	when he stated, "I ca			as not completing the Audiolo		
	clogged up."			received one-on-one in-servic		
				or will receive one prior to wo	rking a shift	
	Further medical reco			by the Director of Nursing reg	•	
		nding order dated 4/20/18,		completion of referral appoint	ments per	
		be seen and treated by an		MD/NP orders.		
		er recorded a discontinue e was no record of an		Completion 12/6/18 Address how corrective action	a will be	
		served in the medical record.		accomplished for those reside		
				potential to be affected by the	•	
	A guarterly minimum	data set, dated 10/4/18, for		deficient practice;		
		ed him with unclear speech,		All residents with an appe	ointment	
	-	inderstands, mild cognitive		referral by MD orders were id		
	deficits, and minimal			Audit was completed on 12/20		
	October 2018 care pl			Director of Nursing and Assist		
		em regarding a hearing		of Nursing to determine wheth		
	deficit with intervention			physician orders were followe		
		s, audiologist consult as for and record any hearing		 the appointment. (Completion Referral appointments with 		
		harge and cerumen/wax		completed per the MD/NP or		
	accumulation).			as psychiatrist evaluations to		
	/			nurse signing off on the appoi		
	Nurse aide (NA) #1 w	vas observed on 12/2/18 at		orders, filling out the referral a		
	4:26 PM to repeat he	rself several times during a		form, giving the referral form	to Medical	
		l with Resident #17 after he		Records to schedule the appo	pintment as	
	said "huh?" to severa	Il questions/comments.		ordered by MD/NP.		
				EHR Designee will provid	de an	

Facility ID: 953008

CENTER	-	ND HUMAN SERVICES MEDICAID SERVICES				MAPPROVE 0. 0938-039
ATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		PLETED
		345304	B. WING			C 106/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/2010
				2727 SHAMROCK DRIVE		
BRIAN CE	ENTER NURSING CARE/	SHAM		CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 685		e 18	EGS	5		
F 685	Resident #17 was int 4:46 PM. During the were repeated when "Sometimes when per them. I need some h me?" During an interview of social worker (SW) s on identifying a common for hearing aides for complaints of hearing them and a request f further stated she was the hearing aides. Th prior conversations w repeat questions to h hearing. A follow up interview 12/05/18 at 2:03 PM. completed an initial a agency regarding he on 8/1/18. The SW s response dated 8/27. additional information which included proof income, a hearing ter The SW then stated was scheduled and of consult in his medica get back to you."	terviewed on 12/02/18 at interview, several questions he stated "huh?" and said cople talk to me, I can't hear earing aides. Will you help on 12/05/18 at 9:00 AM, the tated that she was working munity resource willing to pay Resident #17 because of his g loss, inability to pay for for hearing aides. The SW as not aware of the status of he SW also stated that in with Resident #17, she had to him because of his difficulty with the SW occurred on . She stated that she application with a community aring aides for Resident #17 tated she received an email	F 68	 appointment list weekly for nurses review the list during daily Stand-u meetings conducted by the Admini An updated referral appointment libe provided to nurses and daily St meetings as appointments per MD (Completion 1/3/19) Address what measures will be puplace or systemic changes made the ensure that the deficient practice voccur; An in-service education will be completed for all licensed nurses at EHR Designee by the Director of N or RN designee to include followin MD/NP orders and psychiatric eval for referral appointments (to include changes and cancellations). Any mwho is unable to attend the manda in-service education prior to workin shift. Referral appointment forms w checked daily by the Director of N or designee as per MD/NP orders psychiatric evaluations. Director of Nursing or designee report any new referral appointment forms w checked daily clinical and Sta meetings along with the MD/NP or and/or psychiatric evaluations. MDS Care plans will be review weekly to identify potential referrals/consultations that to need scheduled. 	p istrator. st will and-up //NP. t into o vill not e and the Nursing g luations le turse atory receive ng a ill be ursing and ee will nts nd-up rder wed	
	questions/comments	at times she had to repeat to him. NA #1 further stated are of Resident #17 wearing les.		 Any issues identified will be consistent of the constraint of the const	to daily	

Facility ID: 953008

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	12/31/2018 APPROVED 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
		345304	B. WING			C 12/0	6/2018
NAME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, C	ITY, STATE, ZIP CODE		
	NTER NURSING CARE	CHAM		2727 SHAMROCK DI	RIVE		
	NIER NURSING CARE	SHAM		CHARLOTTE, NC	28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 685	PM that Resident #17 she had not observed The SW conducted at interview on 12/06/18 interview, the SW stat the community agend #17 complete a hear she forwarded the re- be responsible to not hearing test appointm not appear that the h because the schedule referral. An interview with the 12/06/18 at 9:35 AM responsible to make arrange transportatio referrals from nursing stated that Resident test because she did schedule an appointm The director of nursin 12/06/18 at 10:16 AM staff to follow the pro resident appointment stated that once a MI was responsible to pup provide a copy to the	terview on 12/05/18 at 3:05 7 had some hearing loss, but d him wearing hearing aides. In additional follow up 8 at 9:32 AM. During the ted that when she received cy's request to have Resident ing test back in August 2018 ferral to nursing, who would ify the scheduler to make the nent. The SW stated it did earing test was scheduled er did not receive the scheduler occurred on and revealed that she was resident appointments and n once she received written g. The scheduler further #17 did not have a hearing not receive a referral to nent until now. (p (DON) was interviewed on A and stated she expected cess of ensuring that is were made. The DON D order was written, nursing rocess the MD order, and scheduler who was	F 6	Indicate how to its performance solutions are a develop a plat is achieved an be implement evaluated for integrated into system of the • Director of audit 100% of appointments cancellations) weekly x 2 mo Any identified that time. Ress shared with th Director of Nu with QAPI mo at which time	the facility plans to mon ce to make sure that sustained. The facility r n for ensuring that corre- nd sustained. The plan ted and the corrective ar- its effectiveness. The P o the quality assurance	must ection must ction PoC is will d unce. d at vill be the s and	
		n. r of nursing (ADON) was /18 at 11:08 AM. During the		Facility ID: 953008	If cont		

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY DMPLETED
		345304	B. WING			C
	ROVIDER OR SUPPLIER	040004		STREET ADDRESS, CITY, STATE, ZIP CO		12/06/2018
				2727 SHAMROCK DRIVE		
BRIAN CE	NTER NURSING CARE/	SHAM		CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 685	#17's standing MD or audiology consult, bu implemented as need was not aware that R difficulty hearing durin and further stated, "W	e 20 that she processed Resident der dated 4/4/18 for an t that standing orders were led. She further stated she esident #17 complained of ng a psychiatric evaluation Ve should have activated id him for an audiology	F 6	85		
F 689 SS=E	CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu		F 6	89		1/3/19
	§483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by: Based on observation interviews, the facility water temperatures a Fahrenheit (F), with the temperature obtained shared resident bath (bathrooms for share 106/108, 110/112, 113) The findings included	l at 123.2 degrees F, for 6 ooms on 1 of 3 hallways d rooms 101/103, 102/104, 3/115, 114/116).		Based on observations, rec and staff interviews, the fac maintain safe hot water tem or below 116 degrees Fahre the maximum noted temper at 123.2 degrees F, for 6 sh bathrooms on 1 of 3 hallway for shared rooms 101/103, 1 106/108, 110/112, 113/115, F689 • Address how corrective accomplished for those resi	ility failed to operatures at enheit (F), with ature obtained bared resident ys (bathrooms 102/104, 114/116).	
		•		have been affected by the d practice; Criswell Services Inc. was c the facility on 12/2/18 to ens	contracted to	

Facility ID: 953008

If continuation sheet Page 21 of 41

						NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	TE SURVEY
			A. DOILDING			С
		345304	B. WING			2/06/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP		
		CHAM		2727 SHAMROCK DRIVE		
	INTER NURSING CARE	SHAM		CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From pag	e 21	F 68	39		
		dom selection of shared		hot water temperatures for	r all resident	
		all and both showers in the		bathrooms were brought v		
	facility. The Mainten	ance Supervisor stated the		required temperature rang	je of 100-116	
		emperatures range from 100		degrees F.		
		grees F. The Maintenance		One-on-One in-service ed		
		had no reports the hot water sidents' bathrooms or in the		completed on 12/2/18 with Maintenance Director to c		
		to hot or uncomfortable and		required hot water temper		
		During the interview, the		100-116 degrees F.	ature range of	
		isor provided a log of hot		Completion 12/2/18		
		necks. The log revealed the		Address how corrective	ve action will be	
	following temperature	es for the month of		accomplished for those re	sidents having a	
	November 2018:			potential to be affected by	the same	
	11/7/10 -+ 10:17 ANA	adiaining bathraans far		deficient practice;	uill he newsleads to be	
		adjoining bathroom for temperature 106.9		Water temperatures v audited during alternating	-	
	degrees F			(7am-3pm, 3pm-11pm, 11		
	U	bathroom for Room #204		resident bathrooms and 2	. ,	
	water temperature 10			twice daily (am and pm) M		
	11/7/18 at 10:55 AM	bathroom for Room #304		("Manager on Duty" will be	e responsible for	
	water temperature 10	-		monitoring water temperat		
		adjoining bathroom for		Saturday and Sunday) x 3		
		ter temperature 108.2		then weekly x 9 months, to		
	degrees F 11/14/18 at 2:15 PM	bathroom for Room #202		hot water temperatures ma acceptable parameters.	aintain	
	water temperature 10			If the Maintenance Directo	or and/or	
	-	bathroom for Room #304		designee (such as the Ma		
	water temperature 10			identifies an out of range t		
		1 bathroom for Room #304		"out of order" sign will be p	posted outside	
	water temperature 10	-		of the area ensuring reside		
		1 adjoining bathroom for		the water until proper temp	peratures are	
		ter temperature 107.4		maintained.	continuo to ho	
	degrees F 11/21/18 at 11:36 AM	1 adjoining bathroom for		Criswell Services Inc. will contracted for both period		
		ter temperature 109.1		emergency maintenance.		
	degrees F	P		Address what measured	res will be put	
		1 adjoining bathroom for		into place or systemic cha	•	
		ter temperature 107.9		ensure that the deficient p	ractice will not	
	degrees F			occur;		

Facility ID: 953008

		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/31/201 RM APPROVE IO. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345304	B. WING _			1	C 2/06/2018
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/	SHAM			27 SHAMROCK DRIVE HARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Rooms #206/208 wat degrees F 11/28/18 at 2:22 PM I water temperature 10 On 12/2/18, a tour wi Supervisor on the 100 following water temper Digital readings with 1 On 12/2/18 at 5:10 P degrees F in shared I On 12/2/18 at 5:12 P degrees F in shared I On 12/2/18 at 5:13 P degrees F in shared I On 12/2/18 at 5:15 P degrees F in shared I On 12/2/18 at 5:19 P degrees F in shared I On 12/2/18 at 5:19 P degrees F in shared I On 12/2/18 at 5:21 P degrees F in shared I On 12/2/18 at 5:21 P degrees F in shared I On 12/2/18 at 5:21 P	adjoining bathroom for ter temperature 107.4 bathroom for Room #302 07.6 degrees F th the Maintenance 0 Hallway revealed the eratures: the facility's thermometer: M, water temperature 117.3 bathroom for 114/116. M, water temperature 118.5 bathroom for 113/115. M, water temperature 123.2 bathroom for 110/112. M, water temperature 122.3 bathroom for 101/103. M, water temperature 123.1 bathroom for 102/104. M, water temperature 121.2 bathroom for 106/108. 18 at 5:25 PM revealed the isor accessing the boiler in a	F	589	 Water temperatures will be randomly audited during alternating shifts (7am-3pm, 3pm-11pm, 11pm-7am) for resident bathrooms and 2 shower root twice daily (am and pm) Monday-Sund ("Manager on Duty" will be responsible monitoring water temperatures on Saturday and Sunday) x 3 months and then weekly x 9 months, to ensure that hot water temperatures maintain acceptable parameters. Criswell Services Inc. will continue to contracted for both periodic, repair, ar emergency maintenance. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility m develop a plan for ensuring that correct is achieved and sustained. The plan m be implemented and the corrective accevaluated for its effectiveness. The Pointegrated into the quality assurance system of the facility. Maintenance Director or designee will audit water temperatures during alternating shifts (7am-3pm, 3pm-11p 	ms day e for d at be nd that nust ction nust tion pC is	
	rear staff entrance. T at 118 degrees F. On 12/2/18 at 7:25 P Resident#58 in room the water in her bathr adjusted temperature she used the sink to	#103, stated she had noticed room sink to be hot and she by adding cold water when wash her body in the 8 stated she has no injury			11pm-7am) for 9 resident bathrooms a 2 shower rooms twice daily (am and p Monday-Sunday ("Manager on Duty" y be responsible for monitoring water temperatures on Saturday and Sunda 3 months and then weekly x 9 months ensure that hot water temperatures maintain acceptable parameters. Any identified issues will be corrected at the time. Results of the monitoring will be share	om) will y) x s, to nat	
	On 12/2/18 at 7:26 P	M, an interview with			with the Administrator and/or the Direct of Nursing on a daily basis and with Q		

Facility ID: 953008

	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/31/2018 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	COM	E SURVEY PLETED
		345304	B. WING			/06/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/S	SHAM		2727 SHAMROCK DRIVE CHARLOTTE, NC 28205		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	noticed water was hot temperature. Resident sink independently to body. Resident#41 si related to hot water te On 12/2/18, during into oriented residents on reported no awareness their bathrooms. The was used by nurse aid An interview with the 12/02/18 at 7:34 PM, had not checked the vision second (3:00 PM - 11 7:00 AM) shifts. The further stated when he weekends, he had vision thermostat but had not temperatures in the re facility shower rooms. Supervisor stated the degrees F prior to adj boiler. The Maintenar thermostat was set sli recommended hot was usage of hot water in the facility. The Main the 100 Hall was closs likely would have high On 12/2/18 at 7:50 Pf Supervisor stated he the boiler and a tour of bathrooms on the 100	 #104 stated she has not ther than a comfortable ut#41 stated she used the wash her hands and her tated she has no injury emperature. terviews with other alert and the 100 Hall, the residents as of water temperatures in residents reported the sink des. Maintenance Supervisor on the supervisor stated he water temperatures on :00 PM) or third (11:00 PM - Maintenance Supervisor e was on site on the sually checked the boiler of checked the water esidents' bathrooms or the . The Maintenance boiler was set at 118 usting thermostat on the nee Supervisor stated the ightly higher than the ther temperature due to the kitchen and throughout tenance Supervisor stated est to the boiler and most her temperature readings. M, the Maintenance adjusted the thermostat on of the shared resident 	F 689	monthly for a period of 12 month	S.	

Facility ID: 953008

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	-	ID HUMAN SERVICES				FORM	MAPPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		E CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
				-		(С
		345304	B. WING			12/	06/2018
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/S	SHAM			2727 SHAMROCK DRIVE		
					CHARLOTTE, NC 28205		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	E	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE
	1				DEFICIENCY)		
E 690	Continued From none	24		~~~			
F 689	Continued From page	24	F	689			
	Digital readings with t	he facility's thermometer:					
		M, water temperature 112.6					
	degrees F in shared b	pathroom for 101/103.					
		M, water temperature 113.5					
	degrees F in shared to On 12/2/18 at 7:59 PI	M, water temperature 114.0					
		pathroom for 106/108.					
		M, water temperature 108.5					
	degrees F in shared b						
	degrees F in shared b	M, water temperature 109.0 Dathroom for 113/115.					
	-	M, water temperature 108.2					
	degrees F in shared b	bathroom for 114/116.					
	On 12/2/10 at 9.20 DI	M, an interview with the					
		OON), the DON reported no					
	÷ .	piced by staff or residents					
		emperatures in the facility					
	hot water temperature	incidents been attributed to					
	On 12/2/18 at 8:32 PI	M, a review of facility					
		mental grievances revealed					
	no concerns related to	o hot water temperature.					
	An interview with the	administrator on 12/05/18 at					
	2:49 PM, the Adminis	trator stated he was notified					
		perature in the residents'					
	bathrooms on the 100 regulation for hot wate						
	Administrator stated h						
		sor to monitor the hot water					
	-	acility. The Administrator					
	stated his expectation						
F 756		itisfy state requirements. w, Report Irregular, Act On	F	756			1/3/19
SS=D	CFR(s): 483.45(c)(1)(. 00			

Facility ID: 953008

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/31/2018 APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345304	B. WING		_		C 06/2018
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/S	SHAM		2727 SHAMROCK DRIVE CHARLOTTE, NC 28205	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	25	F 756				
	must be reviewed at licensed pharmacist. §483.45(c)(2) This rev of the resident's media §483.45(c)(4) The pha- irregularities to the att facility's medical direct and these reports mus- (i) Irregularities included drug that meets the cl (d) of this section for a (ii) Any irregularities in- during this review mus- separate, written repor- attending physician and director and director of minimum, the residen and the irregularity the (iii) The attending phy- resident's medical reco- irregularity has been to action has been taken- be no change in the n- physician should docu- the resident's medical §483.45(c)(5) The fac- maintain policies and drug regimen review to limited to, time frames the process and steps	ug regimen of each resident east once a month by a view must include a review cal chart. armacist must report any tending physician and the stor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. hoted by the pharmacist st be documented on a bort that is sent to the nd the facility's medical of nursing and lists, at a it's name, the relevant drug, e pharmacist identified. visician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to nedication, the attending ument his or her rationale in l record. cility must develop and procedures for the monthly that include, but are not is for the different steps in is the pharmacist must take					
		fies an irregularity that to protect the resident.					

Facility ID: 953008

If continuation sheet Page 26 of 41

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/31/201 M APPROVEI O. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COM	E SURVEY PLETED
		345304	B. WING				C / 06/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE	SHAM					
	1			С	HARLOTTE, NC 28205		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From pag	e 26		756			
1 700		T is not met as evidenced		/ 50			
	by:	i is not met as evidenced					
		macist, nurse practitioner			F756		
		ews, and record review, the			Based on staff, pharmacist, nurse		
	-	ify the lack of documented surements used to monitor			practitioner and physician interviews, record review, the facility failed to ide		
		cation for 1 of 5 sampled			the lack of documented blood pressu		
		ed medication (Resident			measurements used to monitor blood		
	#38).				pressure medication for 1 of 5 sample	ed	
	The findings includes	4.			residents who received medications		
	The findings included	1.			 (Resident #38). Address how corrective action with the second second	ll be	
	Resident #38 was ad	Imitted to the facility with			accomplished for those residents four		
	-	uded diabetes mellitus and			have been affected by the deficient		
	hypertension.				practice;		
	Review of Resident #	#38's monthly physician's			Resident #38 identified during the sur as not having a blood pressure monit	-	
		8 revealed renewal of orders			was corrected on 12/5/18.	<u>-</u>	
		2017) of direction to hold			Nurse #3 and Nurse #4 identified dur	-	
	-	cation administration for a			the survey as not recording the blood		
		re measurement under 110 ry (mmHg). The physician			pressure for resident #38 received or receive one-on-one in-service educat		
		used to treat high blood			prior to working a shift by the Director		
		ms twice daily (initial order			Nursing on recording a blood pressur		
	date of November 20)17).			MD/NP as ordered.		
	Review of Resident #	#38's October 2019			Completion 12/5/18 Address how corrective action with 	ll bo	
		administration record			 Address now corrective action w accomplished for those residents hav 		
		ection to hold blood pressure			potential to be affected by the same		
	medication for a syst	olic blood pressure			deficient practice;		
		an 110 mmHg. The eMAR			All residents with orders for documen		
		es' initials daily for blood ent. Weekly blood pressure			blood pressure monitoring were ident An audit was completed by the Direct		
		documented on the eMAR.			Nursing or designee to determine who		
					the physicians' orders were followed		
		sident #38's October 2018			document blood pressures (complete		
		dent #38's Metoprolol was			12/5/18).	- 4:	
		3:00 AM, on 10/18/18 at 8:00 at 4:00 PM			Blood pressure monitoring documenta		
	AM and on 10/22/18	al 4.00 PM.			will be completed per the MD/NP orde		

Facility ID: 953008

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/31/2018 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		345304	B. WING		1:	C 2/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
BRIAN CE	NTER NURSING CARE/	SHAM		2727 SHAMROCK DRIVE CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 756 Continued From page Review of Resident #3 revealed documentatio measurements for the		38's progress notes	F 75	56 include the nurse signing off t and adding supplementary do for blood pressure monitoring Any resident with new orders	ocumentation	
	 #38's blood pressure measured 90/55 mmHg on 10/10/18; 102/53 mmHg on 10/18/18 and 85/49 mmHg on 10/22/18. A progress note dated 10/21/18 documented the Metoprolol was held for a blood pressure measurement of 119/66 mmHg. Review of the monthly drug regimen review dated 10/24/18 revealed no recommendations or documentation regarding lack of blood pressure measurements. 			pressure monitoring will be re- during morning clinical meetin issues identified will be correct immediately and Administrato during daily Stand-up meeting (Completion 1/3/19)	ngs. Any cted or notified	
				 Address what measures into place or systemic change ensure that the deficient prac occur; In-service education will be completed 	es made to tice will not	
	revealed direction to medication for a syste measurement less th documented of nurse pressure measureme	-		all licensed nurses by the Dira Nursing or RN designee to in following MD/NP orders for de blood pressures. Any nurse w to attend the mandatory in se 1/3/19 will receive in-service of prior to working a shift.	ector of clude ocumenting vho is unable rvice by education	
	Further review of Resident #38's November 2018 eMAR revealed Resident #38's Metoprolol was held on 11/14/18 at 4:00 PM, on 11/22/18 at 4:00 PM and on 11/23/18 at 8:00 AM.			Director of Nursing and/or de review new orders for docum residents blood pressures da morning clinical standup. Director of Nursing and/or de review blood pressure docum	enting ily during signee will	
		ssure measurement of nented on 11/22/18. There blood pressure e held medication on		ordered by MD/NP in PCC da Any issues identified will be c immediately and will be taken Stand-up meetings and repor Pharmacist will meet with the Nursing during the monthly vi any resident with blood press	aily. Forrected I to daily ted to QAPI. Director of sit to identify	
	11/29/18 revealed no	y drug regimen review dated recommendations or ding lack of blood pressure		 Any resident with block press monitoring undocumented. (Completion 1/3/19) Indicate how the facility p monitor its performance to ma 	plans to	

Facility ID: 953008

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/31/2018 MAPPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345304	B. WING				C 106/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				27	727 SHAMROCK DRIVE		
	NTER NURSING CARE/	SHAM		С	HARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From page		F	756	solutions are sustained. The facility n develop a plan for ensuring that corre		
	Interview with Nurse #4 on 12/04/18 at 3:42 PM revealed Resident #38 received blood pressure measurements prior to Metoprolol administration. Nurse #4 explained she documented the blood pressure measurement when the systolic was below 110 mmHg.				is achieved and sustained. The plan r be implemented and the corrective ac evaluated for its effectiveness. The P is integrated into the quality assuranc system of the facility. Director of Nursing or designee will au	nust tion DC e udit	
	revealed she measur pressure prior to Mete Nurse #3 reported sh pressures on a shift r blood pressure meas	rview with Nurse #3 on 12/05/18 at 8:40 AM ealed she measured Resident #38's blood ssure prior to Metoprolol administration. se #3 reported she documented the blood ssures on a shift report. Nurse #3 explained od pressure measurements with a systolic asurement below 110 would be documented			100% of residents with blood pressure monitoring 3x a week x 4, then 2x a w x 4, then 1x weekly ongoing to ensur compliance. Any issues identified will corrected immediately. Results of the monitoring will be share with the Administrator on a weekly ba and with QAPI monthly for a period of	eek e be ed sis	
	Interview with the Dir 12/05/18 at 8:43 AM documented Residen weekly and when the below 110 mmHg. Th	t #38's blood pressure systolic measurement fell			days at which time frequency will be determined by the QAPI Committee.		
	reviewed blood press residents who receive medication. The com provide a reason Res	18 at 12:12 PM revealed he sure measurements for ed blood pressure sultant pharmacist could not sident #38's drug regimen ess the lack of documented					
	12/05/18 at 1:50 PM Resident #38's blood	rse practitioner (NP) on revealed she expected pressure measurements to ssessment of blood pressure frequency.					

	-	D HUMAN SERVICES MEDICAID SERVICES			FC	TED: 12/31/2018 DRM APPROVED NO. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345304	B. WING			C 12/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		
BRIAN CE	NTER NURSING CARE/S	SHAM		2727 SHAMROCK DRIVE CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page	29	F 75	56		
F 757	PM revealed Residen measurements to be review. The physicial measurements were effectiveness of media	cation.	F 75			12/30/18
SS=D	CFR(s): 483.45(d)(1)- §483.45(d) Unnecess Each resident's drug					12/30/16
	§483.45(d)(1) In exce duplicate drug therap					
	§483.45(d)(2) For exc	cessive duration; or				
	§483.45(d)(3) Withou	t adequate monitoring; or				
	§483.45(d)(4) Withou use; or	t adequate indications for its				
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be				
	stated in paragraphs section.	mbinations of the reasons (d)(1) through (5) of this is not met as evidenced				
	Based on staff, nurse interviews, and record monitor a hemoglobin	e practitioner and physician d review, the facility failed to (Hgb.) A1c level and sure measurements to		F757 Based on staff, nurse physician interviews the facility failed to m	and record review,	

Event ID: S2D211

Facility ID: 953008

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 12/31/20 [.] 1 APPROVE). 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		LETED
		345304	B. WING				C 06/2018
NAME OF P	ROVIDER OR SUPPLIER		•	SI	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	NTER NURSING CARE	SHAM		27	727 SHAMROCK DRIVE		
				С	HARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	Continued From pag	e 30	E 7	757			
		blood pressure medications		51	(Hab) A1a loval and desumant blood		
		sidents who received			(Hgb) A1c level and document blood pressure measurements to monitor		
	medication (Residen				diabetic and blood pressure medication	ns	
		,			for 1 of 5 sampled residents who receiv		
	The findings included	d:			medication		
	Resident #38 was ac	dmitted to the facility with			Address how corrective action will	be	
		luded diabetes mellitus and			accomplished for those residents found	l to	
	hypertension.				have been affected by the deficient		
					practice;		
		y physician's orders dated			Resident #38 identified during the surv		
		rection to obtain a Hgb. A1c			blood pressure monitoring documentat was corrected on 12/5/18	ion	
		eduled for January, April, July A1c is a blood test used to			Resident #38 hemoglobin (Hgb) A1c le	vel	
		e level of blood sugar over			drawn on 12/5/18, reviewed by NP an		
	-	ns.) The physician's orders			put in resident's chart	-	
	included Januvia 100) milligrams daily and sliding			Assistant Director of Nursing received	а	
	scale NovoLog insuli				one-on-one in-service education on		
	medications are used	d to treat diabetes mellitus.)			12/5/18.		
					Address how corrective action will		
		#38's laboratory tests result dated 07/30/18 of			accomplished for those residents havin potential to be affected by the same	iy a	
	•	e range of 5.0% to 6.1%.			deficient practice;		
		er 2018 Hgb. A1c result			All residents with a missing lab and blo	od	
	available for review.	C			pressure monitoring documentation we		
					identified. An audit was completed by t		
		#3 on 12/04/18 at 10:47 AM			Assistant Director of Nursing to determ		
		38's October 2018 Hgb. A1c			if all labs were drawn, reviewed by MD.	/NP	
	result could not be lo	ocated.			and put in resident's chart on 12/4/18. All residents identified will receive bloo	ч	
	Interview with the As	sistant Director of Nursing			draws and blood pressure monitoring	u	
		at 10:55 AM revealed the			documentation for review by MD/NP to	be	
	facility changed labo				completed by 1/4/19.		
		nd Resident #38's Hgb. A1c			Any resident with new orders for blood		
		ADON explained an audit of			pressure monitoring and missed labs w		
	routine blood tests co				be reviewed daily during morning clinic	al	
		did not identify Resident			meetings. Any issues identified will be	-r	
	#38's omitted Hgb. A	ATC.			corrected immediately and Administrate		
					notified during daily Stand-up meetings		

Event ID: S2D211

Facility ID: 953008

If continuation sheet Page 31 of 41

		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			TE SURVEY MPLETED
			A. BUILDING	G		С
		345304	B. WING			2/06/2018
	ROVIDER OR SUPPLIER	0.0001		STREET ADDRESS, CITY, STATE, ZIP		2/06/2018
				2727 SHAMROCK DRIVE	OODL	
BRIAN CE	ENTER NURSING CARE	SHAM		CHARLOTTE, NC 28205		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION
F 757	Continued From pag	e 31	F 75	57		
	Interview with the Di	rector of Nursing (DON) on		Address what measu	res will be put	
	12/04/18 at 11:41 AM	A revealed she expected		into place or systemic cha	•	
	Resident #38's Hgb.	A1c to be done as ordered.		ensure that the deficient p	practice will not	
	later in with Desid			occur;		
		ent #38's physician on revealed the Hgb. A1c was		In-service education will b all licensed nurses by the		
		ne efficiency of the diabetic		Nursing and/or RN design		
		/sician reported he expected		following MD/NP orders fo		
		A1c to be done as ordered.		pressure monitoring, input		
				into PCC, and putting labs		
		OON on 12/05/18 at 2:00 PM		in lab book. Any licensed		
		38's Hgb. A1c drawn on		unable to attend the mano		
	12/05/18 was 8%.			education by 1/4/19 will re in-service education prior		
	2 Review of Reside	ent #38's monthly physician's		shift.	to working a	
		8 revealed renewal of orders		Assistant of Director of Nu	ursina or	
		2017) to hold blood pressure		designee will bring the lab		
	medication administr	ation for a systolic blood		results to morning clinical	meetings daily	
	1.	ent under 110 millimeters of		for review. Labs will be re-		
		he physician ordered		MD/NP with signatures. L	-	
		reat high blood pressure) 25		to Medical Records to put	in residents	
	November 2017).	y (initial order date of		chart. Director of Nursing or des	ianoo will roviow	
				new orders for residents v	-	
	Review of Resident	#38's October 2018		orders and blood pressure		
	electronic medication	n administration record		daily during morning clinic	-	
		ction to hold blood pressure		ensure compliance.		
	medication for a syst			MD/NP will be notified imr		
		nan 110 mmHg. The eMAR es' initials daily for blood		labs that are missed and l		
		ent. Weekly blood pressure		monitoring that goes undo Nurse identified as not fol		
		documented on the eMAR.		orders will receive discipli	-	
				Missed labs and blood pre	-	
	Further review of Re	sident #38's October 2018		monitoring documentation		
		ident #38's Metoprolol was		with Administrator during	daily Stand-up	
		3:00 AM, on 10/18/18 at 8:00		meetings.		
	AM and on 10/22/18	at 4:00 PM.		(Completion 1/4/19)	9 I	
	Bovious of Desident	#20's prograss potes		Indicate how the facil monitor its performance to		
	Review of Resident a	+oos progress notes		monitor its performance to	make sure that	

Facility ID: 953008

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION		10. 0938-03 FE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	<u> </u>	· · · ·	MPLETED
						С
		345304	B. WING			2/06/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
BRIAN CE	NTER NURSING CARE	SHAM		2727 SHAMROCK DRIVE		
		-		CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 757	Continued From page	e 32	F 75	57		
	revealed documentat			solutions are sustained. The	facility must	
		e held Metoprolol. Resident		develop a plan for ensuring t	-	
	#38's blood pressure	measured 90/55 mmHg on		is achieved and sustained. T		
		Hg on 10/18/18 and 85/49		be implemented and the corr		
	-	A progress note dated		evaluated for its effectivenes		
		the Metoprolol was held for		integrated into the quality as	surance	
	a blood pressure mea	asurement of 119/66 mmHg.		system of the facility. Director of Nursing or design	oo will oudit	
	Review of Resident #	38's November 2018 eMAR		100% of residents with blood		
	revealed direction to			monitoring documentation 3x	•	
	medication for a syste	-		then 2x a week x 4, then 1x y		
		an 110 mmHg. The eMAR		ongoing to ensure complian	-	
	documented of nurse	s' initials daily for blood		Director of Nursing or design		
	•	nt. Weekly blood pressure		labs daily during morning clir		
		documented on the eMAR.		meetings. Any issues identifi corrected immediately.		
		sident #38's November 2018		Results of the monitoring will		
		dent #38's Metoprolol was :00 PM, on 11/22/18 at 4:00		with the Administrator on a w and with QAPI monthly for a		
	PM and on 11/23/18			days at which time frequency		
				determined by the QAPI Con		
	Review of Resident #	38's vital sign sheet		All clinical staff received in-se		
		ssure measurement of		education by the Director of I		
		nented on 11/22/18. There		designee on 12/28/18 related		
	were no documented			importance of monitoring and	d inputting	
	measurements for the			labs.		
	11/14/18 and 11/23/1	8.				
	Boviow of Booldoot #	38's December 2018 eMAR		Director of Nursing or design conduct audits of documenta		
		8's Metoprolol was held on		specifically related to lab res		
		a progress note dated		for 4 weeks. Any non-compli	•	
		blood pressure measure of		reported to the Administrator		
	105/55 mmHg.			addressed immediately.		
	Interview with Nurse	#4 on 12/04/18 at 3:42 PM		On-going compliance will be	monitored	
		8 received blood pressure		through the QA committee ar		
		to Metoprolol administration.		noncompliance will be report		
		he documented the blood		Administrator and addressed		
	pressure measureme		1			1

Event ID: S2D211

Facility ID: 953008

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345304	B. WING				C 06/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER NURSING CARE/S	знам		27	727 SHAMROCK DRIVE		
BRIANOL				С	HARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	revealed she measure pressure prior to Meter Nurse #3 reported she pressures on a shift re blood pressure measure measurement below 1 documented on the er 12/05/18 at 8:43 AM re documented Residen weekly and when the below 110 mmHg. The expected staff to docume measurement prior to administration. Interview with the nur 12/05/18 at 1:50 PM re Resident #38's blood be documented. The measurements were to blood pressure medic Interview with the phy PM revealed Residen measurements should medication review. T	 #3 on 12/05/18 at 8:40 AM ed Resident #38's blood pprolol administration. e documented the blood eport. Nurse #3 explained urements with a systolic 110 mmHg. would be MAR. ector of Nursing (DON) on revealed nurses t #38's blood pressure systolic measurement fell ne DON reported she ument each blood pressure the Metoprolol se practitioner (NP) on revealed she expected pressure measurements to NP explained the used for assessment of cation dose and frequency. rsician on 12/05/18 at 1:54 t #38's blood pressure d be documented for he physician explained urements were used to of blood pressure		757			1/3/19
	-	-		101			1/3/19
SS=D	CFR(s): 483.45(g)(h)(§483.45(g) Labeling c	of Drugs and Biologicals					

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EDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C
345304	B. WING		12/06/2018
	- I	STREET ADDRESS, CITY, STATE, ZIP CODE	12:00:2010
A M		2727 SHAMROCK DRIVE	
AW		CHARLOTTE, NC 28205	
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
 sed in the facility must be vith currently accepted and include the and cautionary piration date when Drugs and Biologicals lance with State and y must store all drugs and mpartments under proper and permit only authorized ss to the keys. ty must provide separately ixed compartments for ugs listed in Schedule II of ug Abuse Prevention and lother drugs subject to a facility uses single unit on systems in which the hal and a missing dose can s not met as evidenced and staff interviews, the f 3 medication carts when a expired over-the-counter dy for use in 1 of 1 m. PM the weekend survey team to the facility's ervations made during that cation cart on the 200 hall 	F 76	F761 Based on observations and staff interviews, the facility failed to lock 1 of medication carts when unattended an remove expired over-the-counter medications stored ready for use in 1 medication storage room • The plan of correcting the specific deficiency. The plan should address to processes that lead to the deficiency	d of 1
	AM M M M M M M M M M M M M M	1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN 345304 B. WING	I) PROVIDER/SUPPLEX/CLA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING

Facility ID: 953008

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM APPRO OMB NO. 0938-0	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C 12/06/2018	
		345304	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE		
BRIAN CE	ENTER NURSING CARE/	SHAM		2727 SHAMROCK I CHARLOTTE, NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	DVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLET	
F 761	 weekend manager locart. On 12/02/18 at 2:45 f was interviewed about cart and stated she locbecause it was unloc where Nurse #2 was. On 12/02/18 at 3:22 f interviewed about the explained she was as medication cart and t including the locking stated she was trained locking the medication was going to be left ustated it was an over unlocked. On 12/05/18 at 10:00 (DON) was interviewed that when a nurse ne medication cart that t times. 2. On 12/02/18 at 3: 200-hall medication cart that t times. 2. On 12/02/18 at 3: 200-hall medication cart that t times. 2. On 12/02/18 at 3: 200-hall medication cart that t times. 	s were seated in medication cart. The ocked the 200-hall medication PM the weekend manager ut the unlocked medication ocked the medication cart ocked the medication cart ocked, and she did not know PM Nurse #2 was e medication cart. She ssigned the 200 Hall the cart worked fine, mechanism. The nurse ed to secure medications by on cart if the medication cart unattended. The nurse sight for leaving the cart 0 AM the Director of Nursing ed and stated she expected beded to step away from the the cart be locked at all 18 PM observations of the cart revealed the cart was cked. Residents were s near the medication cart. to be in a room behind a the observation, the	F 7	Nurse #2 an identified dur the medication in-service economic Nursing on 1 Facility failed over-the-cound storage room • The pro- acceptable prespecific defind In-service economic all licensed medication of left unattend to attend the education by in-service economic shift. In-service economic all licensed medication for y 1/3/19. Any issues in immediately Stand-up medication • The monomic that the plan that specific	d to remove expired unter medications from n. cedure for implementing the blan of correction for the ciency cited; ducation will be completed nurses by the Director of lesignee regarding locking cart when medication carts led. Any nurse who is unal e mandatory in-service y 1/3/19 will receive the ducation prior to working a ducation will be completed nurses and central supply y the Director of Nursing o garding removing expired rom the storage room wee dentified will be corrected and will also be taken to c eetings and/or reported to or and QAPI.	he for the ble for r ekly daily ure and e	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/31/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345304	B. WING		C 12/06/2018
NAME OF PI	ROVIDER OR SUPPLIER	·	- ·	STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CE		SHAM		2727 SHAMROCK DRIVE	
BRIAN OF				CHARLOTTE, NC 28205	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 761	Continued From page	e 36	F 76	.1	
	Continued From page 36 should not be left unattended and unlocked. On 12/02/18 at 3:22 PM Nurse #2 was interviewed about the medication cart. She explained she was assigned the 200 Hall medication cart and the cart worked fine, including the locking mechanism. The nurse stated she was trained to secure medications by locking the medication cart if the medication cart was going to be left unattended. Nurse #2 stated she asked another nurse to stand by the medication cart while she walked away but offered no explanation why the medication cart was left unattended. On 12/05/18 at 10:00 AM the Director of Nursing (DON) was interviewed and stated she expected that when a nurse needed to step away from the medication cart that the cart be locked at all times. 3. During a continuous observation on 12/05/18, the 200 Hall medication cart was first observed unattended and unlocked at 9:21 AM. No residents were near the medication cart or in the 200 Hallway. At 9:24 AM, the Director of Nursing (DON) approached the medication cart and verified the medication cart was unlocked. The DON locked the medication cart at this time. The			 person responsible for implementia acceptable plan of correction. Data corrective action will be completed corrective action dates must be acceptable to the State. Director of Nursing or designee wirrandomly audit medication carts to they are locked 3x weekly for 4 weeks, and then 2x weekly for 4 weeks to ensight once per week for a weekly ongoing. Any identified issible corrected at that time and discident action provided to the staff member Results of the monitoring will be swith QAPI monthly for a period of at which time frequency of monito be determined by the QAPI Commits of the completion 01/3/19 	es when d. That d. Tha
	from a medication ca by the nurse. On 12/05/18 as the o #6 returned to her as the 200 Hall at 9:34 A interviewed regarding	n a nurse stepped away rt, the cart should be locked bservation continued, Nurse signed medication cart on AM. Nurse #6 was g the unlocked medication view, the nurse explained			

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	-	ID HUMAN SERVICES				FORM	APPROVED	
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	LETED	
		345304	B. WING				C 06/2018	
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER NURSING CARE/	SHAM		2727 SHAMROCK DRIVE CHARLOTTE, NC 28205				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 761	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 37 she was asked by another nurse to assist in the medication storage room. The nurse stated she had been trained to secure medications by locking the medication cart if the medication cart was going to be left unattended. Nurse #6 stated she had not realized she left the medication cart unlocked while she assisted another nurse. 4. An observation was made on 12/2/2018 at 3:05 PM of the medication storage room with Nurse #5. Two bottles of expired over the counter (OTC) vitamins were identified- Vitamin A and Vitamin E. Each bottle had an expiration date noted as October 2018. An interview with Nurse #5 on 12/2/2018 at 3:05 PM stated she would discard the vitamins due to them being expired. Nurse #5 stated the Central Supply clerk was responsible for checking for expired medications/ biologicals in the medication storage room. An interview was completed with the Central Supply clerk on 12/4/2018 at 10:19 AM. The Central Supply clerk stated she and the nurses checked the medication storage room for inventory and expired medications (including vitamins) twice weekly. The Central Supply clerk further stated the nurse's checked the medication storage room for expired drugs. The Central Supply clerk verbalized the nurses would be responsible for discarding the medications/ biologicals if they were expired.		F	761				
	An interview was con	npleted with the Director of						

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDI	NG		COMPLETED		
		345304	B. WING			12	C 2/06/2018	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
		CUAM		2727 SHAMROCK DRIVE				
	NTER NURSING CARE/	SHAW		Cł	HARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 761	Continued From page	e 38	F.	761				
		2/9/2018 at 12:16 PM. The	•					
		ected her nurses, as well as,						
	· ·	erk to check for expired						
		als in the medication storage						
	· ·	sis. The DON also stated						
		armacy consultant to check ge room during their monthly						
	visit.							
F 867	QAPI/QAA Improvem	ent Activities	F	367			1/3/19	
SS=E	CFR(s): 483.75(g)(2)	(ii)						
	§483.75(g) Quality as	ssessment and assurance.						
		ality assessment and						
	assurance committee							
	action to correct iden	ement appropriate plans of tified quality deficiencies; is not met as evidenced						
	by:							
		ons, resident and staff			Based on observations, resident and s			
		review, the facility's Quality			interviews and record review, the facility	y's		
		urance (QAA) Committee			Quality Assessment and Assurance (QAA) Committee failed to maintain			
		ntions the committee put			implemented procedures and monitor			
		2018. This was for a recited			these interventions the committee put in	nto		
		originally cited during a			place in January 2018. This was for a			
		completed December 2017.			recited deficiency which was originally			
	The deficiency was in	n the area of accident ed failure of the facility			cited during a recertification survey completed December 2017. The			
		rveys of record show a			deficiency was in the area of accident			
		s inability to sustain an			hazards. The continued failure of the			
	effective Quality Assu	•			facility during two federal surveys of record shows a pattern of the facility's			
	Findings included:				inability to sustain an effective Quality Assurance Program.			
	This tag is cross refe	rred to:			F867 Address how corrective action will be			
	F689 Accident Hazar	ds: Based on observations,			accomplished for those residents found	l to		

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Facility ID: 953008

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/31/2018 APPROVED D: 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345304	B. WING				C 106/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
BRIAN CE	BRIAN CENTER NURSING CARE/SHAM				727 SHAMROCK DRIVE HARLOTTE, NC 28205			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 867	ENTER NURSING CARE/SHAM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	867	 have been affected or have the potent to be affected by the deficient practicate. The administrator will reeducate Interdisciplinary team (IDT) and memo of the Quality Assurance and Improvement Committee by 1/3/19 regarding accurately reporting and revising current action plans as well at developing and implementing new acciplans to assure state and federal compliance in the facility. IDT, including the facility Medicate Director, will meet at least monthly to conduct the facility's Quality Assurance and Performance Improvement meeting for a facility may need an Adhoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator woorganize a meeting and notify all tear members regarding the need to revise any present action plan or for the development of a new action plan to ensure compliance. Completion 1/3/19 Address what measures will be put in place or systemic changes made to ensure that the deficient practice will occur; The administrator will reeducate Interdisciplinary team (IDT) and mem of the Quality Assurance and Improvement Committee by 1/3/19 regarding accurately reporting and revising current action plans as well at developing and implementing new acciplans to assure state and federal compliance in the facility. 	e; the bers as tion I ce ing. vill n e to not the bers		

Event ID: S2D211

Facility ID: 953008

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/31/2018 ORM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345304	B. WING				C 12/06/2018	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	I		
BRIAN CE	NTER NURSING CARE/S	SHAM		2727 SHAMROCK DRIVE				
		-		C	HARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 867	Continued From page	e 40	F	867	 IDT, including the facility Mean Director, will meet at least monthl conduct the facility's Quality Assurand Performance Improvement metring for a facility may need an Adhoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administration organize a meeting and notify all members regarding the need to reany present action plan or for the development of a new action plan ensure compliance. Indicate how the facility plans to react its performance to make sure that solutions are sustained. The facility evaluated for its effectiveness. The integrated into the quality assurant system of the facility. Quality Assurance monitoring place at each Quality Assurance and Performance Improvement meeting monthly and any Adhoc meetings. This monitoring tool will be signed each IDT member after each meeting monitoring and revisions set forth Quality Assurance and Performance Improvement committee. 	ly to irrance heeting. the ty y tor will team evise h to monitor t lity must correction lan must ve action he PoC is nce g will take and ng s held. d off by eting h by the		

Facility ID: 953008

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