PRINTED: 01/28/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	C 12/20/2018
CHARLOTTE HEALTH & REHABILITATION CENTER 1735 TODDVILLE ROAD CHARLOTTE, NC 28214 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 1735 TODDVILLE ROAD CHARLOTTE, NC 28214 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATION)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APP	N (X5)
DEFICIENCY)	
F 550 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	1/17/19 (X6) DATE

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

01/17/2019 **Electronically Signed**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345405	B. WING		C 12/20/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/20/2010	
				1735 TODDVILLE ROAD		
CHARLOT	TE HEALTH & REHAB	ILITATION CENTER		CHARLOTTE, NC 28214		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
F 550	Continued From pag	ge 1	F 550			
	subpart.	er rights as required under this				
	by:					
		ons, resident and staff		The statements included are not an		
		ord review, the facility failed to		admission and do not constitute		
	·	anner to protect a resident's		agreement with the alleged deficiencie	es	
		I assistance with incontinent		herein. The plan of correction is		
		ents reviewed for dignity and		completed in the compliance of state a		
	respect (Resident #	12).		federal regulations as outlined. To rein compliance with all federal and stat		
				regulations the center has taken or wi		
	Findings included:			take the actions set forth in the followi		
				plan of correction. The following plan	9	
				correction constitutes the center□s		
		dmitted on 2/1/2018.		allegation of compliance. All alleged		
	Resident #72's med	ical diagnoses were inclusive		deficiencies cited have been or will be	;	
	of unspecified bladd	ler disorder and arthritis.		completed by the dates indicated.		
				Address how corrective action will be		
				accomplished for those residents four	id to	
		erly Minimum Data Set (MDS)		have been affected by the deficient		
		aled that Resident#72 was		practice;	d for	
		lesident #72 required e of one person with bed		Bowel Incontinence care was provided resident #72 on 12/17/2018.	101 L	
		ependence of one person with		Address how the facility will identify of	her	
	•	#72 had an external (condom)		residents having the potential to be		
	•	ways incontinent of bowel.		affected by the same deficient practice	e:	
		ection of care regarding ADL		All residents with bowel incontinence		
		ce deficit was noted during		identified as being at risk. At risk		
	•	erence period. Resident #72's		incontinent residents are identified by		
	vision was noted to	be adequate.		MDS section H. All residents with a B	IMS	
				of 12-15, bowel incontinence, and		
				identified at risk will be interviewed		
	-	olan with a focus area for ADL		regarding incontinent timeliness. Res		
	-	ce deficit, revised and dated		will be reviewed by Director of Nursing	j tor	
		an revealed Resident #72		further problem resolution if needed		
	•	ance and indicated a goal to		Address what measures will be put int	.0	
		el of function. Interventions		place or systemic changes made to	not	
	included assist with	toilet use and encourage the		ensure that the deficient practice will r	IUI	

		IDENTIFICATION NUMBED:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345405	B. WING		- 1	C / 20/2018	
NAME OF P	ROVIDER OR SUPPLIER	1 1 11		STREET ADDRESS, CITY, STATE, ZIP CODE	12	20/2010	
				1735 TODDVILLE ROAD			
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER		CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 550	Continued From page	e 2	F 55	0			
	resident to use bell to			recur; All Nursing staff will be educated timeliness of bowel incontinence of			
		AM, Resident #72 was in bed awake. Resident #72		to not turn off a call light until the part care need has been met. Educati	patient		
		oursing staff of his need to be el incontinence. Resident		also be provided on resident right including dignity with bowel incom			
	#72's room was odor	ous. The call light was Resident #72 reported he		care and timeliness of incontinent requests. Education will be provide	ce care		
	used the call light to	notify staff of his need for		the DON, SDC, or designee. Nur staff who have not received education will be provided the DON, SDC, or designee.	sing		
	incontinent care and a nursing staff member came in, turned the call light off, and informed him she would get someone to provide			or before 1/17/2019, will not be all work until education is received.			
	incontinent care. Res	sident #72 was unable to		All New nursing staff will be educa			
		ber by name or identify if a nurse or nurse aide.		during orientation on the timelines bowel incontinence care and to no off a call light until the patient care has been met. Education will also	ot turn e need		
	observed lying in bed	AM, Resident #72 was I and he reported no staff		provided on resident rights includi dignity with bowel incontinence ca	ing are and		
		d to assist him with room was odorous at the		timeliness of bowel incontinence of requests by Staff Development No	urse.		
	time.			Indicate how the facility plans to n its performance to make sure that solutions are sustained:			
		AM, Resident#72 was lying was odorous, and NA #1		10% of residents with bowel incor			
	was standing in the re	oom in front of Resident d. Nurse Aide (NA) #1 stated		MDS section H will be interviewed DON/UC/UM or designee for time	•		
	she was preparing to Resident #72.	provide incontinence care to		bowel incontinence care. The into will be conducted 3x week x4 wee monthly x 2 months. Interview an findings will be reported to Quarte	erviews eks, then d audit		
	Resident #72, he rep	PM, during an interview with orted he had been changed orted to him, she had		Quality Assurance and Improvement committee x1. The QAPI Committee valuate the effectiveness of the a	ent ee will		
	assisted another resi			plan, and will add additional intervious based on identified trends/outcom	entions		
		two and a half hours after he		ensure continued compliance.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345405	B. WING			C 12/20/2018	
	ROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD HARLOTTE, NC 28214	<u> 121</u>	20/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT FAG CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)			(X5) COMPLETION DATE
F 550	had made the reques NA#1 was not the starequest to and turned during the interview, feeing "pitiful and hel the nursing staff to perfect the nursing staff to perfect the nursing staff to	at. Resident #72 stated aff member he made the a off the call light. Also, a Resident #72 described a pless" while he waited for a form incontinent care. The expected to have his a he nursing staff he informed a for care for two and a half a for Resident #72's room a fock was on the wall facing The properties of the provide with a completed her morning and of her assigned shift an observation of assigned and observation of assigned and observation of assigned and on 12/17/18 she was a forker Resident #72 had used a fested incontinent care. The effort another resident a son assistance. NA#1 antered Resident #72's room, a to the roommate to allow and an activity. NA#1 stated a continent care for Resident a fested in the roommate to allow and an activity. NA#1 stated a forthinent care for Resident a fested in the roommate to allow and an activity was at the time of his care. The during an interview with a fested was to provide	F	550	Include dates when corrective action was be completed. The Director of Nursing is responsible ensuring the plan of correction is completed by January 17, 2019.		

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING				C 20/2018
	ROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD CHARLOTTE, NC 28214	<u> 12</u> /	20/2010
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page when involved in proving resident.	e 4 viding care for another	F	550			
	The DON stated residence prolonged periods of The DON stated residence within a reasonal	irector of Nursing (DON). Idents should not have to wait time for incontinent care. Idents should be provided ble amount of time, If minutes. The DON stated fff would be to treat					
F 582 SS=B	CFR(s): 483.10(g)(17) §483.10(g)(17) The fa (i) Inform each Medical writing, at the time of facility and when the information Medicaid of- (A) The items and sernursing facility services for which the resident (B) Those other items facility offers and for incharged, and the amoservices; and (ii) Inform each Medical changes are made to specified in §483.10(g) section.	acility must aid-eligible resident, in admission to the nursing resident becomes eligible for rvices that are included in es under the State plan and	F	582			1/17/19
	available in the facility	e resident's stay, of services / and of charges for those ly charges for services not					

`` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			C 2/20/2018	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		2/20/2016	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 582	facility's per diem (i) Where changes and services cove Medicaid State pla notice to residents reasonably possib (ii) Where change items and service facility must inform 60 days prior to in (iii) If a resident di transferred and de facility must refun representative, or deposit or charge per diem rate, for resided or reserve facility, regardless discharge notice r (iv) The facility mu resident represen the resident withir date of discharge (v) The terms of a behalf of an indivi facility must not ce these regulations. This REQUIREME by: Based on record facility failed to pr and Medicaid Ser Non-Coverage an Advanced Benefic from Medicare Pa residents reviewe	edicare/ Medicaid or by the rate. s in coverage are made to items and the facility must provide and the change as soon as is ble. s are made to charges for other as that the facility offers, the in the resident in writing at least applementation of the change. ses or is hospitalized or is been not return to the facility, the dot the resident, resident estate, as applicable, any as already paid, less the facility's the days the resident actually and or retained a bed in the confany minimum stay or equirements. Just refund to the resident or tative any and all refunds due and 30 days from the resident's from the facility. In admission contract by or on dual seeking admission to the conflict with the requirements of	F 5	Address how corrective act accomplished for those resi have been affected by the correctice: Resident #138 expired on 6 Resident #139 discharged on 6 Address how the facility will residents having the potential affected by the same deficients affected by the same deficients	idents found to deficient 6/30/2018 and on 10/31/2018 I identify other ial to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(XS	(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			C 12/20/2018	
NAME OF PI	ROVIDER OR SUPPLIER	1	1	STREET ADDRESS, CITY, STATE, Z	IP CODE	12/20/2010	
				1735 TODDVILLE ROAD			
CHARLOI	TE HEALTH & REHABIL	LITATION CENTER		CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE	
F 582	Continued From page	e 6	F 5	582			
	Findings included:	s admitted to the facility on		The Business Office Ma Designee will audit all d the past 30 days starting the issuance of a NOMN	ischarges within g 1/10/2019, for NC and SNF ABN.		
	5/18/2018.	·		Address what measures place or systemic change ensure that the deficient recur:	ges made to t practice will not		
	letter (NOMNC) and (Skilled Nursing Faci Notice) were not issu Resident #138's Res	f Medicare Non-Coverage a CMS-10055 SNF ABN lity Advanced Beneficiary led to Resident #138 and/ or ponsible Party (RP) which Part A coverage for skilled		Education was provided Office Manager on Busi Policies & Procedures Fresidents who are disch Medicare Part A service CMS Notice of Medicare (NOMNC) and Skilled Nadvanced Beneficiary Nours before discharge, Office Manager or design	ness Office Policy #715. All larged from es will receive a e Non-Coverage lursing Facility Notice (ABN) 48 by the Business		
	Manager (RBOM) wa at 9:26 AM. The RBO policy was to issue th together. The RBON resident and/ or famil covered day for servi explained and offered Manager (BOM). The	Regional Business Office as completed on 12/18/2018 OM stated the company he NOMNC and SNF-ABN of stated she expected the ly to be notified of the last ces, and appeal rights to be do by the Business Office he RBOM further stated she ropriate notices to be issued on the last ces and appeal rights to be do by the Business Office he RBOM further stated she ropriate notices to be issued on the last ces and appeal rights to be do by the Business Office he RBOM further stated she ropriate notices to be issued on the last complete the last ces and th		Monday-Friday during of the issue date of NOMN be discussed and verification hours before discharged Indicate how the facility its performance to make solutions are sustained: An audit of all discharged conducted weekly x 4 w x2 months, to verify a N are issued timely before of services. Audits will the Administrator or des reviewed with the Quart	NCs and ABNs will ed to be issued 48 d. plans to monitor e sure that es will be veeks and monthly IOMNC and ABN e a discontinuation be conducted by signee and		
	Administrator on 12/2 Administrator stated the BOM or designed	19/2018 at 10:35 AM. The the expectation would be for e to issue the appropriate puired time frame to the		Assurance and Improve 1. The QAPI Committee effectiveness of the abo add additional interventi identified trends/outcom continued compliance.	ement Committee of e will evaluate the ove plan, and will ions based on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING _				C 20/2018
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20,2010
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			35 TODDVILLE ROAD HARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 582	82 Continued From page 7		F 5	82			
	2. Resident #139 was 9/3/2018.	s admitted to the facility on			Completion date January 17, 2019		
	letter (NOMNC) and a (Skilled Nursing Facil Notice) were not issu Resident #139's Resp	f Medicare Non-Coverage a CMS-10055 SNF ABN ity Advanced Beneficiary ed to Resident #139 and/ or consible Party (RP) which Part A coverage for skilled					
	Manager (RBOM) wa at 9:26 AM. The RBO policy was to issue th together. The RBOM resident and/ or famil covered day for servic explained and offered Manager (BOM). The expected for the appr by the BOM.	Regional Business Office is completed on 12/18/2018 DM stated the company is NOMNC and SNF-ABN is stated she expected the yto be notified of the last ces, and appeal rights to be it by the Business Office is RBOM further stated she copriate notices to be issued					
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)	ents	F 6	41			1/17/19
	resident's status. This REQUIREMENT by: Based on staff interv review, the facility fail annual Minimum Data	is not met as evidenced iews and medical record led to accurately code the a Set (MDS) to indicate the ning and Annual Resident			Address how corrective action will be accomplished for those residents found have been affected by the deficient practice: The facility failed to accurately code the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345405	B. WING		C 12/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/20/2010
CHARLOT	TE HEALTH & REHAB	ILITATION CENTER		1735 TODDVILLE ROAD CHARLOTTE, NC 28214	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 641	Continued From page 8			1	
	sampled residents r	eviewed (Resident #14).		Annual Minimum Data Set (MDS) to indicate the Preadmission Screenin Annual Resident Review (PASRR) I	g and ∟evel II
	The findings include			status 1 of 3 sampled residents revi (Resident #14). Resident #14 □s Ar MDS 9/29/18 was modified on 1/14/	nnual 19 to
	5/06/17. Diagnoses	e-admitted to the facility included schizoaffective malformations of corpus		code Question A1500 correctly to in that resident was considered by the Level II PASRR process to have a s	State
	callosum and development disorder of scholastic skills (intellectual disability).			mental and/or intellectual disability of related condition. Address how the facility will identify residents having the potential to be	
	Notification dated 6/	Level Determination 29/17, revealed Resident #14		affected by the same deficient pract All current residents□ most recent	
	PASRR process to h	dered by the State Level II nave a serious mental and/or or a related condition.		comprehensive MDS considered by state level II PASRR process to hav serious mental illness and/or intelled disability ("mental retardation" in fed	e ctual
		al MDS dated 9/29/18, section e MDS coded that Resident		regulation) or a related condition will reviewed for correct coding according the documentation from the residen	ng to
	#14 was not current Level II PASARR pr	ly considered by the State ocess to have a serious ectual disability or a related		medical records by Compliance Dat 1/17/19. Any issues identified as be coded incorrectly, will be modified b	e of ing
	condition.	ectual disability of a related		MDSC/Discharge Planner. Address what measures will be put place or systemic changes made to	into
	During an interview on 12/20/18 at 1:45 PM the discharge planner (DCP) stated that she was responsible for the completion of section A of the			ensure that the deficient practice wi recur: Education was provided to the MDS	II not
	MDS and that she c the annual MDS, for	ompleted section A 1500 on Resident #14. The DCP		DC Planner on 1/14/19 by the MDS Regional Consultant on the RAI	С
	coded the MDS to re	nistake when she incorrectly eflect that Resident #14 was ered by the State Level II		requirements for coding Question A Is the resident currently considered state level II PASRR process to hav	by the
	PASRR process to hintellectual disability	nave a serious mental and/or or a related condition. She e coded that he has a PASRR		serious mental illness and/or intelled disability ("mental retardation" in fed regulation) or a related condition? A	ctual Ieral

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345405	B. WING				C 20/2018
	ROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD HARLOTTE, NC 28214	12/	20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 641	with the director of nu stated that the DCP v completing section A expected the MDS to The DON confirmed t	d on 12/20/18 at 1:47 PM ursing (DON). The DON	F	641	MDSC employees will be educated dur orientation on proper coding of the Leve PASRR in Section A. Indicate how the facility plans to monitority performance to make sure that solutions are sustained: The MDS Consultant or designee will audit 5 residents MDS to ensure Question A1500 Is the resident current considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related conditions are correctly coded in Section A once weekly for 4 weeks, twice a month for one month, and monthly x month. The findings will be reviewed at the Quarterly Quality Assurance and Improvement meeting X1 for further problem resolution. Date of Completion: January 17, 2019	el II or ly ce 1	
F 645 SS=D	with intellectual disable §483.20(k)(1) A nursi or after January 1, 19 (i) Mental disorder as (i) of this section, unleauthority has determindependent physical performed by a person State mental health a (A) That, because of	sion Screening for ntal disorder and individuals ility. In a facility must not admit, on 189, any new residents with: defined in paragraph (k)(3) less the State mental health	F	645			1/17/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		12/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 645	the level of services and (B) If the individual r services, whether th specialized services (ii) Intellectual disab (k)(3)(ii) of this section intellectual disability authority has determ (A) That, because of condition of the individual r services, whether th specialized services §483.20(k)(2) Exception (i) The preadmission paragraph(k)(1) of the for determinations in to a nursing facility of being admitted to the transferred for care (ii) The State may of preadmission screen paragraph (k)(1) of the total and the complete of the compl	provided by a nursing facility; equires such level of e individual requires ; or ility, as defined in paragraph on, unless the State or developmental disability nined prior to admission- f the physical and mental vidual, the individual requires provided by a nursing facility; equires such level of e individual requires for intellectual disability. btions. For purposes of this screening program under his section need not provide in the case of the readmission of an individual who, after e nursing facility, was in a hospital. hoose not to apply the hing program under his section to the admission	F	545			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345405	B. WING _			C 12/20/2018	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	ODE	12/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 645	section-	e 11 ion. For purposes of this nsidered to have a mental	F 6	345			
	disorder if the individ disorder defined in 4 (ii) An individual is contellectual disability intellectual disability or is a person with a described in 435.101 This REQUIREMENT by:	ual has a serious mental 83.102(b)(1). onsidered to have an if the individual has an as defined in §483.102(b)(3) related condition as 0 of this chapter. I is not met as evidenced					
	review, the facility faidiagnosis of severe repsychotic symptoms schizophrenia for a Fannual Resident Rev	views and medical record led to refer a resident with a manic episodes with and a new diagnosis of Pre-Admission Screening and view (PASRR) Level II screen sidents reviewed (Resident		Address how corrective ac accomplished for those res have been affected by the practice: Resident #16 received a ned diagnosis of schizophrenia facility and a new Preadmis and Resident Review (PAS was not requested. A new requested and a Level II was	sidents found to deficient ew psychiatric while in the ssion Screening SARR) Screen PASARR was		
	with a PASRR Level admission included a	Imitted to the facility 5/23/18 I screen. Diagnoses on anxiety disorder, severe psychotic symptoms and		January 4, 2019. Address how the facility will residents having the potent affected by the same deficit An audit of all residents was and residents that had recepsychiatric diagnosis of solutions of solutions.	Il identify other tial to be ient practice: as conducted eived a new hizophrenia cred for a		
	5/25/18, revealed the behavioral symptoms paranoia, anxiety, ha	#16's care plan, dated e Resident exhibited adverse s to include psychosis with illucinations and behaviors uest for medical transport,		PASARR screening by the Planner. Any residents the new psychiatric diagnosis with discussed during morning the IDT. Address what measures with place or systemic changes	at receive a will be meeting with ill be put into		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CON	STRUCTION	(X3) DATE SURVEY COMPLETED	
		345405	B. WING _				C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			ODDVILLE ROAD		
				CHAR	RLOTTE, NC 28214		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 645	Continued From page non-compliant with many line included antipsychotic/antidep psychiatric referrals. Review of the admiss (MDS) dated 5/30/18 Resident #16 had no State Level 2 PASRE have a serious mental or a related condition daily use of antipsychmedications. An initial Psychiatric indicated Resident #10 psychosis related to inagitation, and behavior requesting to leave faction to line increased depression hallucinations. The errecommendation to incurrent antipsychotical and a new diagnosis. A follow up Psychiatric medication check was noted that nursing state continued to have has agitation and behavior and behavior and behavior and behavior and state of the page 12 psychotic and a new diagnosis.	de 12 dedications/nursing). de ressant medication and desion Minimum Data Set Section A 1500 indicted to been evaluated by the de process and determined to all and/or intellectual disability . The MDS also indicated notic and antidepressant Evaluation dated 6/2/18, 16 was being evaluated for ncreased paranoia, ors (yelling/resisting care, decility as soon as possible). The MDS also indicated notic and antidepressant evaluation dated 6/2/18, the was being evaluated for ncreased paranoia, ors (yelling/resisting care, decility as soon as possible). The MDS also indicated notic and antidepressant defined the reported the paranoia and auditory valuation included a ncrease the dosage of dentidepressant medications of schizophrenia. The MDS also indicated for a second the reported the reported the reported and the reported Resident #16 Illucinations, paranoia,		rector (M)		ot ner or a on nner ARR or ee / tted	DATE
		ted with paranoia symptoms		tre	ends/outcomes to ensure continued ompliance. ompletion date January 17, 2019		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345405	B. WING _		C 12/20/2018
	ROVIDER OR SUPPLIER TE HEALTH & REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	12/20/2010
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 645	discharge planner (D responsible for the common MDS and that she conthe admission MDS for stated she did not reference with a Level II screened id not review diagnous section A and she has for a Level II screened reviewed the PASRR resident on admission	on 12/20/18 at 1:44 PM the CP) stated that she was ompletion of section A of the impleted section A 1500 on or Resident #16. The DCP for Resident #16 for a in because he was admitted. She further stated that she is sees when she completed dinever referred a resident perfore. The DCP stated she is Level that was in place for a in, and stated, "They either is level II, I am not sure who	F 6	45	
F 677 SS=D	with the director of nustated that the DCP we PASRR Level II references to the resident #16 had not Level II screen, but sidiagnoses and currence pisodes with psychoschizophrenia. ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resident activities of daily is services to maintain of personal and oral hydrights. BEQUIREMENT by: Based on observations.	or Dependent Residents lent who is unable to carry living receives the necessary good nutrition, grooming, and	F6	F677 Address how corrective action wi	1/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345405	B. WING _			l	C / 20/2018
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From pag	e 14	F	677			
	providing incontinent	t care for a resident after hours, for 1 of 3 dependent #72) reviewed for activities of			accomplished for those residents found have been affected by the deficient practice: Bowel Incontinence care was provided resident #72 on 12/17/2018. Address how the facility will identify other residents having the potential to be	for ner	
		dmitted on 2/1/2018. cal diagnoses were inclusive er disorder and arthritis.			affected by the same deficient practice All residents with bowel incontinence a identified as being at risk. At risk incontinent residents are identified by MDS section H. All residents with a BI of 12-15, bowel incontinence, and identified at risk will be interviewed	re	
	dated 11/30/18 rever cognitively intact. Re extensive assistance bed mobility, and tot one-person assistan had an external (con always incontinent o rejection of care rega was noted during the	e, one-person assistance with			regarding incontinent timeliness. Resulting incontinent timeliness. Resulting further problem resolution if needed Address what measures will be put into place or systemic changes made to ensure that the deficient practice will need to ensure that the deficient practice	for ot and nt ill	
	self-care performance 12/7/18, the care plated required staff assistate maintain current level	elan with a focus area for ADL ce deficit, revised and dated in revealed Resident #72 ance and indicated a goal to be of function. Interventions toilet use and encourage the o call for assistance.			requests. Education will be provided be the DON, SDC, or designee. Nursing staff who have not received education or before 1/17/2019, will not be allowed work until education is received. All New nursing staff will be educated during orientation on the timeliness of bowel incontinence care and to not turn off a call light until the patient care nee	y on d to	
		AM, Resident #72 was in bed awake. Resident #72			has been met. Education will also be provided on resident rights including	-	

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345405	B. WING			C 12/20/2018	
	ROVIDER OR SUPPLIER	LITATION CENTER	·	STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214			-0.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	changed due to bowe #72's room was odor Resident #72 reporter notify staff of his nee nursing staff member light off, and informer someone to provide #72 was unable to id name or identify if the or nurse aide. On 12/17/18 at 9:56 observed lying in been member had returner incontinent care. The time. On 12/17/18 at 11:23 in the bed, the room was standing in the r #72's roommate's be preparing to provide Resident #72.	nursing staff of his need to be el incontinence. Resident rous. The call light was off. and he used the call light to d for incontinent care and a roame in, turned the call d him she would get incontinent care. Resident entify the staff member by a staff member was a nurse. AM, Resident #72 was d and he reported no staff d to assist him with a room was odorous at the staff of the community of	F	677	dignity with bowel incontinence care an timeliness of bowel incontinence care requests by Staff Development Nurse. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained 10% of residents with bowel incontinent and BIMs score 12-15 as identified on MDS section H will be interviewed by DON/UC/UM or designee for timeliness bowel incontinence care. The interview will be conducted 3x week x4 weeks, the monthly x 2 months. Interview and auditings will be reported to Quarterly Quality Assurance and Improvement committee x1. The QAPI Committee with evaluate the effectiveness of the above plan, and will add additional intervention based on identified trends/outcomes to ensure continued compliance. Include dates when corrective action where the completed. Completion date January 17, 2019.	ce s of vs nen lit	
	Resident #72, he rep by Nurse Aide (NA)# she had assisted and providing incontinent stated the care was of hours after he made stated NA#1 was not the request to and tu during the interview,	PM, during an interview with ported he had been changed 1 and she reported to him, other resident before care for him. Resident #72 completed two and a half the request. Resident #72 if the staff member he made rned off the call light. Also, Resident #72 described lpless" while he waited for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			C 12/20/2018
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		12/20/20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA	
F 677	Continued From pag	e 16 erform incontinent care.	F 6	577		
	Resident #72 stated needs met by the numerot have to wait for continuous metals.	he expected to have his rsing staff he informed and care for two and a half hours. ident #72's room revealed a				
	Nurse Aide (NA), NA completed her morni of her assigned shift 12/17/18. NA#1 state observation of assign on 12/1718 she was Resident #72 had us requested incontinent time of notification, sproviding care to anothered Resident #72 care to the roommate attend an activity. Na provided incontinent	ng rounds at the beginning (7:00 AM - 3:00PM) on ed her rounds included an ned residents. NA#1 reported informed by her coworker ed his call light and at care. NA#1 stated at the he was in the process of other resident who required ce. NA#1 reported when she 2's room, she first provided e to allow the roommate to A#1 stated next, she care for Resident #72. Ident #72 was incontinent of				
	Unit Manager #1, the expectation for nursing residents with inconting residents have notified.	ng staff was to provide inent care at the time ed nursing staff of their need g a task when involved in				
	On 12/20/18 at 4:32	PM during an interview with				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING		1:	C 2/20/2018	
	ROVIDER OR SUPPLIER TE HEALTH & REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 677	her expectation was sincontinent care at the residents or staff show member to aid with care expected incontinent thirty minutes of an ocare required for a refree of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensure \$483.25(d)(1) The resident facility must ensure sident facility must ensure sidents. This REQUIREMENT by: Based on observation resident (Resident #6 and review of facility maintain safe hot was 116 degrees Fahrenheit (degrees Fahrenheit (degrees Fahrenheit)	g (DON), the DON stated staff would provide et ime of the request by uld request another staff are. The DON stated she care to be provided within beservation or notification of sident. ards/Supervision/Devices (2) ure that - sident environment remains azards as is possible; and estance devices to prevent	F 68	77	found to nt peratures ees, the adjusted	1/17/19	
	5:00 PM revealed she	,		was run under the supervision of department managers until hot was temperatures decreased to 116 desor below. Water temperatures we monitored in patients□ rooms hou 24 hours, 3x day for 1 week and of thereafter. During these checks, the temperatures did not exceed 116 Address how the facility will identic	egrees ere urly for daily the degrees.		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING				C	
NAME OF DE	ROVIDER OR SUPPLIER	0.10.100		9	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	/20/2018	
NAME OF T	COVIDER OR SOLT EIER							
CHARLOT	TE HEALTH & REHA	BILITATION CENTER			735 TODDVILLE ROAD			
				C	CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 689	Continued From pa	age 18	F	689				
	maintenance direc	tor was currently not in the			residents having the potential to be			
		istrator stated the maintenance			affected by the same deficient practice	<u>;</u>		
	-	anager on duty (MoD) that day,			Monday-Friday the Maintenance Direct			
		n, but she was unable to reach			or designee will check water temperat			
		rator stated she was not aware			in locations accessible to patients,	2100		
		ncerns related to hot water and			including 2 random patient rooms on e	ach		
	•	ow what the safe water			of the two units. Saturday and Sunday			
		should be for resident use,			Manager on Duty or designee will also			
	she stated "I will ha				check water temperatures in locations			
					accessible to patients, including 2 pati			
					rooms on each of the two units.			
	The administrator	rounded with the surveyor on			Address what measures will be put int	0		
	12/16/18 from 5:22	2 - 5:48 PM to check water			place or systemic changes made to			
	temperatures at ha	and sinks in resident rooms on			ensure that the deficient practice will r	ot		
	the 200 hall and th	e mechanical room using a			recur:			
	facility thermometer	er that she verified for accuracy.			The Maintenance Director received			
	The administrator	obtained the following			education on Maintenance Policies an	d		
	temperatures:				Procedures Policy #203. The			
					Maintenance Director will document de	aily		
					temperature checks into the TELS			
	Room 215, shared	bathroom with room 216,			system. A temperature log was create			
	118.9 degrees F				for the Manager on Duty to complete t			
		bathroom with room 227,			addresses locations accessible to pati			
	118.2 degrees F				including 2 random patient rooms on e	ach		
		equipment room, gauge set to			of the two units. All Department			
	126 degrees F, pe				Managers responsible for fulfilling			
	•	- 118" degrees F, per			Manager on Duty duties were educate			
	administrator				on the completion of this temperature	•		
					and that in the event temperatures exc			
					116 degrees, the Maintenance Director	r		
		Resident #69 (identified as			and Administrator are to be notified			
	•	staff) occurred on 12/16/18 at			immediately.			
		aled a couple weeks ago			Indicate how the facility plans to monit	or		
		ed the hot water at the hand			its performance to make sure that			
		om was too hot so she added			solutions are sustained:			
		ent #69 denied being injured			The Administrator or designee will veri	-		
	due to water that v	vas too not.			water temperatures are logged and wi	เทเท		
					range of 100-116 degrees by auditing			
					temperature logs weekly x4 weeks and	J.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG		، ا	3
		345405	B. WING				20/2018
	ROVIDER OR SUPPLIER	BILITATION CENTER	•	17	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD	•	
					HARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFICE DEFICIENCY)			(X5) COMPLETION DATE
F 689	the maintenance d assumed his role in he monitored water Friday, first thing in rooms, therapy, lau checked hand sink each hall. He state responsible for monithe weekends and be MoD, but he haweekend, due to a advised the administ He clarified that in temperatures had in weekend. He further monitor water temps afe range of "101-maintenance direct the gauge for the high 125-133 degrees Frange for the mixin maintenance direct residents voiced the rooms was too cold	on 12/16/18 at 7:06 PM with rector he revealed he August 2018. He stated that remperatures Monday - the morning, in the shower undry, dietary and randomly in in resident bathrooms on that the MoD was nitoring water temperatures on added it was his weekend to do not been in the facility that family emergency, nor had he strator that he would not be in this absence as MoD, the water not been monitored that er stated he was trained to be reatures for resident use at a confurther stated that he kept not water tank set between and adjusted the temperature governed as needed. The cor then stated that last week at the water in the shower do, so he adjusted the mixing and increased the hot water	F	689	monthly x2. Audit findings will be reviewed monthly with the Quality Assessment and Assurance Committee x3 months. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventio based on identified trends/outcomes to ensure continued compliance. Completion date January 17, 2019	e ns	
	surveyor on 12/16/ check water temperesident rooms on mechanical room uthat he verified for could explain the dreadings obtained the maintenance d	director rounded with the 18 from 7:20 PM - 7:44 PM to ratures at hand sinks in the 200 hall and the sing a facility thermometer accuracy. When asked if he ifference in temperature approximately 2 hours earlier, irector stated "I have noticed eks when I come in and check					

AND DLAN OF CORRECTION IDENTIFICATION NUMBER			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 12/20/2018
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	I	12/20/2010
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F 689	the gauge at the hot higher/lower than the valve the same, so I adjustments." He als requested any repair equipment recently of administrator. The mithe following temperature for the following for the following for the past 10 preventative mainteners for the following temperature for the following for the	water tank it is either e day before and the mixing have just been making o clarified that he had not s to heating/cooling or reported this to the aintenance director obtained atures: athroom with room 216, athroom with room 227, uipment room, gauge set to naintenance director legrees Fahrenheit, per or d on 12/17/18 at 11:20 AM ing supervisor. He stated that ractor that had serviced the o years providing	F 68			
	A follow up telephone	e interview on 12/17/18 at				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345405	B. WING			12/	20/2018
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
CHADI OT	TE HEALTH & REHABIL	ITATION CENTER		1735	TODDVILLE ROAD		
CHARLOI	TE HEALTH & REHABIL	HATION CENTER		CHA	ARLOTTE, NC 28214		
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F 689	revealed he replaced gauge for the hot wat of calibration and ord would complete once further stated that he that the needed repai increased water tempresident bathrooms, to the complete once with the needed repai increased water tempresident bathrooms, to the complete of the complete of the interview with the needed repai increased water tempresident bathrooms, to the complete of the needed repair of the interview with the needed repair of the facility in Septemble of the interview. The additional participation of the interview of the lot of concerns regard logs." The administration maintenance director not sure how much the needed repair of the needed repair increase.	ting/cooling supervisor the temperature control er tank because it was out ered parts for repairs he the parts came in. He could not say definitively rs contributed to the peratures at hand sinks in out that it was possible. administrator occurred on I. During the interview, the hat she assumed her role at per 2018. She provided dity temperature logs during ministrator stated that she logs and replied "I have a ding these temperature tor stated the current assumed his role in August the with the previous before he left, but she was aining he received. The	F	689	BEHOLINOTY		
	2018, she verified that monitored and docume but she did not review what the water temper stated "This is educated aware of any temperatures." The affective was not aware the supervisor serviced the equipment in October recommendations for get hundreds of faxes	dministrator also stated that at when the heating/cooling ne heating/cooling					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345405	B. WING			1	C
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		TODDVILLE ROAD	<u> 12/</u>	/20/2018
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 689	looking for it." The act that the maintenance he made temperature valve, but that he did adjustments were matemperatures exceeds he ask. She also stainjuries to residents at temperatures exceeds remperatures exceeds ask. She also stainjuries to residents at temperatures exceeds remperatures exceeds remperatures exceeds. Review of water temperatures exceeds remperatures exceeds remper	dministrator further stated e director did inform her that e adjustments at the mixing I not tell her temperature ade because water ded 116 degrees F, nor did ated that there had been no as a result of water ding 116 degrees F. perature logs and s for September 2018 - 12/17/18 at 12:16 PM, g: documentation of monitoring d September 22 - 30. Inperatures recorded as: 00 hall shower head B, 121 00 hall shower sink, 128 00 hall Resident room (no	F	689			

		A. BUILDING	G		(X3) DATE SURVEY COMPLETED	
	345405	B. WING			C 2/20/2018	
ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		2/20/2010	
TE HEALTH & REHABIL	LITATION CENTER		CHARLOTTE, NC 28214			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE	
- 9/17/18, 20 room documented), 1 - 9/18/18, 10 room number docum - 9/18/18, 10 degrees F - 9/18/18, 10 degrees F - 9/18/18, 20 degrees - 9/18/18, 20 room number docum - 9/19/18, 10 degrees F - 9/19/18, 10	200 hall Resident room (no 125 degrees F 200 hall, Resident room (no ented), 123 degrees F 200 hall shower head B, 120 200 hall shower head C, 125 200 hall shower sink 124 200 hall shower room tub 124 200 hall, Resident room (no ented) 122 degrees F 200 hall shower head A, 117 200 hall shower head B, 120 200 hall shower head C, 126 200	F 68	39			
- 9/19/18, 10 room documented), 7 - 9/19/18, 20 degrees F - 9/19/18, 20 room documented), 7	125 degrees F 100 hall shower head A, 129 100 hall shower head B, 126 100 hall shower head C, 126 100 hall shower sink, 126 100 hall shower room tub, 125 100 hall Resident room (no 118 degrees F					
	SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page	Continued From page 23 - 9/17/18, 200 hall Resident room (no room documented), 125 degrees F - 9/18/18, 100 hall shower room tub 124 degrees F - 9/18/18, 200 hall, Resident room (no room number documented) hall shower head A, 117 degrees F - 9/18/18, 100 hall shower head B, 120 degrees F - 9/18/18, 100 hall shower room tub 124 degrees F - 9/18/18, 100 hall shower room tub 124 degrees F - 9/18/18, 100 hall shower room tub 124 degrees F - 9/18/18, 200 hall, Resident room (no room number documented) 122 degrees F - 9/19/18, 100 hall shower head A, 117 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head C, 126 degrees F - 9/19/18, 100 hall shower head A, 129 degrees F - 9/19/18, 100 hall shower head A, 129 degrees F - 9/19/18, 200 hall shower head A, 129 degrees F - 9/19/18, 200 hall shower head B, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower sink, 126 degrees F - 9/19/18, 200 hall shower sink, 126 degrees F - 9/19/18, 200 hall shower room tub, 125	ROVIDER OR SUPPLIER TE HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 - 9/17/18, 200 hall Resident room (no room documented), 125 degrees F - 9/18/18, 100 hall, Resident room (no room number documented), 123 degrees F - 9/18/18, 100 hall shower head B, 120 degrees F - 9/18/18, 100 hall shower sink 124 degrees F - 9/18/18, 200 hall shower room tub 124 degrees F - 9/18/18, 200 hall shower head A, 117 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head C, 126 degrees F - 9/19/18, 100 hall shower head C, 126 degrees F - 9/19/18, 100 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head A, 129 degrees F - 9/19/18, 200 hall shower head B, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower sink, 126 degrees F - 9/19/18, 200 hall shower sink, 126 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F	TE HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 - 9/17/18, 200 hall Resident room (no room documented), 125 degrees F - 9/18/18, 100 hall shower head B, 120 degrees F - 9/18/18, 100 hall shower room tub 124 degrees F - 9/18/18, 200 hall shower room tub 124 degrees F - 9/18/18, 100 hall shower head B, 120 degrees F - 9/18/18, 100 hall shower room tub 124 degrees F - 9/18/18, 100 hall shower head A, 117 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head C, 126 degrees F - 9/19/18, 100 hall shower head C, 126 degrees F - 9/19/18, 100 hall shower head A, 129 degrees F - 9/19/18, 200 hall shower head A, 129 degrees F - 9/19/18, 200 hall shower head B, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F	TE HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 - 9/17/18, 200 hall Resident room (no room documented), 125 degrees F - 9/18/18, 100 hall shower lead B, 120 degrees F - 9/18/18, 200 hall shower room tub 124 degrees F - 9/18/18, 200 hall shower room tub 124 degrees F - 9/19/18, 200 hall shower head A, 117 degrees F - 9/19/18, 100 hall shower sink, 124 degrees F - 9/19/18, 100 hall shower sink, 124 degrees F - 9/19/18, 100 hall shower head A, 117 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head A, 117 degrees F - 9/19/18, 100 hall shower head A, 117 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head A, 129 degrees F - 9/19/18, 100 hall shower head A, 129 degrees F - 9/19/18, 200 hall shower head B, 126 degrees F - 9/19/18, 200 hall shower head B, 126 degrees F - 9/19/18, 200 hall shower head B, 126 degrees F - 9/19/18, 200 hall shower head B, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower head B, 126 degrees F - 9/19/18, 200 hall shower nom tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING				20/2018
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD CHARLOTTE, NC 28214	<u> 12/</u>	20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page monitoring October 1 December 2018, nor for December 1 - 2 and Review of the incident residents received in temperatures which of Fahrenheit. A follow up interview director on 12/17/18 assumed his role in Amonitoring water temperature her could not endocumentation of monitoring water temperature her monitored that he may have gowhen he recorded the have missed checking dates. He stated that by the previous main him check water temperature him what he was a was adequately train maintenance director returned demonstratitemperatures and her for resident use should be a solution of the continuation of	e 24 - 14 and October 22 - 26. documentation of monitoring nd December 15. nt/accident logs revealed no jury as a result of water exceeded 116 degrees with the maintenance at 12:25 PM revealed he august 2018 and he started aperatures immediately. He explain why he was missing onitoring for some dates, and temperatures routinely, but atten some dates mixed up the temperatures and may g temperatures on a few the was trained "really quick" tenance director by watching peratures. He further stated intenance director explained doing and stated, "I thought I		689			
	resident use exceeded watched the previous the mixing valve and never told him to repanyone. He further swater temperatures fexceeded 116 degreadjustments and more	ed 116 degrees F he is maintenance director adjust monitor temperatures, but ort the adjustments to tated that when he identified or resident use that					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		345405	B. WING _				C 20/2018
	ROVIDER OR SUPPLIER	ITATION CENTER		173	REET ADDRESS, CITY, STATE, ZIP CODE 85 TODDVILLE ROAD HARLOTTE, NC 28214		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	the water temperature maintenance director recommendations for heating/cooling super administrator.	ny resident complaints that es were too hot. The stated he was aware of the	F 6				1/17/19
SS=D	CFR(s): 483.45(f)(1) §483.45(f) Medication The facility must ensu §483.45(f)(1) Medicat percent or greater; This REQUIREMENT by: Based on record revi interviews, the facility medications with a 59 rate as evidenced by	n Errors. ure that its- tion error rates are not 5 is not met as evidenced tiew, observations and staff			Address how corrective action will be accomplished for those residents found have been affected by the deficient practice: Resident #186 had a G-tube and was a		
	error rate of 8% wher administered via gast the physician order w medications by mouth The findings included	crostomy tube (G-tube) and ras to administer n. (Resident #186)			able to take PO intake. Resident #186 order was changed to give his medications by mouth. Nurse #1 review the report sheet that stated Gt/PO as the was a new order for resident to start receiving meds via PO route instead of G-tube. Nurse #1 was educated after administered the medications via G-tub. She was educated to make sure to follow	nis she pe.	
	12/5/18 with medical gastro-esophageal re obstructive pulmonary				doctor orders that were on the EMAR/TAR. Resident #186 complained nausea when taking meds PO. Order obtained from Nurse Practitioner obtain to give meds via G-tube when resident was nauseated.	ned	
	A review of the physic revealed an order for	cian medication orders Loratadine Tablet 10			Address how the facility will identify oth residents having the potential to be	er	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345405	B. WING		1	C 2/20/2018	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	•	2/20/2010	
NAME OF T	TO VIDEIT OIT OOI 1 EIEIT			1735 TODDVILLE ROAD	<i>,</i> ∟		
CHARLOT	TE HEALTH & REHA	BILITATION CENTER					
				CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 759	Continued From p	age 26	F 7	59			
	Potassium Chloric milliequivalents tw day. The physician for medications to together at one tin A medication adm	th one time a day and le Extended Release 20 to tablets by mouth two times a n orders also included an order be crushed and administered ne for oral only. inistration was observed on M with Nurse #1. Nurse #1		affected by the same deficient All current residents with G-tu will be audited for medication administration route. Report supdated for residents with G-appropriate medication admir routes. Address what measures will be place or systemic changes measure that the deficient praces.	sheets will be tube for nistration be put into ade to		
	prepared the med crushed each table Medications were cups. Nurse #1 en and informed him medication via G-tube due to in the tube. Nurse would attempt to svia his G-tube. Nuthe crushed medication to flow Nurse #1 used a comedication to go trushed contacted Unit Maren were contacted unit medications.	ications for Resident #186 and let and opened the capsule. placed in individual medication latered Resident #186's room she was going to give him his labe. Resident #186 informed langer received his medication the medication getting clogged with a #1 informed Resident #186 she lauccessfully give the medication larse #1 added normal saline to cation and contents from the let medication administration, and allow the saline with the laterough the tube via gravity. Heclogger to allow the hrough the G-tube. Nurse #1 inager #1 and informed her of minister Resident #186's		ensure that the deficient practice. All Licensed Nurses will be enfive rights of medication admit including right dose, right per route, right medication and right Education will be completed by SDC or designee on or before 2019. Licensed Nurses who received education on or before 17, 2019 will not be allowed the education is received. 100 per licensed charge nurses will be completing med pass by SDC/DON/Designee All new licensed Nurses will be during orientation on five right medication administration incompletion administration incompletion and right time by Development nurse. Indicate how the facility plans its performance to make sure	ducated on inistration son, right ght time. by the DON, e January 17, have not pre January o work until ercent e observed be educated ts of sluding right staff at to monitor		
	the Director of Nui #1 and informed h to receive his med #1 also attempted medication via G-t	:03 AM, Unit Manger #1 and rsing (DON) approached Nurse er Resident #186 was ordered lication by mouth. Unit Manager to give Resident#186 his tube. The DON attempted to 6 his medication via G-tube		solutions are sustained: Two licensed nurses will be a G-tube medication administra by SDC/DON/Designee x 4 w monthly x 2 months. No licer will be audited more than one licensed nurses have been a	nudited on ation weekly veeks then nsed nurse se until all		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345405	B. WING		4.	C 2/20/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	•		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 759	DON used a declog gravity to allow for managed medications until all medications G-tube. On 12/20/18 at 10:1 had used the daily medication administration, she medication administration administration administration administration medications were to Nurse #1 stated the changed on 12/16/1 On 12/20/18 at 2:29 the Nurse Practition Resident #186 had medications via G-tube were changed to by nursing reported the medication administration administration on 12/16/10 on 12/20/18 at 2:43 expected nurses to medication administration administration administration administration administration by the compan DON stated the five	#1 was not successful. The ger and was able to use nedication administration. medication administration of and contents from capsule were administered via 7 AM, Nurse #1 reported she nurse sheet which identified ived his medication via eported after the medication checked the electronic ration record that indicated be administered by mouth. medication order route 8. PM, during an interview with er (NP), the NP reported difficulty receiving ube and medication orders mouth. The NP stated e G-tube had clogged during ration. The NP voiced no his were administered via deers to give medications via atted following the medication	F 75	Results of the observations a be reported to Quarterly Qual Assurance and Improvement x1. The QAPI Committee wil the effectiveness of the above will add additional intervention identified trends/outcomes to continued compliance. Completion date January 17,	lity committee I evaluate e plan, and ns based on ensure		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			C 12/20/2018	
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		12/20/2010	
(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 ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 759 F 761 SS=E	to follow the doctor's Label/Store Drugs and CFR(s): 483.45(g)(h) §483.45(g) Labeling or Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of S483.45(h)(1) In according to the fact biologicals in locked of the same	stated she expected nurses orders. Id Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be ewith currently accepted is, and include the yand cautionary expiration date when in the dility must store all drugs and compartments under proper and permit only authorized	F 7	59		1/17/19	
	locked, permanently storage of controlled the Comprehensive I Control Act of 1976 a abuse, except when package drug distribut quantity stored is mirribe readily detected. This REQUIREMENT by: Based on manufacturobservations and starfailed to store medical in 3 of 4 medication (200A), failed to date	ff interviews, the facility ation in the original container earts (100A, 100B, and		Address how corrective actic accomplished for those resid have been affected by the depractice: 3 out of 4 medication carts fa medications in original contai	ents found to eficient		

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE A. BUILDING O		PLETED				
		345405	B. WING _				C / 20/2018
	ROVIDER OR SUPPLIER	LITATION CENTER		1735 T	T ADDRESS, CITY, STATE, ZIP CODE ODDVILLE ROAD LOTTE, NC 28214	<u>,</u>	720/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Continued From pag	je 29	 F7	61			
	solution in 1 of 4 me to discard an expired	card expired inhalation dication carts (100B), failed d insulin pen in 1 of 4 0B), and failed to label an lication carts (100B).		cai inh dis of an	manufacturer □s guidelines. 1 out of the failed to date foil package for nalation solution, 1 out 4 failed to scard expired inhalation solution, 1 of 4 failed to discard expired insulin per d 1 out of 4 failed to label inhaler. A dedications found to be out of compliant.	out en All	
	Findings included:			we Ad	ere discarded immediately. Idress how the facility will identify of sidents having the potential to be		
		facturer's guideline for and Albuterol Sulfate ead in part:		All 12 dis	ected by the same deficient practice medication carts were audited on /16/2018 and medications were scarded that were not in original ckaging and not labeled. All	e:	
		Once removed from the foil I vials should be used within if the solution is not		me dis Ad pla en:	edications that were expired were a scarded. Idress what measures will be put inface or systemic changes made to sure that the deficient practice will r	:0	
	Medication Cart on which revealed six (Bromide and Albuter which were loose ar packaging. The six packaging were not unidentified loose pi	dated. Thirteen (13) lls, which ranged in size and erved in the bottom of the		All sto who be wo nu me lab nu do we	licensed nurses will be educated or prage of medications. Licensed nurses on have not received education on of fore 1/17/2019 will not be allowed took until education is received. Charses are responsible for ensuring not edications are expired and all are beled and dated appropriately. Charses will be responsible for cumenting their cart audit each shifteeks. Charge nurses will be responsible for	ses or	
	PM stated she has wone (1) year. Nurse were checked daily responsibility to che	urse #2 on 12/16/2018 at 1:11 worked at the facility for over #2 stated medication carts and it was every nurse's ck the medication carts on all dications and loose pills.		All on ori	reporting their negative findings to DN or Nurse Manager. new licensed nurses will be educat storage of medications during entation by Staff Development nurs dicate how the facility plans to monit performance to make sure that	ed e.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 12/20/2018	
	OVIDER OR SUPPLIER 'E HEALTH & REHABIL			STREET ADDRESS, CITY, STATE, ZIP COL 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		12/20/2016	
(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 E APPROPRIATE	(X5) COMPLETION DATE	
	medication cart that of would discard the six Bromide and Albutero not being dated and of packaging, and the the An interview with the on 12/16/2018 at 4:04 medications/ biologic when opened, and streakaging by the number of the medication Cart on 13 revealed an unlabeled (Hydrofluoroalkane) in the medication cart, eand Albuterol Sulfate date 10/19/2018), and (date opened 11/15/2 unidentified loose pillicolor, were also obserd drawers throughout the An interview was compared to the medication was at 1:25 P worked as needed for stated the medication Nurse #3 referred to the time frames of insuling Humalog kwikpen was opened. Nurse #3 di	cate if she had checked the day. Nurse #2 stated she (6) vials of Ipratropium of Sulfate Inhalation due to outside the original foil nirteen (13) loose pills. Director of Nursing (DON) 4 PM stated she expected all als to be labeled, dated ored in the original ses on the medication carts. as made of the 100B 2/16/2018 at 1:08 PM which d Ventolin HFA nhaler in the first drawer of expired Ipratropium Bromide Inhalation Solution (open expired Humalog kwikpen 2018), and eighteen (18) s, which ranged in size and erved in the bottom of the	F 76	solutions are sustained: Shift audits will be conducted charge nurse during each sh Medication carts will be audit member of the Nurse Manag 5X weekly x4 weeks, weekly then monthly x 10 months. Faudits will be reported to Qua Assurance and Improvement X1. The QAPI Committee will effectiveness of the above pladd additional interventions to continued compliance as need. Completion date January 17,	iff x2 weeks. ied by a ement team x4 weeks Results of arterly Quality committee I evaluate the an, and will based on ensure eded.		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		FIPLE CONSTRUCTION NG	· ,	(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			C 12/20/2018	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	ODE	12/20/2010	
(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 X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 761	Continued From pag Bromide and Albuter and the unlabeled in	ol Sulfate Inhalation Solution	F7	761			
	on 12/16/2018 at 4:0 medications/ biologic when opened, and s	e Director of Nursing (DON) 04 PM stated she expected all cals to be labeled, dated tored in the original rses on the medication carts.					
	Medication Cart on revealed five (5) union ranged in size and control of the cont	vas made of the 200A 12/16/2018 at 1:34 PM which dentified loose pills, which olor, were also observed in awers throughout the					
	12/16/2018 at 1:44 F worked at the facility #4 further stated me on nights (11-7 shift) Nurse #4 explained be easily managed v not full and there are when the rehabilitati medication cards we	ere hard to manage and pills se #4 stated she would					
	on 12/16/2018 at 4:0 medications/ biologic when opened, and s	e Director of Nursing (DON) 04 PM stated she expected all cals to be labeled, dated tored in the original rses on the medication carts.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345405	B. WING		C 12/20/2018
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	12/20/2010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 812 F 812 SS=D	CFR(s): 483.60(i)(1)(1)(1)(1)(1)(2)(4)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	tore/Prepare/Serve-Sanitary 2) ty requirements. re food from sources red satisfactory by federal, ies. food items obtained directly subject to applicable State ulations. es not prohibit or prevent froduce grown in facility compliance with applicable d-handling practices. es not preclude residents les not procured by the facility. prepare, distribute and ance with professional ervice safety. T is not met as evidenced and staff interviews, the te two cartons of milk, with ars' expiration dates, were not erved to 1 of 1 residents	F 81	2	t she her
	medical diagnoses in reflux disease with es	lmitted on 7/27/18 with clusive of gastroesophageal		both milk cartons had a use by date of 12/14/18. A CNA discarded the expire milk and brought the resident two new cartons of milk from the kitchen. The Dining Services Manager review proper food storage procedures with a dining services staff working on 12/20	ed v ed all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 12/20/2018	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	<u></u>	12/20/2010	
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F 812	A review of the Minin significant change da Resident #29's cogni impaired. The MDS i vision was adequate independently. During an interview of Resident #29 reported milks for breakfast or reported she request morning. Resident #2 cartons of milk and to breakfast. Resident she opened a carton box of cereal. Resident she opened a carton box of cereal. Resident sopened the second of milk smelled sour. Resident informed the nursing were expired and recept #29 stated the date of 12/14/18. On 12/17/18 at 11:04 she had no abdominate vomiting or diarrhead reported expired milk. On 12/17/18 at 11:20 had not been informed expired milk during the significant content in	num Data Set (MDS) noting a sted 10/24/18 revealed tion was moderately indicated Resident #29's. Resident #29 fed herself on 12/16/18 at 11:40 AM, and she received two expired in 12/16/18. Resident #29 fed the same breakfast each for the same breakfast each for the same breakfast each for fed in 12/16/18 for milk and poured it into a fent #29 reported on 12/16/18 for milk and poured it into a fent #29 stated she tasted a feal and the taste was of fed in 12/16/18 for milk and noticed the fed fed fed fed fed fed fed fed fed fe	F 8	Address how the facility will idresidents having the potential affected by the same deficient All remaining dining services in-serviced on proper food sto practices on 1/15/19. Address what measures will be place or systemic changes may ensure that the deficient practice. The Corporate Dietitian review above in-services with the Din Manager to ensure they meet requirements on 1/15/2019. The Corporate Dietitian will me proper food storage during helfacility visits X 4 and include the weekly visit report to Administre further problem resolution if note that the Dining Services Manager food storage in all refrigerators weeks, then monthly x 2 mont deficient practice does not recomplete to make sure solutions are sustained: Address how the facility plans its performance to make sure solutions are sustained: Audit findings will be reported Quality Assurance and Improve committee x1. The QAPI Come evaluate the effectiveness of the plan, and will add additional in based on identified trends/outensure continued compliance. Completion 1/17/19	to be practice: staff were rage e put into ade to ice will no wed the ing Service regulatory nonitor for weekly his on her ration for eeded. will audit is weekly in to monito that to Quarte rement mittee will he above terventior comes to	t ees /	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345405	B. WING_			C 1 2/20/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	•		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 812	stated nurse aides h	e 34 nd her needs. Nurse #2 ave the responsibility to request made regarding their	F 8	12			
	the Dietary Manager the morning of 12/16 informed of a resider The Dietary Manage received milk weekly placed under the mil refrigerator. The Diet expectation was the	and the new milk was k crates in the facility's tary Manager stated her kitchen staff checked the lk cartons in the crate before					
	12/16/18, Resident # received for breakfas NA #2 stated she rer from Resident #29's cartons of milk from stated she had not locartons and had not milk had been report #2 reported nurse aid checking the meal sl correct resident whe meal tray. NA #2 sta	O AM, NA #2 reported on #29 informed her the milk she st was spoiled and expired. moved two cartons of milk tray and requested two new the kitchen staff. NA #2 booked at the date on the milk informed kitchen staff the ed expired by a resident. NA des were responsible for ip for the correct diet and in serving the residents their ted she does not check bod and liquid items on meal					
	conducted with the D	PM an interview was Director of Nursing (DON). expected milk from the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345405	B. WING _			12/	20/2018
	ROVIDER OR SUPPLIER	ITATION CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD HARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	The DON stated she nursing staff checking and liquid items serve residents received tra DON stated she does	resident not to be expired. had no expectation for g expiration dates of food ed to the residents when ays from the kitchen. The s expect nursing staff to request regarding their	F	812			
F 835 SS=E	items and liquids servexpired. Administration CFR(s): 483.70 §483.70 Administration A facility must be admenables it to use its reefficiently to attain or practicable physical, well-being of each reserver.	dministrator. The her expectation was food wed to the residents have not on. ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. I is not met as evidenced	F 8	8335	Address how corrective action will be		1/17/19
	resident (Resident #6 review of medical rec manufacturer's guide administration failed t oversight to meet res hot water temperature Fahrenheit at hand si shared by 4 residents also failed to sustain Assessment Program	sey), a technician and staff, cords, facility records and lines, the facility's to provide management ident needs as evidenced by es in excess of 116 degrees inks in 2 resident bathrooms s. The facility's administration			accomplished for those residents found have been affected by the deficient practice: The facility will continue the plan of correction initiated for F689 and F761 " 3 out of 4 medication carts failed to store medications in original containers based on manufacturer □s guidelines. 1 out of 4 carts failed to date foil package for inhalation solution, 1 out 4 failed to discard expired inhalation solution, 1 or	o s 1	

NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH & REHABILITATION CENTER CHARLOTTE HEALTH & REPORT OF LIST DEPOSITION OF CONFECTION PROPERTY IN A CONTINUE OF PROVIDER SITUATION OF CONFECTION PROPERTY IN A CONTINUE OF CONFECTION OF PROPERTY IN A CONTINUE OF PROVIDER SITUATION OF CONFECTION OF PROPERTY IN A CONTINUE OF THE PROPERTY IN A	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
STREET ADDRESS. CITY, STATE, ZIP CODE 1735 TOBDVILLE ROAD CHARLOTTE HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEPICIONIES (EACH DEPICIONY OR USE DENTIFYING INFORMATION) F 835 Continued From page 36 that the committee put into place during 2 federal surveys of record for 1 repeat deficiency in the area of labeling and storing drugs and biologicals. The findings included: The findings included: This tag is cross referred to: The findings included: 4. 48.3.25 (F689) Free of Accident Hazards/Supervision/Devices: Based on observations, interviews with a resident (Resident #69), a technician and staff and review of facility records, the facility failed to maintain safe hot water temperatures at or below 116 degrees Fahrenheit (F) as evidenced by water temperatures at or below 116 degrees Fahrenheit (F) as resident hand sinks in bathrooms shared by 4 residents to a 1 of 4 hallways (rooms 215, 216, 227, and 228). An interview with the administrator cocurred on 12/17/18 at 11-43 AM. During the interview, the administrator stated that she assumed her role at the facility in September 2018. She provided documentation of facility temperature logs during the interview. The administrator stated that she had just reviewed the logs and replied "I have a lot of concerns regarding these temperatures in locations accessible to patients, including 2 patient rooms on each of the two units. Saturday and Sunday the Manager on Duty or designee will also check water temperatures in locations accessible to patients, including 2 patient rooms on each of the two units. An interview The administrator stated the surrent maintenance director before he left, but she was not sure how much training he received. The			345405	B. WING			C 12/20/2018	
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not sure how much training he received. The Address what measures will be put into					Tooms on each of the two units.			
					Address what measures will be n	out into		
administrator also stated that since deptember			•		1			
2018, she verified that the maintenance director ensure that the deficient practice will not					, .			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345405			B. WING _			C 12/20/2018		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		2/20/2010		
				1735 TODDVILLE ROAD				
CHARLOI	TE HEALTH & REHABI	LITATION CENTER		CHARLOTTE, NC 28214				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 835	Continued From pag	ge 37	F8	35				
	monitored and docu	mented water temperatures,		recur:				
	but she did not revie	w the logs to verify exactly		All licensed nurses will be edu	cated on			
	what the water temp	eratures were. She further		storage of medications. Licen	sed nurses			
	stated "This is educated	ation for me, I was not made		who have not received educat	ion on or			
	•	ratures out of range, but I		before 1/17/2019 will not be al				
	also did not check the			work until education is receive	•			
	-	administrator also stated that		nurses are responsible for ens	-			
		hat when the heating/cooling		medications are expired and a				
		the hot water tank in October		labeled and dated appropriate	ly. Charge			
		recommendations for repairs.		nurses will be responsible for	ach chiff v2			
	_	hundreds of faxes per day, if		documenting their cart audit exweeks. Charge nurses will be				
		ng a specific fax I would not or it." The administrator		for reporting their negative find	•			
	_	e maintenance director did		DON or Nurse Manager.	alligs to the			
		ade temperature adjustments		The Maintenance Director rec	eived			
		but that he did not tell her		education on Maintenance Po				
		nents were made because		Procedures Policy #203. The				
		exceeded 116 degrees F, nor		Maintenance Director will docu	ument daily			
	did she ask.	3		temperature checks into the T	•			
				system. A temperature log wa				
				for the Manager on Duty to co	mplete that			
	2. 483.45 (F761) La	bel/ Store Drugs and		addresses locations accessibl	e to patients			
	_	on manufacturer's guidelines,		including 2 random patient roo				
		aff interviews, the facility		of the two units. All Departme				
		ation in the original container		Managers responsible for fulfil	-			
		carts (100A, 100B, and		Manager on Duty duties were				
	•	foil packaging for an		on the completion of this temp	•			
		1 1 of 4 medication carts		and that in the event temperat				
		card expired inhalation		116 degrees, the Maintenance				
		dication carts (100B), failed dinsulin pen in 1 of 4		and Administrator are to be no immediately.	runeu			
		00B), and failed to label an		The Administrator was educate	ed on the			
		lication carts (100B).		monitoring and management of				
	initial in 1 of 7 med	industriound (1000).		water temperature documenta	-			
				as maintaining an effective Qu				
	An interview on 12/2	20/2018 at 5:25 PM with the		Assessment Program through	-			
		ed that medication storage		implemented procedures and				
		area that the facility evaluated		interventions.	J			
		e monthly QAA meeting. The		Indicate how the facility plans	to monitor			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345405	B. WING _			12/20/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER		1735 TODDVILLE ROAD			
OHARLOT	TE TIERETTI & RETIRETE	TIATION SERVER		CHARLOTTE, NC 28214			
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 835	Administrator stated that the repeated deficiency in medication storage could be attributed to the need for continued education and monitoring for		F 8	its performance to make sure solutions are sustained Shift audits will be conducted charge nurse during each shi	by the		
	need for continued education and monitoring for the nursing staff.			Medication carts will be audite member of the Nurse Manage 5x weekly x4 weeks, weekly x then monthly x 10 months. R audits will be reported to Qua Assurance and Improvement 3. The QAPI Committee will effectiveness of the above pla add additional interventions be identified trends/outcomes to continued compliance. The Administrator or designed water temperatures are logger range of 100-116 degrees by temperature logs weekly x4 we monthly x3 months. Audit find reviewed monthly with the Quality Assurance and Improvement Committee x 3. The QAPI Coevaluate the effectiveness of plan, and will add additional in based on identified trends/outensure continued compliance. Completion January 17, 2019	g each shift x2 weeks. Il be audited by a se Management team se, weekly x4 weeks months. Results of ted to Quarterly Quality provement committee x mittee will evaluate the make above plan, and will eventions based on tromes to ensure more. In designee will verify mare logged and within make eekly x4 weeks and make Audit findings will be with the Quarterly mand Improvement make QAPI Committee will more events of the above dditional interventions more trends/outcomes to more difference.		
F 867 SS=E	<u></u>		F 8	667		1/17/19	
	-	sessment and assurance.					
	action to correct ident	•					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	A. BUILDING			<u></u>	
	345405 B. WING				C 12/20/2018			
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
CHARLO	TTE HEALTH & REHAE	RII ITATION CENTED		17	35 TODDVILLE ROAD			
CHARLO	I IE NEALIN & RENAL	BILITATION CENTER		C	HARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE		
F 867	Continued From pa by: Based on record re facility's Quality As: (QAA) committee for procedures and mo	F	867	Address how corrective action will be accomplished for those residents found have been affected by the deficient practice:				
	the committee put into place in February 2018. This was for one recited deficiency, F761, which was originally cited in February 2018 during an annual recertification and was subsequently recited in April 2018 on an on-site follow up survey and complaint investigation. The deficiency was in the area of label/ store drugs and biologicals. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.				3 out of 4 medication carts failed to sto medications in original containers base on manufacturer squidelines. 1 out of carts failed to date foil package for inhalation solution, 1 out 4 failed to discard expired inhalation solution, 1 or of 4 failed to discard expired insulin per and 1 out of 4 failed to label inhaler. Al Medications found to be out of complia were discarded immediately. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice	d 4 ut n Il nce		
	The findings includ This tag is cross re				All medication carts were audited on 12/16/2018 and medications were discarded that were not in original packaging and not labeled. All medications that were expired were als			
	483.45 (F761) Labe Biologicals: Based observations and s failed to store medi in 3 of 4 medication 200A), failed to dat inhalation solution (100A), failed to dis solution in 1 of 4 m to discard an expire medication carts (1 inhaler in 1 of 4 medication			discarded. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur: All licensed nurses will be educated on storage of medications. Licensed nurse who have not received education on or before 1/17/2019 will not be allowed to work until education is received. Charnurses are responsible for ensuring no medications are expired and all are labeled and dated appropriately. Chargnurses will be responsible for documenting their cart audit each shift	es ge			
	During the annual i	recertification survey			weeks. Charge nurses will be respons			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						С			
		345405	B. WING _			12/	20/2018		
NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214					
(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 CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO T			(X5) COMPLETION DATE		
F 867	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	TAG CROSS-REFERENCED TO THE APPRO		eks. eam ss f ttee dill ve			