PRINTED: 04/02/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345130	B. WING			C 02/28/2020	
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER	1	515	EET ADDRESS, CITY, STATE, ZIP CODE LAKE CONCORD ROAD NE NCORD, NC 28025	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
SS=F	*[For RNCHIs at §403. Hospice at §418.113, at §460.84, Hospitals §484.102, CORFs at "Organizations" unde §485.920, OPOs at § §491.12:] (d) Training and testir develop and maintain preparedness training based on the emerge paragraph (a) of this sparagraph (a) of this sparagraph (a)(1) of the procedures at paragraph the communication plesection. The training be reviewed and update to the training be reviewed and testing be reviewed and tes	B.748, ASCs at §416.54, PRTFs at §441.184, PACE at §482.15, HHAs at §485.68, CAHs at §486.625, r 485.727, CMHCs at 486.360, RHC/FHQs at an emergency g and testing program that is ncy plan set forth in section, risk assessment at as section, policies and aph (b) of this section, and an at paragraph (c) of this and testing program must ated at least every 2 years. (d):] (d) Training and testing, develop and maintain an ness training and testing d on the emergency plan set of this section, risk raph (a)(1) of this section, res at paragraph (b) of this munication plan at section. The training and be reviewed and updated at B.475(d):] Training and must develop and maintain redness training and testing d on the emergency plan set		036	TITLE		3/23/20 (X6) DATE

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

03/23/2020 **Electronically Signed**

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

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		345130	B. WING _		C 02/28/2020	0
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		•
CUDIC AT	CONCORD NURSING 8	DELIA DII ITATIONI CENTED		515 LAKE CONCORD ROAD NE		
CURIS AI	CONCORD NURSING &	REHABILITATION CENTER		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	BE COMPLI	ETION
E 036	Continued From page section, and the comparagraph (c) of this stesting program must least every 2 years. Trequirements for evac §483.470(i). *[For ESRD Facilities testing, and orientation develop and maintain preparedness training orientation program the emergency plan set for section, risk assessmenthis section, policies at (b) of this section, policies and orientation program the section, policies and orientation program the section, and paragraph (c) of this seand orientation program program for the facility failed to develop the section of the facility failed to develop mergency prepared program for the facility failed: The facility's emerger manual was reviewed.	munication plan at section. The training and be reviewed and updated at the ICF/IID must meet the cuation drills and training at at §494.62(d):] Training, on. The dialysis facility must an emergency g, testing and patient nat is based on the borth in paragraph (a) (1) of and procedures at paragraph d the communication plan at section. The training, testing am must be evaluated and ears. The is not met as evidenced the wand staff interviews the pop and maintain an annual ness training and testing y's staff. The preparedness (EP) If on 2/26/2020. The EP	EO	This Plan of Correction constitutes the facilities allegation of compliance for deficiencies citied in the CMA-2567 statement made in the plan of Correction are not admission to and do not indice an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance all Federal and State regulations such	he The tions ate es. with	
		e any information about the he facility's emergency uring 2019 and 2020.		all alleged deficiencies cited have be will be corrected by the date (s) indica Response to this statement of Delice does not constitute an admission that	nted. nse	
	and testing staff for E	s responsible for training mergency Preparedness . n Emergency Preparedness		deficiency is accurate. No residents we named in the citation On 2-27 20 the Administrator comple an annual Emergency Management	vere	

Facility ID: 953050

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			1	28/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	20/2020
					15 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER			ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
E 036	the facility. The Main able to provide inform discussed or who was preparedness discuss. Director stated the provide information regard. Preparedness tableto and neither him or the been able to find the During an interview w 2/28/2020 at 2:42 pm should have provided emergency prepared Administrator stated a since December 2019 became the facility's a no training or testing	previous Administrator left tenance Director was not nation regarding what was a present at the emergency sion. The Maintenance evious Administrator kept ding the Emergency p discussion in his office enew Administrator had information. With the Administrator on she stated the facility training and testing of the ness plan. The she had been at the facility of the facility of the facility's EP plan, but	E	036	Preparedness training program with administrative staff. On 3-5-2020 administrator in-serviced other facility staff on the facility Emergency Management Preparedness training program. The facility emergency preparedness training program will be reviewed and approved by the Facility Safety Commi and reviewed annually with committee. Administrator will update changes to the emergency preparedness plan as they change throughout the year. Any change will be reviewed in the monthly Facility Safety Committee meeting. The safety committee consists of the Administrato Director of Nursing, Maintenance Directory, Staff development Coordinal Unit Managers. Distant Managers.	ges	
F 000	at CFR 483.45 at tag severity J. The tag F Quality of Care. Imm 2/10/2020 and was re	ey and complaint ducted 2/23/2020 to te Jeorpardy was identified	F(000	Unit Managers, Dietary Manager, Administrative and line staff from other departments. Updated Emergency Preparedness Pla will be reviewed with Quality Assurance Process Improvement Committee and updates will be reviewed /approved by QAPI Committee as they arise.	an e any	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	COMPLETI	(X3) DATE SURVEY COMPLETED		
		345130	B. WING _		02/28/2	2020		
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 515 LAKE CONCORD ROAD NE CONCORD, NC 28025				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE CO	(X5) OMPLETION DATE		
F 000	Continued From pag		F (000				
F 580 SS=E		allegation was substantiated. njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F 5	580	3/2	23/20		
	consult with the resic consistent with his or representative(s) who (A) An accident invoresults in injury and physician intervention (B) A significant characteristic in either life-the clinical complications (C) A need to alter the aneed to discontinuate treatment due to advocommence a new for (D) A decision to trained the form the facts (483.15(c)(1)(ii). (iii) When making nor (14)(i) of this section all pertinent information is available and proven physician. (iii) The facility must resident and the residen	nediately inform the resident; dent's physician; and notify, r her authority, the resident en there is- lving the resident which has the potential for requiring in; nge in the resident's physical, cial status (that is, a ch, mental, or psychosocial areatening conditions or s); eatment significantly (that is, e an existing form of verse consequences, or to rm of treatment); or insfer or discharge the cility as specified in static ion specified in §483.15(c)(2) rided upon request to the dent representative, if any, or roommate assignment cons as specified in paragraph or one as specified in paragraph or one as specified in paragraph						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 02/28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		02/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 580	phone number of the representative(s). §483.10(g)(15) Admission to a composite di §483.5) must disclose its physical configurat locations that compris part, and must specifications that compris part, and must specific room changes between under §483.15(c)(9). This REQUIREMENT by: Based on record reviphysician interviews, clarification and obtain of a cardiac monitor when he was admitted (Resident #77) for onfor notification. The findings included Review of Resident #78 upon direction included included: Stroke, diable heart, cognitive command adjustment disorder.	posite distinct part. A facility stinct part (as defined in a in its admission agreement action, including the various see the composite distinct by the policies that apply to en its different locations. The is not met as evidenced ew, observations, staff, and the facility failed to seek an orders regarding the use which was on the resident different hospital erof three residents sampled. The is hospital discharge 1/19, revealed no a cardiac monitor for scharge from the hospital. The initial discharge 1/19, revealed no a cardiac monitor for scharge from the hospital. The initial discharge 1/19, revealed no a cardiac monitor for scharge from the hospital. The initial discharge 1/19, revealed no a cardiac monitor for scharge from the hospital.	F 58	This Plan of Correction constitutes th facilities allegation of compliance for t deficiencies citied in the CMA-2567. statement made in the plan of Correct are not admission to and do not indica an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance all Federal and State regulations such all alleged deficiencies cited have bee will be corrected by the date (s) indica Response to this statement of Delicer does not constitute an admission that deficiency is accurate. Resident #77 no longer at facility. The facility contacted the cardiac mor providing company, who was monitorithe device. The providing company informed the facility that the company	he The tions ate ss. with that en or ated. ase any
		77 ' s admission orders for I1/19, revealed no physician cardiac monitor.		notifies the prescribing physicians offi monitoring results. (i.e.: compliance of non-compliance). The facility was als	or

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUI IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345130	B. WING _			0:	2/28/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				51	15 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING	& REHABILITATION CENTER		С	ONCORD, NC 28025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
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F 580	Continued From page	200 5		580			
1 300	Continued From pa	age 3		000	:	L -	
	An admission nota	for Decident #77, detect			informed that if any changes were to		
		e for Resident #77, dated d 6:28 PM, by Nurse #2			made regarding the cardiac monitor the company would contact the facility and		
		esident had a cardiac monitor in			when someone is not using the device		
		into place prior to discharge			to be retuned to the monitor company		
from the hospital and the resident was to continue				This information was communicated t			
		or for 30 days. Further review			resident #77's responsible party by th		
		e documented the resident had			company and the responsible party		
		up cardiac visit (no date, nor			retrieved the monitoring device and		
	time, was docume	nted in the note).			returned to the company .		
	The Treatment Adı	ministration Record (TAR) for			The cardiac monitor belonging to resi	dent	
		ne months of December,			#77 was not in use and was given to		
		ruary were reviewed and no			Responsible Party so that cardiac mo		
	_	ing the use of a cardiac			can be returned to the manufacturer of	n	
	monitor was disco	vered.			2/25/20. The facility had no contact	~~ r	
	The Medication As	Iministration Record (MAR) for			information for the provider. Unit man spoke with power of attorney for resid		
		ne month of December,			#77 who provided contact information		
		uary was reviewed and there			regarding the company that provide the		
		d 12/19/19 regarding changing			cardiac monitor . The cardiac monitor		
		ne cardiac monitor every three			company informed the unit manager t		
	days and were sig	ned off on 12/19/19, 12/22/19,			the device was for monitoring purpose	es	
	12/25/19, 12/28/19	9, 12/31/19, 1/3/20, 1/6/20,			only and was returned .		
		15/20, 1/18/20, 1/21/20,					
		1/30/20, 2/2/20, 2/8/20, 2/11/20,			All residents requiring cardiac monito	•	
		20. The resident was			devices have the potential to be affect		
		aving had a note to see nurses '			If a resident is admitted to facility wea	ring	
	notes regarding 2/	5/20, 2/17/20, and 2/23/20.			a device (i.e.:cardiac monitor)and no orders or information about the device	a io	
	Pavious of Pacidor	et #77 ' a comprehensive					
		nt #77 ' s comprehensive m Data Set assessment with a			included in the admission paper work admitting nurse is to contact the facili		
		12/13/19 revealed the resident			resident was admitted from and reque	-	
		having cognitive loss and			information related to the device, suc		
		e assistance of one, two, or			duration , reason for monitoring , and		
		ed mobility, dressing, toilet use,			follow up is needed. There are no		
		pendent for bathing.			residents requiring the use of a cardia	ac	
		-			monitoring device. All licensed nursin		
	During an observa	tion conducted in conjunction			staff will be educated on receiving pro		

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		345130	B. WING			1	28/2020
NAME OF P	ROVIDER OR SUPPLIER		'	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0=11	
				5′	15 LAKE CONCORD ROAD NE		
CURIS AI	CONCORD NURSING &	REHABILITATION CENTER		С	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 580	Continued From page	e 6	F:	580			
	11:03 AM, a cardiac r floor to the left of the plugged into a charge screen which had a v chest and a message electrodes up. The c observed to have been bue to the resident 's was unable to provide device was and if he buring an observation #77, on 2/24/20 at 11 was observed on the the left of the residen into a charger. There had a visual picture of message was display	Resident #77, on 2/23/20 at monitor was observed on the resident 's bed and was er. There was a display isual picture of a human was displayed to hook the ardiac monitor was not en hooked up to the resident. It is confusion, the resident er an answer as to what the should have been wearing it. In conducted of Resident 1:52 AM, a cardiac monitor resident 's bedside table to to t's bed and was plugged er was a display screen which of a human chest and a red to hook the electrodes itor was not observed to			care and follow up orders for any cardimonitor device that a resident may be admitted into the facility with on 3/22/2020. The Director of Nursing Services, or designee, will audit all potentially affect residents upon admission 5 times a wex 4 weeks, then 3 times a week x 4, the weekly x 1 month or until corrective act is achieved. Findings will be reviewed with the administrator weekly. Results will be discussed and addressed as needed during the facility smonthly Quality Assessment and Performance Improvement (QAPI) meeting.	ted eek en	
	During an interview was PM she stated she was and he was supposed but he was non-comp. An interview was con PM with Nurse #3 who on her assignment. Shave a cardiac monitor of Attorney (POA) had day and she had told monitor. The nurse sany phone calls from where the cardiac monher assumption was to non-compliant with the	with NA #1 on 2/24/20 at 1:24 as assigned to Resident #77 d to wear a cardiac monitor, oliant and would take it off. ducted on 2/24/20 at 1:50 to stated Resident #77 was She stated the resident did for but the resident 's Power d come to the facility that the POA to take the cardiac tated she had not received a cardiologist asking as to onitor was. The nurse stated					

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		345130	B. WING			C	
NAME OF PI	ROVIDER OR SUPPLIER	343130		STREET ADDRESS, CITY, STATE, ZIP CO	•)2/28/2020	
		G & REHABILITATION CENTER		515 LAKE CONCORD ROAD NE			
				CONCORD, NC 28025			
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F 580	Continued From p	page 7	F 5	580			
		nonitor and the admission sident was to wear the monitor					
	PM with the Medic stated she was try	conducted on 2/25/20 at 3:08 cal Records Director. She ving to track down the ordered the cardiac monitor for					
	conjunction with a 3:58 PM. She sta admitted from the the cardiac monitor was put in his discharge from remembered the rwith the cardiac mleads off and putti drawer. The nurs resident was suppledays but was una she reviewed the nurse stated there resident wearing the should have we stated when she hurse at the hospi resident was to we days. The nurse stated the not documented to the nurse stated.	Nurse #2 was conducted in an observation on 2/25/20 at a steed when Resident #77 was hospital on 12/11/20, he had or in place. The nurse said the not place at the hospital prior to a the hospital. The nurse resident was very non-compliant anonitor such as pulling the wireing the cardiac monitor into the estated she remembered the posed to wear the monitor for 30 bile to discover the order when resident's medical record. The eswas no order regarding the cardiac monitor or how long forn the cardiac monitor. She had received report from the stall it was reported to her the ear the cardiac monitor for 30 stated he had the cardiac monitor for 30 stated he had the cardiac monitor for 30 stated he had the cardiac men he was admitted but it was on the admission assessment. The daughter had came to the up the monitor and was going					
	to send it back. Uthe cardiac monitor box which the card	Ipon observation of the room, or was not in the room, but a diac monitor was to be placed in a still in the resident 's wardrobe					

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		345130	B. WING _				28/2020
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	Ε	V=1	20,2020
CLIDIS AT	CONCODD NITESING &	REHABILITATION CENTER		515 LAKE CONCORD ROAD NE			
CURIS AI	CONCORD NORSING &	REHABILITATION CENTER		CONCORD, NC 28025			
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F 580	2:56 PM with the recedepartment at the host discharged from she Practitioner had order to Resident #77 having his hospital state. A phone interview was 3:44 PM, with the Far (FNP) who had order to Resident #77 's discharged because the some abnormal cardination. She sinformation from the coccurrences where the abnormal cardiac rhy although they were not the monitoring compather FNP said she has communication from the communication from the monitoring compather properties and she has communication from the resident 's use of the there any documental facility trying to contain regarding the monitor it would have been be more cardiac reading history of cardiac abnurber of the state of the	riew conducted on2/27/20 at eptionist at the neurology spital the resident was stated the Family Nurse red the cardiac monitor dueing had heart palpitations ay. Is conducted, on 2/27/20 at mily Nurse Practitioner ed the cardiac monitor prior scharge from the hospital. ardiac monitor had been resident had experienced ac rhythms during his said upon review of the cardiac monitor there were 3 are monitor had picked up thms which concerned her, of serious enough to trigger any to have sent her an alert, do not received the facility regarding the cardiac monitor nor was tion in his record of the cot someone at the hospital and the facility regarding the cardiac monitor had picked up the facility regarding the cardiac monitor nor was tion in his record of the cot someone at the hospital and the facility for her to have had so due to the resident 's ormalities. She stated she	F	580			
	cardiac monitor. She monitor was suppose and upon completion monitor was to be pla	t 's non-compliance with the explained the cardiac d to be worn for 30 days of the 30 days, the cardiac					

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	ROVIDER OR SUPPLIER	& REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		212012020
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F 580	did not understand had not been sent be The FNP additionall contacted the numbin information in the bowhat to do with the recontact her or the horizontact her or parameters monitor was put into information in the different horizontact her or parameters monitor and he was nurses had attempted regarding the moniton and horizontact her were several keeps the length of their uses horizontact her would have the horizontact her or what the estated he did not know would go on the MA been documented in the nurses had told non-compliant with the horizontact had been documented in the nurses had told non-compliant with the had a foll non-compliant w	onitor. The FNP stated she now come the cardiac monitor ack after the 30-day period. It is stated the facility could have er on the box or on the pox if they had questions as to monitor in addition to trying to	F 5	80		

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F 580	cardiac monitor had cardiologist for the was for the cardial. The resident 's pl 2/28/20 at 11:26 A facility 5 days per questions regarding Resident #77, he nurses to have follogist regard the cardiologist regard the cardiac monitor resident arrived was no information would expect for sand possibly some come the resident monitor. The phy reasonable for the some information between the resident and 2/23/20. During an intervied (DON) conducted stated there should Resident #77 to he check to make suin place each shift to be worn. The Enot known who had then she stated it nursing staff to had ordered the monitor were regarding the	hospital to find out why the ad been placed, if there was monitor, and what the plan	F 5	80			

F 580 Continued From page 11 F 580 she would have expected the nursing staff to	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CURIS AT CONCORD NURSING & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 580 Continued From page 11 she would have expected the nursing staff to STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025 ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE F 580 Continued From page 11 F 580 STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE F 580 Continued From page 11 F 580			345130	B. WING _		a l	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 580 Continued From page 11 she would have expected the nursing staff to			REHABILITATION CENTER		515 LAKE CONCORD ROAD NE		
she would have expected the nursing staff to	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
contact the physician or Nurse Practitioner to make them aware of the resident 's non-compliance and seek a clarification order regarding if the monitor should be continued or discontinued. The DON stated she was unable to find in the facility or hospital medical records who had ordered the monitor and there was no cardiac consult from the hospital nor had the resident been to a cardiologist since his admission to the facility. During an interview conducted on 2/26/20 at 12:39 PM with the Administrator she stated the information regarding cardiac monitor had been mailed to the resident 's home address and when the POA picked up the resident 's smail she came to the facility to get the monitor. The Administrator stated there was no information regarding the cardiac monitor in the discharge summary from the hospital. F 582 Medicaid/Medicare Coverage/Liability Notice F 582 SS=B CFR(s): 483.10(g)(17)(18)(i)-(v) \$483.10(g)(17) The facility must-(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident twen changes are made to the items and services	she wo contact make the non-content find in the had orderesident admiss. During 12:39 Finformal mailed the PO to the factor Administregardi summal Medica (CFR(s)) \$483.11 (i) Inforwriting, facility Medica (A) The nursing for white (B) The facility charger service (ii) Information (ii) Information (iii) Information (iiii) Information (iii) Information	e would have expendent act the physician ke them aware of accompliance and arding if the monit continued. The Doll in the facility or he did acconsult from a dident been to a carbon and interview of the facility of the facility of the facility to get the facility from the holdicaid/Medicare CR(s): 483.10(g)(17) The facility and when the dicaid of-The items and seesing facility service which the resident Those other items and for wices; and Inform each Medicing and the amovices; and Inform each Medicing and Medicing	cted the nursing staff to or Nurse Practitioner to the resident 's seek a clarification order or should be continued or ON stated she was unable to ospital medical records who itor and there was no the hospital nor had the rdiologist since his ity. Onducted on 2/26/20 at ministrator she stated the cardiac monitor had been to 's home address and when the resident 's mail she came the monitor. The chere was no information to monitor in the discharge spital. Overage/Liability Notice (1/28)(i)-(v) Cacility must aid-eligible resident, in admission to the nursing resident becomes eligible for revices that are included in the sunder the State plan and the may not be charged; and services that the which the resident may be count of charges for those				3/23/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY
		345130	B. WING _			C)2/28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		32/20/2020
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 582	section. §483.10(g)(18) The fresident before, or at periodically during the available in the facility services, including an covered under Medicifacility's per diem rate (i) Where changes in and services covered Medicaid State plan, notice to residents of reasonably possible. (ii) Where changes a items and services the facility must inform the 60 days prior to imple (iii) If a resident dies transferred and does facility must refund to representative, or est deposit or charges all per diem rate, for the resided or reserved of facility, regardless of discharge notice requivity. The facility must resident representative the resident within 30 date of discharge from (v) The terms of an abehalf of an individual facility must not conflithese regulations.	acility must inform each the time of admission, and e resident's stay, of services y and of charges for those by charges for services not eare/ Medicaid or by the ear. coverage are made to items If by Medicare and/or by the the facility must provide the change as soon as is the resident in writing at least ementation of the change. For is hospitalized or is not return to the facility, the earth the facility offers, and the resident, resident the facility's days the resident actually or retained a bed in the any minimum stay or uirements. The refunds the resident or we any and all refunds due of days from the resident's	F5	582		
	by:	iew and staff interviews, the		This Plan of Correction consti	tutes the	

PRINTED: 04/02/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345130	B. WING			C	
NAME OF D	DOVIDED OD CLIDDLIED	343130	B. WING_	CTDEET ADDRESS CITY STATE 71	•	2/28/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
CURIS AT	CONCORD NURSING 8	REHABILITATION CENTER		515 LAKE CONCORD ROAD NE			
		-	CONCORD, NC 28025				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 582	Continued From pag	e 13	F 5	82			
F 582	facility failed to provid (Centers for Medicar Skilled Nursing Facili Notice) prior to disch skilled services to 2 dischediciary protection and #77). The findings included 1. Resident #72 was 12/27/19 with diagnot palsy, need for assist generalized anxiety of disorder and irritable. Resident #72's Minimadmission assessmenthe resident's cognition of Medicare Non-Cov 10123-NOMNC with ending on 1/23/20. It on 1/21/20. Further rishowed an un-dated of Noncoverage (ABI	de a CMS-10055 SNF ABN e and Medicaid Services ity Advanced Beneficiary arge from Medicare Part A of 3 residents reviewed for in notification (Residents #72 d: admitted to the facility on ses that included cerebral tance with personal care, disorder, major depressive bowel syndrome. hum Data Set (MDS) ent dated 12/29/19 specified on as being cognitively intact. cal record revealed a Notice verage Form CMS an effective date of coverage was signed by Resident #72 eview of the medical record Advance Beneficiary Notice N) Form CMS - R-131 with	F 5	facilities allegation of condeficiencies citied in the statement made in the pare not admission to and an agreement with allegathis Plan of Correction is executed as to remain in all Federal and State regall alleged deficiencies of will be corrected by the orange of the constitute and deficiency is accurate. Note that the condense of the condense o	CMA-2567 . The clan of Corrections of do not indicate ed deficiencies. It is written and in compliance with gulations such that sited have been or clate (s) indicated. It is ent of Delicense dmission that any lo residents were eanalysis by the facility ermine that there extranding of the oprovide a skilled ea Beneficiary to discharge from a for residents.		
	out. The form was no medical record did no Skilled Nursing Facil Notice of Non-Covers CMS-10055.	me and was partially filled of signed by the resident. The of include the required ity Advance Beneficiary age (SNF ABN) Form Inpleted with the Business		Skilled Nursing Facility A Beneficiary Notice of No (SNF-ABN) form CMS-1 On 3-20-2020 a 100% a days of discharges was Social Services Director others who may have be	n-Coverage. 10055. udit of the last 30 conducted by the to determine		
	Manager (BM) on 2/2 Resident #72 had Moremaining. She ackn	26/20 at 1:16 pm who stated		the alleged deficient Pra On 3-20-2020 education the Administrator to the S Director regarding the re	was provided by Social Services		

Facility ID: 953050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _				28/ 2020
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	20/2020
					5 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER			ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 582	Continued From page	e 14	F 5	582			
	been filled out complete new to the role and having issued Form that issued the Form the facility. An interview was con Administrator on 2/28 is the expectation that would be given to the its entirety. 2. Resident #77 was 12/11/2019 with diagred Cerebral Infarction, In Type 2 Diabetes mell thrombosis of atrium, ventricle as current or myocardial infarction. Resident #77's Minim quarterly assessment resident 's cognition Resident #77's medic of Medicare Non-Cov 10123-NOMNC with a ending on 1/24/20. Roon 1/22/20. An Advar Noncoverage (ABN) been given to Reside #77's representative of filled out. The medicar required Skilled Nurs Beneficiary Notice of Form CMS-10055.	etely. BM stated she was ad not been responsible for CMS - R-131. The staff that CMS - R-131 is no longer at appleted with the 1/20 at 2:45 pm who stated it the required CMS forms resident and completed in admitted to the facility on noses to include Other attracardiac Thrombosis, auricular appendage, and complications following acute as being cognitively intact. The state of the facility on noses to include Other attracardiac Thrombosis, auricular appendage, and complications following acute as being cognitively intact. The state of the facility on noses to include the form CMS and effective date of coverage esident #77 signed the form face Beneficiary Notice of Form CMS - R-131 had and #77 and signed Resident for 1/2/20 and was partially all record did not include the fing Facility Advance Non-Coverage (SNF ABN)		J02	requirement for issuing an ABN. This education included the residents who remain in the facility or discharged after Medicare A services ended who require an ABN be given. Beginning 3- 23 20 the Social Services Director will maintain a of residents who are discharged from Medicare Part A services. On this log whom be the resident some shaded and shaded are part A discharge and the date the ABN was provided. The log will be kept in a binder Beginning 3-23-2020 the administrator the facility will review the Medicare Part discharge binder weekly and validate the ABN has been provided to those residents whose Medicare Part A service have ended. The administrator will sign the Medicare Part A discharge log weefor 4 weeks and then monthly for three months. Findings will be reported to the Quality Assurance Performance Improvement committee for recommendations or modification until pattern of compliance is achieved.	of t A ces n kly	
		npleted with the Business 6/20 at 1:16 pm who stated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(С
		345130	B. WING _			02/	28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 582	had been given to Rebeen filled out completed new to the role and having issued Form Chad issued the Form the facility. An interview was come Administrator on 2/28 is the requirement the be filled out and comp Comprehensive Assected CFR(s): 483.20(b)(1). §483.20 Resident Assected The facility must conducted a comprehensive, accomprehensive, a	edicare Part A days owledged the wrong form esident #77 and should have etely. BM stated she was ad not been responsible for CMS - R-131. The staff that CMS - R-131 is no longer at inpleted with the B/20 at 2:45 pm who stated it e correct CMS form would pleted in its entirety. essments & Timing (2)(i)(iii) sessment duct initially and periodically curate, standardized ment of each resident's ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, I preferences, using the instrument (RAI) specified sment must include at least demographic information e. s.		582 636	**		3/23/20
		ning and structural problems.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C 02/28/2020	
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	1 0	212012020	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 636	(xi) Dental and nutrit (xii) Skin Conditions (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatme (xvi) Discharge plant (xvii) Documentation regarding the addition the care areas tricthe Minimum Data S (xviii) Documentation assessment. The assinclude direct observing the resident, as licensed and nonlice members on all shift §483.20(b)(2) When timeframes prescribed chapter, a facility muassessment of a restimeframes specified through (iii) of this seprescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmission significant change in mental condition. (For readmission means following a temporar or therapeutic leave (iii) Not less than one This REQUIREMEN by: Based on medical residual services and services are serviced in States.	ints and procedures. Ints and procedures. Ining. In of summary information In all assessment performed In assessment performed In assessment process must In a communication In a co	F 6	This Plan of Correction constit facilities allegation of compliance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345130	B. WING	B. WING		C 02/28/2020	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		02/20/2020	
	.07.52.1.01.100.1.2.2.1			515 LAKE CONCORD ROAD NE	0052		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER		CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICI	DATE		
F 636	636 Continued From page 17		F 6	36			
	admission date for 1 reviewed for timely co Minimum Data Set (M Findings included: Resident #1 was adm 9/24/19.	nitted to the facility on		deficiencies citied in the statement made in the pare not admission to and an agreement with alleg This Plan of Correction executed as to remain in all Federal and State reall alleged deficiencies will be corrected by the Response to this statem	olan of Correction d do not indicate ged deficiencies is written and n compliance w gulations such to cited have been date (s) indicate ment of Delicens	ons e . ith that or ed. se	
	revealed an admission Assessment Reference Further review reveal been completed on 1 The Final Validation Freviewed. The report	Report dated 10/9/19 was tincluded a warning		does not constitute an a deficiency is accurate. N named in the citation On 2/26/2020 resident # Assessment dated 9/30, completion date of 10/8, and noted completed late Data Set Nurse.	to residents we to Comprehens to With a to Was reviewe	ive ed	
	completed late for the the completion date with admission date, 9. An interview was con AM with the MDS Coexplained she was the time and she had assessments change system of Patient Driv (PDPM). An interview was con PM with the facility Administrator revealed MDS assessments to	ARD of 9/30/19 had been admission assessment and was more than 13 days after 0/24/19. ducted on 2/26/20 at 11:01 ordinator. She further e only MDS Coordinator at gotten backed up after the d on 10/1/20 to the new ven Payment Model ducted on 2/26/20 at 12:39		On 3/19/2020, the Minin Assessment Nurse performance improvement monitoring residents with Comprehassessments in progres late assessments. Any were addressed. On 3/18/2020, the Minin Nurse swere re-educa Regional Minimum Data timeliness of Comprehe completion. The Directo and/or Regional Minimum Assessment Nurse will purpovement Monitoring Comprehensive assessing	ormed Quality of for all current ensive as to identify any issues identified num Data Set ted by the a Set Nurse on nsive assessment of Nursing m Data perform Quality of MDS	d ent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C 02/28/2020	
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025			
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 636	Continued From page	ssment After Signifcant Chg	F 6	four weeks, then twice we weeks, then one time per months and then one time three months. Audits will 3/23/2020. The Director of Nursing we results of the Quality Monto to the Quality Assurance Improvement Committee. reviewed by QAPI Command Quality Monitoring (Achanges are needed based The Quality Assurance Pollimprovement Committee and quarterly at a minimum Date of Compliance is 3/2	week for two e monthly for begin will report on the nitoring (Audits Performance Findings will nittee monthly audit) updated ed on findings erformance meets monthly im.	ne s) I be if s.	
SS=D	S483.20(b)(2)(ii) With determines, or should there has been a sign resident's physical or purpose of this sectio means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the reside requires interdisciplinicare plan, or both.) This REQUIREMENT by: Based on record revi	ii) nin 14 days after the facility I have determined, that		This Plan of Correction of facilities allegation of com			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C 02/28/2020	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, <u>02</u> /	20/2020
					15 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER			ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 637	37 Continued From page 19		F 6	337			
	residents reviewed for # 47).	IDS) assessment for 1 of 1 r hospice services (Resident			deficiencies citied in the CMA-2567 . T statement made in the plan of Correction are not admission to and do not indicat an agreement with alleged deficiencies	ons e	
	Findings included:				This Plan of Correction is written and executed as to remain in compliance w	rith	
	revealed that he was 04/04/2014 with diagramal malnutrition, chronic hypertension. The quarterly MDS da Resident #49did not shospice services duri (review) period. The medical record a	pain, depression and ated 05/01/2019 for specify the resident received ng the MDS look back Ind billing census of that he was placed on			all Federal and State regulations such all alleged deficiencies cited have beer will be corrected by the date (s) indicat Response to this statement of Delicens does not constitute an admission that a deficiency is accurate. No residents we named in the citation On 2/26/2020, resident #47□ Significant Change Assessment was scheduled for 26-2020 by the Minimum Data Set Nur to reflect initiation of Hospice Services. On 3/19/2020, the Minimum Data	that n or ed. se any ere nt r 2- se	
	The quarterly MDS dathat Resident #47 was rejected care for 4 to time period. Resident assist with bed mobilified himself after me bladder and bowel ar and as needed (prn) #47 was also coded to with a life expectancy received an opioid on hospice care.	ated 08/01/2019 revealed s cognitively intact and 6 days of the MDS review #47 required extensive ity and toileting, was able to al set up, incontinent of a received both scheduled pain medications. Resident to have a poor prognosis of less than 6 months, a 7 review days and received sident #47 updated on			Assessment Nurse performed Quality Improvement monitoring for all current Hospice residents to identify any reside requiring a Significant Change assessment. Any issues identified wer addressed. On 3/18/2020, the Minimum Data Set Nurse swere re-educated by the Regional Minimum Data Set Nurse on timeliness of Significant Change assessment completion. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS	e of a	
	12/11/2019 revealed received hospice serv	in part that Resident #47 vices and was at risk for ependent for facility staff to			assessments for timeliness of completi of Significant Assessment by reviewing Hospice residents three times weekly f four weeks, then twice weekly for two	l	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C 02/28/2020	
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 021	20/2020
				51	5 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER	CON		ONCORD, NC 28025		
(X4) ID PREFIX TAG			ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 637	Continued From page	÷ 20	F 6	37			
		pice with care and to notify es in status for Resident			weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020.		
	conducted with Nurse she was not certain we started for Resident # believed it was quite last Summer. An interview conducte 02/25/2020 at 11:10 we been employed at the months and that she 47 received hospice semployment. Review well as the census bil #47 the MDS nurse semployed MDS should	24 AM an interview was #1. Nurse #1 stated that when hospice services 47 but did recall that she a few months ago possibly ed with the MDS nurse on AM revealed that she had a facility for about the past 7 was aware that Resident # services since prior to her of the MDS assessments as ling information for Resident that a significant have been completed for 4 days of the initiation of			The Director of Nursing will report on the results of the Quality Monitoring (Audit to the Quality Assurance Performance Improvement Committee. Findings will reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets month and quarterly at a minimum. Date of Compliance is 3/23/2020.	s) I be if s.	
F 638 SS=D	conducted with the far Administrator stated to significant change MI completed as per stated and as per the require Assessment Manual) Qrtly Assessment at I CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instru	te and federal regulations ements in the RAI (Resident for MDS completion. Least Every 3 Months Review Assessment a resident using the fument specified by the State S not less frequently than	F 6	338			3/23/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING			l	28/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	20/2020
	10115211 011 001 1 21211				15 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER	CONCORD, NC 28025				
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 638	Continued From page	÷ 21	f F	638			
	This REQUIREMENT by:	is not met as evidenced					
	Based on medical re interviews, the facility quarterly resident ass the Assessment Referesidents (Resident # reviewed for timely common Data Set (MFindings included: 1. Resident #26 was facility on 2/10/18 and readmitted on 3/5/18. Review of Resident # revealed a quarterly and Assessment Reference Further review reveal been completed on 1	failed to complete a sessment within 14 days of rence Date (ARD) for 2 of 2 26 and Resident #55) ompletion of quarterly MDS) assessments. originally admitted to the d was most recently 26 's MDS assessments assessment with an ce Date (ARD) of 10/14/19. ed the assessment had 1/3/19.			This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567. The statement made in the plan of Correction are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance we all Federal and State regulations such all alleged deficiencies cited have been will be corrected by the date (s) indicated Response to this statement of Delicent does not constitute an admission that a deficiency is accurate. No residents we named in the citation On 2/26/2020 resident #26 and 55 Quarterly Assessment dated 10/14/19 1/3/2020 with a completion date of 11/3 and 2/4/2020 respectively were reviewed and noted completed late by the Minimer.	e he ons e in ith that n or ed. se anny ere and 3/19 ed	
	reviewed. The report message indicating R assessment with an A	tesident #26 ' s MDS ARD of 10/14/19 had been se completion date was			Data Set Nurse. On 3/19/2020, the Minimum Data Assessment Nurse performed Quality Improvement monitoring for all current		
	AM with the MDS Coo Resident #26 's quar	ducted on 2/26/20 at 11:01 ordinator. She reviewed terly MDS assessment			residents with Quarterly assessments i progress to identify any late assessments. Any issues identified were addressed.		
	on 11/3/19, which was not completed the ass another MDS Coordir another facility. She the only MDS Coordir	tated it had been completed is late. She stated she had sessment, there was nator who was helping from further explained she was nator at the time and she of after the assessments			On 3/18/2020, the Minimum Data Set Nurse swere re-educated by the Regional Minimum Data Set Nurse on timeliness of Quarterly assessment completion. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING			۰,	C 2/28/2020	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	2/20/2020	
	1011211 011 001 1 21211				15 LAKE CONCORD ROAD NE			
CURIS AT	CONCORD NURSING	& REHABILITATION CENTER			ONCORD, NC 28025			
(V4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE	
F 638	Continued From pa	age 22	F	638				
		0 to the new system of Patient odel (PDPM). The MDS			Improvement Monitoring of MDS Quarterly assessments for timeliness of	of		
		she had 14 days to finish the			completion by reviewing the In Progres MDS list 3 times per week for four wee then twice weekly for two weeks, then	ss eks,		
	An interview was c	onducted on 2/26/20 at 12:39			time per week for two months and ther			
		Administrator. The			one time monthly for three months.			
	Administrator reve	aled her expectation was for			Audits will begin 3/23/2020.			
	MDS assessments	to be completed timely and for						
	the MDS Coordina	tor to follow the RAI manual.			The Director of Nursing will report on t results of the Quality Monitoring (Audit			
	2. Resident #55 w	as admitted to the facility on			to the Quality Assurance Performance			
	11/21/18.				Improvement Committee. Findings wi	ll be		
					reviewed by QAPI Committee monthly			
		t #55 ' s MDS assessments			and Quality Monitoring (Audit) updated			
	-	ly assessment with an ARD of			changes are needed based on finding	3.		
		view revealed the assessment			The Quality Assurance Performance	_		
	had been complete	ed on 2/4/20.			Improvement Committee meets month and quarterly at a minimum.	ıly		
		n Report dated 2/4/20 was						
		ort included a warning			Date of Compliance is 3/23/2020.			
		g Resident #55 ' s MDS						
		n ARD of 1/3/20 had been						
		the completion date was						
	more than 14 days	s after the ARD.						
		conducted on 2/26/20 at 11:01 Coordinator. She stated she						
		he assessment for Resident						
		ed date of 2/4/20 and she did						
		en she had completed the						
		MDS Coordinator stated she						
		sh the assessment from the						
	ARD.							
		v, which took place on 2/26/20,						
		onsultant explained the						
		ent for Resident #55 had been						
	∣ attempted to be tra	ensmitted prior to 2/4/20 but it						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345130	B. WING _		C 02/28/2020
	ROVIDER OR SUPPLIER	& REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	1 02/20/2020
(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 CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON CROSS-REFERENCED TO THE APPROPRIES OF T	JLD BE COMPLETION
F 638	validation report with they were unable to assessment report v because the report l	nd he provided a copy the the rejection. He stated complete and submit the within 14 days of the ARD had been rejected because of	F 6	38	
F 640 SS=D	PM with the facility Administrator reveal MDS assessments the MDS Coordinate	nducted on 2/26/20 at 12:39 Administrator. The led her expectation was for so be completed timely and for or to follow the RAI manual. ng Resident Assessments	F 6	40	3/23/20
	a facility completes facility must encode each resident in the (i) Admission assessing (ii) Annual assessming (iv) Significant change (iv) Quarterly review (v) A subset of items reentry, discharge, a (vi) Background (facis no admission ass	ing data. Within 7 days after a resident's assessment, a the following information for facility: sment. ent updates. ge in status assessments. a assessments. a upon a resident's transfer, and death. ee-sheet) information, if there eessment.			
	after a facility compl a facility must be ca CMS System inform contained in the MD standard record layer	mitting data. Within 7 days etes a resident's assessment, pable of transmitting to the ation for each resident S in a format that conforms to outs and data dictionaries, indardized edits defined by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345130	B. WING		C 02/28/2020	
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	02/20/2020	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 640	Continued From pag	e 24	F 64	40		
	14 days after a facility assessment, a facility encoded, accurate, athe CMS System, ind (i)Admission assessment (ii) Annual assessment (iii) Significant correct (v) Significant correct (v) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, at (viii) Background (facinitial transmission of does not have an addischarge at the discharge date at (Resident #1) review. Findings included: Resident #1 was addiscontributed to the state of the same and the discharge date at (Resident #1) review.	ment. Int. Int. Int. Int. In in int. In in int. In int. In int. In int. In int. In in int. In int. In int. In int.		This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 statement made in the plan of Correction are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance all Federal and State regulations such all alleged deficiencies cited have been will be corrected by the date (s) indicate Response to this statement of Delicer does not constitute an admission that	he The tions ate es. with a that en or ated. ase	

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			1	28/ 2020
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	20/2020
				5	15 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER			ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	page 1		F 6	340			
	Reference Date (ARE revealed the assessment 2/19/20. The Final Validation Freviewed. The report message indicating R				deficiency is accurate. No residents we named in the citation On 2/26/2020 resident #1□ Discharge Assessment dated 11/19/19 was review and noted Transmitted late by the Minimum Data Set Nurse. On 3/19/2020, the Minimum Data		
	completed late for the anticipated assessme and the completion da after the date of disch	e discharge return not ent had been completed late ate was more than 14 days			Assessment Nurse performed Quality Improvement monitoring for all Validation Reports for the past 30 days to identify any late transmissions. Any issues identified were addressed.		
	AM with the MDS Codischarge assessmer and the resident was when she had review report it had shown the Resident #1 had not late when she had op An interview was con PM with the facility Administrator revealed MDS assessments to	ordinator. She explained the off for Resident #1 was done discharged. She stated ed the missing assessments are discharge assessment for open completed and it was ened it.			On 3/18/2020, the Minimum Data Set Nurse swere re-educated by the Regional Minimum Data Set Nurse on timeliness of assessment transmission. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS assessment for timeliness of transmission by reviewing the Validation Report 3 times per week for four weeks then twice weekly for two weeks, then the time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020.	al ng nn s, one	
					The Director of Nursing will report on the results of the Quality Monitoring (Audits to the Quality Assurance Performance Improvement Committee. Findings will reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly	s) I be if s.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345130	B. WING _				28/ 2020
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 5 LAKE CONCORD ROAD NE ONCORD, NC 28025	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	Continued From page	· 26	F 6	40	and quarterly at a minimum. Date of Compliance is 3/23/2020		
F 641 SS=D	resident's status.		F 6	41			3/23/20
	resident and staff inte accurately code the M assessments for Antip (Resident #64) and for	r tobacco use (Resident npled residents reviewed for			This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567. The statement made in the plan of Correctionare not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance we all Federal and State regulations such all alleged deficiencies cited have beer	e he ons te s. vith that	
	1/29/16. Resident #5 diagnoses included: [Dementia with behaviors, c disorder with delusions,			will be corrected by the date (s) indicat Response to this statement of Delicens does not constitute an admission that a deficiency is accurate. No residents we named in the citation	ed. se any	
	indicated Resident #6 received antipsychotic of the seven day asse review of the MDS as resident was coded a antipsychotic medicat or the prior assessme	ce Date (ARD) of 1/14/20 4 was coded as having had c medication for seven days essment period. Further sessment revealed the s having not received ions since admission/entry			On 2-28-2020, resident #64 MDS Quarterly assessment dated 1-14-2020 was modified to accurately reflect the residents use of Antipsychotic Medicati by the Minimum Data Set Nurse. On 2 -20 resident #292 MDS admission assessment was modified to accurately reflect the residents smoking status by Minimum Data Set Nurse. was updated accurately reflect the residents use of Antipsychotic Medication by the Minimum	ion 2-26 y the d to	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _				28/2020	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	20,2020	
				5	15 LAKE CONCORD ROAD NE			
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER			CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page	e 27	F	641				
		dated on 1/29/20 revealed ea: Resident #64 was			Data Set nurse.			
	_	chotropic medications			On 3/19/2020, the Minimum Data Set			
		pressant, and anti-anxiety)			Nurse performed Quality Improvement			
	for the diagnoses of o	dementia with behavioral			monitoring of the most recent assessm	ent		
		is, depression, anxiety, and			for resident□s currently receiving			
	delusions.				Antipsychotic medications and the mos			
	A navianu af tha Madia	estion Advaission Descend			recent Comprehensive Assessment of			
		cation Admission Record 64 for the period of 1/08/20			Residents who currently smoke for iter accuracy. Any issues identified were	n		
	, ,	aled the resident received			addressed.			
		tion for each day of the			dui cooca.			
	assessment period.				On 3/18/2020, the Minimum Data Set			
	'				Nurse s were re-educated by the			
	During an interview c	onducted with the MDS			Regional Minimum Data Set nurse on:			
	Coordinator on 2/26/2	20 at 10:58 AM she stated			a. N0410 □ Antipsychotic Medication	1		
	she should have code	ed the resident as having			use, and			
		c medication for the 1/14/20			b. J1300 □ Tobacco Use			
	quarterly assessment	t.			The Director of Nursing and/or Region Minimum Data Assessment Nurse will	al		
	An interview was con	ducted on 2/26/20 at 12:39			perform Quality Improvement Monitoria	าต		
	PM with the facility A				of MDS assessments for Accuracy of	.9		
		d her expectation was for			MDS Assessments □ to include	ĺ		
		be completed accurately			Antipsychotic Medication use and	ĺ		
	and for the MDS Coo	rdinator to follow the			Tobacco Use □ on four random MDS			
	Resident Assessmen	t Instrument (RAI) manual.			assessments three times per week for			
	0 Di-l				four weeks, then one time per week for			
		s admitted to the facility on is of Low back pain, other			two months and then one time monthly	tor		
	chronic pain and acut	• •			three months. Audits will begin 3/23/2020.			
	D:	orienie a Minimum D. (O. (The Discount of Mr			
		mission Minimum Data Set			The Director of Nursing will report on the			
	, ,	ated 2/6/20 coded the derately impaired. Health			results of the Quality Monitoring (Audit to the Quality Assurance Performance			
		derately impaired. Health tobacco use was marked '			Improvement Committee. Findings wil			
	No ' on the MDS ass				reviewed by QAPI Committee monthly			
		e facility provided a list of			and Quality Monitoring (Audit) updated			
		smoke and Resident #292			changes are needed based on findings			
	was included on the I				The Quality Assurance Performance			

Facility ID: 953050

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING				C 28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025			20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 641	Continued From page 28 An observation of Resident #292 smoking was conducted on 02/24/20 at 2:10 pm. Resident #292 stated he had been smoking at the facility since he was admitted. An interview was conducted on 2/25/20 at 11:00			641	Improvement Committee meets month and quarterly at a minimum	ily	
	that a smoking asses Resident #292 upon a resident was admit the resident smoking	nager (UM). She indicated ssment was completed for admission. She stated when sted a staff member observe to ensure the resident would smoking assessment was ent #292 on 2/4/20.					
	pm with the facility's the interview, the ME Resident #292's 2/6/ assessment. She co related to tobacco us	nducted on 2/25/20 at 4:15 MDS Coordinator. During DS Coordinator reviewed 20 admission MDS onfirmed Health conditions se was marked no. The MDS I she would review the					
	at 10:08 am with the Coordinator reported MDS and the change	was conducted on 2/26/20 MDS Coordinator. The MDS I a review of Resident #292's es to Health conditions - en revised and that it was an					
	showed a revision w pm. to reflect Reside An interview was con Administrator on 2/2 indicated the MDS a						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	(X3) DATE SURV		
		345130	B. WING _		02/28/2	020
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	1 02/20/2	<u> </u>
(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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE CO	(X5) MPLETION DATE
F 641	Continued From pag	e 29	F 6	41		
	needs or what he wa Baseline Care Plan CFR(s): 483.21(a)(1)		F 6	55	3/23	3/20
	Planning §483.21(a) Baseline §483.21(a)(1) The faimplement a baseline that includes the insteffective and person that meet profession. The baseline care pl (i) Be developed with admission. (ii) Include the minim necessary to properl including, but not lim (A) Initial goals base (B) Physician orders (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recomm §483.21(a)(2) The facomprehensive care care plan if the comp (i) Is developed with admission. (ii) Meets the require (b) of this section (extension).	cility must develop and e care plan for each resident ructions needed to provide -centered care of the resident al standards of quality care. an must- nin 48 hours of a resident's rum healthcare information y care for a resident ited to- d on admission orders.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			_		(
	345130	B. WING			02/	28/2020	
NAME OF PROVIDER OR SUPPLIER CURIS AT CONCORD NURSING &	REHABILITATION CENTER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE ONCORD, NC 28025			
PREFIX (EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
dietary instructions. (iii) Any services and administered by the facilit (iv) Any updated infor of the comprehensive This REQUIREMENT by: Based on record revi interviews, the facility summary of the basel and/or resident represe reviewed for baseline #290, #292, and Resi The findings included 1. Resident #72 was a 12/27/19 with diagnost palsy, need for assist generalized anxiety disorder irritable bowed constipation. Resident #72 's Minimal admission assessment the resident 's cognit intact. Resident #72 's medibaseline care plan was a request was made to 2/25/20 for a copy of care plan with signatures Resident #72's baseline the re	treatments to be acility and personnel acting y. mation based on the details a care plan, as necessary. is not met as evidenced ew, resident and staff failed to provide a copy or line care plan to the resident sentative for 4 of 4 residents care plans. (Resident #72, dent #15) : admitted to the facility on ses that included cerebral ance with personal care, isorder, major depressive el syndrome with mum Data Set (MDS) nt dated 12/29/19 specified ion as being cognitively ical record revealed a as completed on 12/30/19. to the MDS coordinator on Resident #72's baseline	F	655	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567. The statement made in the plan of Correctionare not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance we all Federal and State regulations such all alleged deficiencies cited have been will be corrected by the date (s) indicate Response to this statement of Delicens does not constitute an admission that a deficiency is accurate. No residents we named in the citation On 2/26/2020, residents #72, 290, 292, and 15□ Baseline Care Plans were reviewed by the Minimum Data Set Nurand determined not presented timely to the residents for review. On 3/20/2020, the Minimum Data Set Nurse performed Quality Improvement monitoring of all resident admissions within the last 30 days for Baseline Car Plan review and signature. Any issues identified were addressed.	e he ons e ith that or ed. se any ere		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _				C / 28/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	12012020
				51	15 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER		С	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 655	Continued From pag	e 31	F6	355			
	Resident #72's signa	iture.			On 3/18/2020, Minimum Data Set Nurs	es	
	J				were re-educated by the Regional		
		mpleted with Resident #72 on			Minimum Data Set Nurse on Baseline		
		ho indicated she did not			Care Plan review with the Resident and	d	
	_	a copy or summary of her			RP.		
	care plan.				The Director of Nursing and/or Regions	al	
	A i t i	and the desitte the Director of			Minimum Data Assessment Nurse will		
		npleted with the Director of 26/2020 at 10:58 am. DON			perform Quality Improvement Monitoring of Baseline Care Plans for timely review		
		vith the regional consultant			with Residents and RP s on four	N	
		ated that all residents or			Resident admissions three times per		
		t sign and receive a copy of			week for four weeks, then one time per	r	
	_	an. DON stated she was not			week for two months and then one time		
		and Resident #72 did not			monthly for three months. Audits will		
	sign or receive her ca	are plan. DON stated, "We			begin 3/23/2020.		
	now know this must I	be done in the future".					
	A i t i				The Director of Nursing will report on the		
	An interview was cor				results of the Quality Monitoring (Audit	3)	
		8/20 at 2:45 pm who stated should have been signed			to the Quality Assurance Performance Improvement Committee. Findings wil	l he	
	_	family or the resident per the			reviewed by QAPI Committee monthly	, DC	
	Resident Assessmen				and Quality Monitoring (Audit) updated	if	
					changes are needed based on findings		
	2. Resident #290 wa	as admitted to the facility on			The Quality Assurance Performance		
		oses to include Type 2			Improvement Committee meets month	ly	
	Diabetes mellitus wit	hout complications.			and quarterly at a minimum.		
	Resident #290 Minim admission assessme the resident 's cogni impaired.	ent dated 2/17/20 specified			Date of Compliance is 3/23/2020.		
		lical record revealed a as completed on 2/18/20.					
		to the MDS coordinator on Resident #290 's baseline ures.					

		IDENTIFICATION NITIMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345130	B. WING_			C 02/28/2020	
	ROVIDER OR SUPPLIER	& REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		32/26/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 655	on 2/26/20 at 9:00 a Resident #290 's sig signature. An interview with Re on 2/26/20 at 9:43 a remember if he or hi copy of his care plan An interview was co Nursing (DON) on 2 stated she had met on 2/25/20 who indic representatives mus the base line care pl aware of the proces sign or receive his c now know this must An interview was co Administrator on 2/2 base line care plans and shared with the Resident Assessme 3. Resident #292 wa 2/4/20 with a diagno chronic pain, acute I Resident #292 Minir admission assessme	seline care plan was reviewed m and it did not include gnature or representative esident #290 was completed m who indicated he did not is representative received a n. Impleted with the Director of 1/26/2020 at 10:58 am. DON with the regional consultant cated that all residents or it sign and receive a copy of an. DON sated she was not is and Resident #290 did not are plan. DON stated, "We be done in the future". Impleted with the 8/20 at 2:45 pm who stated should have been signed family or the resident per the int Manual. In admitted to the facility on sees of Low back pain, other	F 6	55			
	baseline care plan w	dical record revealed a vas completed on 2/5/20. to the MDS coordinator on copy of Resident #292 's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345130	B. WING _				28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		515 LA	T ADDRESS, CITY, STATE, ZIP CODE KE CONCORD ROAD NE CORD, NC 28025	, ,	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	Continued From pag baseline care plan w		F	855			
	on 2/26/20 at 9:00 a	eline care plan was reviewed m and it did not include gnature or representative					
		mpleted with Resident #292 m who indicated he did not by of his care plan.					
	Nursing (DON) on 2, stated she had met on 2/25/20 who indice representatives must the base line care plaware of the processign or receive his care.	mpleted with the Director of /26/2020 at 10:58 am. DON with the regional consultant cated that all residents or t sign and receive a copy of an. DON stated we were not a and Resident #292 did not are plan. DON stated, "We be done in the future".					
	base line care plans and shared with the Resident Assessmen 4. Resident #15 was	8/20 at 2:45 pm who stated should have been signed family or the resident per the nt Manual. admitted to the facility on oses of pressure ulcer to					
		ssion Minimum Data Set dated 1/2/2020 revealed ognitively intact.					
	12/27/19. The care blank indicating the	line care plan was dated plan signature lines were care plan had not been esident and/or the Resident's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C 02/28/2020	
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		5212012020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 655	Continued From page 34		F 6	55			
F 656 SS=D	(MDS) Coordinator of stated the residents at 48-hour baseline care. An interview with the 2/26/2020 at 10:58 ar aware the 48-hour bareviewed, and a copy resident representation. During an interview who 2/26/2020 at 11:24 argive the resident or the of the care plan or resident. The Unit Manabeen told she should resident's responsible plan or go over it with During an interview who 2/28/2020 at 2:42 pm baseline care plan sharesident or resident regulation. Develop/Implement CCFR(s): 483.21(b)(1) \$483.21(b) Comprehe \$483.21(b)(1) The facing plement a comprehe care plan for each resident rights set for \$483.10(c)(3), that in objectives and timeframedical, nursing, and	Director of Nursing on m revealed she was not iseline care plan should be given to the resident or the ve. With the Unit Manager on m she stated she did not he responsible party a copy view the care plan with ager stated she had never give the resident or exparty a copy of the care of them. With the Administrator on she stated the 48-hour ould be reviewed with the expresentative per the Comprehensive Care Plan Comprehensive Care Plan Comprehensive care plan diensive person-centered sident, consistent with the th at §483.10(c)(2) and	F6	56		3/23/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	COMP	(X3) DATE SURVEY COMPLETED		
		345130	B. WING _		02/:	28/2020		
	ROVIDER OR SUPPLIER CONCORD NURSING	& REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	1 027	20/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 656	describe the followin (i) The services that or maintain the reside physical, mental, an required under §483 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclutreatment under §48 (iii) Any specialized rehabilitative service provide as a result of recommendations. If findings of the PASA rationale in the resident's represent (A) The resident's represent (A) The resident's p desired outcomes. (B) The resident's p future discharge. Fawhether the resident community was assolocal contact agencial entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on record reand staff interviews	omprehensive care plan must ang - care to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and to would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights adding the right to refuse 33.10(c)(6). Services or specialized es the nursing facility will of PASARR of a facility disagrees with the ARR, it must indicate its dent's medical record. With the resident and the sative(s)-oals for admission and reference and potential for acilities must document t's desire to return to the essed and any referrals to less and/or other appropriate	F6	This Plan of Correction constitute facilities allegation of compliance deficiencies citied in the CMA-256	for the			
		ed for 1 of 1 resident reviewed		statement made in the plan of Co are not admission to and do not in an agreement with alleged deficie	rrections ndicate			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION (X3) DATE S COMPLI		
		345130	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	343100	5::	CT.	REET ADDRESS, CITY, STATE, ZIP CODE	02/	28/2020
INAIVIE OF F	KOVIDER OR SUFFLIER						
CURIS AT	CONCORD NURSING	& REHABILITATION CENTER			5 LAKE CONCORD ROAD NE		
				C	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From pa	ge 36	F6	556			
	The finding include	d:			This Plan of Correction is written and		
	J				executed as to remain in compliance w	/ith	
	Resident #292 was	admitted to the facility on			all Federal and State regulations such		
	2/4/20 with a diagn	oses of Low back pain, other			all alleged deficiencies cited have beer		
	chronic pain, other	abnormalities of gait and			will be corrected by the date (s) indicat	ed.	
	mobility.				Response to this statement of Delicens		
					does not constitute an admission that a	-	
		the facility provided a list of ho smoke and Resident #292			deficiency is accurate. No residents we	re	
	was included on the			named in the citation			
	Resident #292's me	edical record revealed a			On 2-25-2020, resident #292□ Care Pl	lan	
	smoking assessme	nt was completed on 2/4/20			was updated to accurately reflect the		
		Resident #292 to be			residents use of Tobacco by the Minim	um	
	supervised when si	moking. A baseline care plan			Data Set Nurse.		
	was completed on 2	2/5/20 revealed resident was a					
	smoker.				On 3/19/2020, the Minimum Data Set		
					Nurse performed Quality Improvement		
		imum Data Set (MDS)			monitoring of all Care Plans on Reside		
		nent dated 2/6/20 specified the			who use Tobacco for Care Plan accura	асу.	
	_	n was moderately impaired. elated to tobacco use was			Any issues identified were addressed.		
	marked No on the N				On 3/18/2020, the Minimum Data Set		
	I I I I I I I I I I I I I I I I I I I	VIDO 433C33ITICITE.			Nurses were re-educated by the Regio	nal	
	The care plan date	d 2/10/20 did not identify any			Minimum Data Set Nurse on Care	· iai	
		als related to Resident #292 's			Planning of Residents who use Tobacc	ю	
	smoking or tobacco				to accurately reflect the resident.		
					The Director of Nursing and/or Regiona	al	
		Resident #292 smoking on			Minimum Data Assessment Nurse will		
		om was conducted. Resident			perform Quality Improvement Monitoring	ıg	
		been smoking at the facility			of Care Plans for Residents who use		
	since he arrived.				Tobacco behaviors on four		
	An interview was s	andusted on 2/25/20 at 11:00			Comprehensive assessments three time		
		onducted on 2/25/20 at 11:00 anager (UM). She indicated			per week for four weeks, then one time per week for two months and then one		
		essment was completed for			time monthly for three months. Audits		
		n admission. She stated when			begin 3/23/2020.	VVIII	
		nitted, the resident and a staff			50giii 0/20/2020.		
		ne resident smoking to ensure			The Director of Nursing will report on the	ne	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345130	B. WING				C 28/2020
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	02/	20/2020
					LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING	& REHABILITATION CENTER			DNCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 656	PM with the facility's the interview, the M Resident #292's 2/6 assessment. She crelated to tobacco utime, the MDS coord was no care plan in related to smoking of	-	F 6	556	results of the Quality Monitoring (Audit to the Quality Assurance Performance Improvement Committee. Findings wireviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated changes are needed based on finding The Quality Assurance Performance Improvement Committee meets month and quarterly at a minimum. Date of Compliance is 3/23/2020.	III be	
	A follow-up interview at 10:08 am with the Coordinator reporte care plan and stated revised to reflect casmoking. Resident #292's car 2/26/20 at 10:15 am was revised on 2/25 plan interventions for	w was conducted on 2/26/20 e MDS Coordinator. The MDS d a review of Resident #292's d the care plan had been re plan interventions for re plan was reviewed on n. The care plan dated 2/10/20 5/20 at 5:55 pm to reflect care or smoking. The goal stated smoker, the resident will not					
	suffer injury from un through the review of the facility policy on safety concerns. Mo smoking apron as o designated smoking An interview was co Nursing (DON) on 2 stated that Nursing would develop the of reviewed the printed	nsafe smoking practices date. Instruct resident about smoking: locations, times, onitor oral hygiene, offer ordered resident to smoke in					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345130	B. WING _		C 02/28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	02/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE COMPLETION	
F 656	baseline care plan did section regarding Sm yes was selected was DON stated she had care plan but would h section for Care Plan new form as of Nover An interview was com Administrator on 2/28 that she would expect	I not populate the next oking Care Planning when the resident a smoker. Inot printed off the baseline ave seen this did have a ning. DON stated this was a mber 1, 2019.	F6	56	
F 695 SS=D	CFR(s): 483.25(i) § 483.25(i) Respirato tracheostomy care ar The facility must ensure needs respiratory car care and tracheal succare, consistent with practice, the comprehare plan, the resider and 483.65 of this sul This REQUIREMENT by: Based on observation manufacturer 's manufacturer 's manufacturer 's manufacturer of the findings included The manufacturer 's Continuous Positive Acleaning recommends	ind tracheal suctioning. In that a resident who is including tracheostomy Itioning, is provided such professional standards of itensive person-centered Its' goals and preferences, part. It is not met as evidenced Ins, record review, It is included to clean It for 1 of 1 resident reviewed Resident #12).	F6	This Plan of Correction constitutes th facilities allegation of compliance for t deficiencies citied in the CMA-2567 statement made in the plan of Correctare not admission to and do not indican agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance all Federal and State regulations such all alleged deficiencies cited have bee will be corrected by the date (s) indicates the corrected by	he The tions ate es. with a that en or ated.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345130	B. WING		C 02/28/2020
NAME OF PE	ROVIDER OR SUPPLIER		1 9	STREET ADDRESS, CITY, STATE, ZIP CODE	02/20/2020
NAME OF T	TO VIDER OR OUT LIER			, , ,	
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER	I	515 LAKE CONCORD ROAD NE	
				CONCORD, NC 28025	
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 695	Continued From page	≥ 39	F 695		
	tubing thoroughly and	inse the water tub and air I allow to dry out of direct		does not constitute an admission that a deficiency is accurate.	any
	sunlight and/or heat. Further review of the manual revealed a recommendation to clean the air filter and replace it at least every six months.				
	1			On 2-25-2020 the Continues Positive	
		addition, replace the air filter more often if there Airway Pressure machine filter was			
	are any holes or blockages by dirt or dust and the air filter was not washable or reusable.			changed and will be changed per facilit	-
				policy. Facility policy is per manufactur	
		the recommendations are to		recommendation (every six months an as needed). An ordered was confirmed	
	handwash the mask components with warm water with a mild soap, rinse with drinking quality water, and allowed to air dry, daily/after each use.			and written on 3-20-20 for cleaning	
				Continues Positive Airway Pressure ma	ask
	water, and anomou to	an ary, danyraner each acc.		and tubing daily. resident # 12	
	Resident #12 was ad	mitted to the facility on		and tabing daily. Fooldon: # 12	
		nt 's cumulative diagnoses		CPAP cleaning of masks and tubing wa	as
	included: Dementia, o	chronic obstructive		provided as ordered for Resident # 12	
	pulmonary disease (C	COPD), obstructive sleep		(3-20-20).	
	apnea, restlessness a	and agitation.			
				An audit of all residents with CPAP	
		t recent Minimum Data Set		Respiratory equipment was completed	to
		d an annual comprehensive		ensure that cleaning is provided as	
		Assessment Reference Date		ordered by the physician. Audit comple	ted
		of the assessment revealed		on 3-20-20 by Director of Nursing	
		ed as having moderate and was not coded as		A Visual audit of residents was comple	tod
	having used a CPAP			by the DON on 3-20-20 to validate a	ieu
	naving used a Or Ar	device.		resident that is receiving CPAP	
	Resident #12 's care	nlan which was last		Respiratory therapy equipment has an	
		revealed the resident had a		order and those residents with an orde	
		of a CPAP machine at night		for CPAP Respiratory therapy equipme	
	related to ineffective			are receiving it.	
		ory illness. Review of the		_	
	interventions revealed	d no recommendations or			
		cleaning, servicing, or		On 3-20-2020 Licensed staff educated	by
	maintenance of the m	nachine.		Director of Nursing or/Unit Manager	
				regarding the importance of following	
	Resident #12 's Med			physician orders for maintenance and	
	, ,	/20 through 2/24/20 was		cleaning of CPAP Respiratory equipme	
	reviewed. The review	v revealed the resident had		and ensuring those residents with orde	rs

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345130	B. WING				C 28/2020
NAME OF PE	ROVIDER OR SUPPLIER	0.0.00	 	S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	20/2020
NAME OF T	TOVIDER OR SOLT EIER						
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER			15 LAKE CONCORD ROAD NE		
					CONCORD, NC 28025		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	e 40	F 6	395			
		20, to receive have a CPAP			for maintenance and cleaning of CPAP)	
					are receiving it.		
	on at night and remove in the morning. The application and removal of the CPAP was signed				are receiving it.		
	by several nurses for				Audits will be conducted by Director of		
	by several harses for	the reviewed period.			Nursing/Nurse Managers to monitor		
	An observation condu	ucted in conjunction with an			residents with CPAP Respiratory		
		ent #12 in his room, on			equipment to ensure maintenance and		
	2/23/20 at 12:05 PM,	•			cleaning of CPAP respiratory equipmen		
	•	mask on the nightstand			provided and with an order by the		
		s bed. Closer observation of			physician. This audit will be conducted	on	
	the CPAP machine re	evealed a buildup of			all residents with CPAP Respiratory		
		debris over a series of			equipment 5 x per week x 12 weeks		
	holes on the lower lef	ft side of the machine.					
	Further observation r	evealed the facial mask			Effective 3-20-2020 the director of nurs	sing	
	connected to the tubi	ng had dried white debris			will report the findings of the audits and	t	
	and white flakes on the	ne inside, mouth and nose			observations to the Quality Assurance and		
	facing, part of the ma	sk. The resident stated he			Performance Committee for any addition	onal	
	had not used the CPA	AP machine in a few nights			monitoring or modification of this plan		
	because he did not h	ave water to put into it. A			monthly for 3 months. The Quality		
		er for the CPAP machine			Assurance and Performance		
	was observed on the	upper shelf of the			Improvement Committee can modify the	is	
	nightstand.				plan to ensure the facility remains in		
					compliance		
		conducted in conjunction					
		Resident #12 in his room,					
		M, revealed the CPAP					
		mask on the nightstand					
		s bed. Closer observation of					
	the CPAP machine re	·					
	• •	debris over a series of					
		ft side of the machine.					
		evealed the facial mask					
		ng had dried white debris					
		ne inside, mouth and nose					
	•	sk. Inspection of the bottom					
		revealed a service sticker					
	which had a service of	•					
		ety inspection of May 2019 next service of November					

STATEMENT OF AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	_ (X3	3) DATE SURVEY COMPLETED
		345130	B. WING _		_	C 02/28/2020
	OVIDER OR SUPPLIER	& REHABILITATION CENTER		STREET ADDRESS, CITY, S 515 LAKE CONCORD RO. CONCORD, NC 28025	AD NE	02/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	company 's contact stated he had used and there was a dat for the CPAP machi resident 's nightstar A third observation of Resident #12 in conthe Director of Nurs AM, revealed the Cimask on the nightstar bed. Closer observative and bed over a series of hole machine. Further of mask connected to debris and white flamose facing, part of the mask did not appear as it had be stated second shifts the might or third shifts the tubing. The DON stated the sink in the bathred outside of nursing. A phone interview was a phone interview was a data of the contact of the machine. The DON stated the sink in the bathred outside of nursing. A phone interview was a data of the contact of	Iso contained the service information. The resident the CPAP machine last night ed bottle of water to be used ne on the top shelf of the	F	95		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			02/	28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		1 0211	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 695	2019, he had not reconfacility regarding serve and he had not been service on a machine service technician state filters they would pressure settings in the correctly and the right being produced. A fourth observation of Resident #12 in conjusting produced. A fourth observation of Resident #12 in conjusting the Administrator, on revealed the CPAP in the nightstand next to observation of the CF buildup of whitish/graseries of holes on the machine. Further observation of the was opened which revisibly built up with whe point the dust wavent holes on the filter stated the filter had a matter, and it appears cleaned or replaced. was her expectation of manufacturer 's reconcare and maintenance. A second interview woon 2/25/20 at 2:18 PN expectation to follow guidelines. The DON	cian stated since October eived information from the ricing their CPAP machines to the facility to conduct in November of 2019. The sted in addition to changing also make sure all of the he machine were set up to amount of pressure was conducted in the room of sunction with an interview with 2/25/20 at 2:14 PM, sachine, tubing, and mask on the resident 's bed. Closer PAP machine revealed a sy dust and debris over a solower left side of the servation revealed the facial set tubing had dried white eas on the inside, mouth and he mask. The air filter cover vealed a small air filter thite/gray dust and debris to so built up in the pattern of the er cover. The Administrator buildup of gray/white dust ed to need to either be The Administrator stated it for to follow the mmendations regarding e of the CPAP machine.	F	595			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3	O DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		V 2 2 3 3 3 3 3 3 3 3 3 3
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	the filters with central stated there used to (RT) company who was prior to October 2019 CPAP machines. The filters and would also	ne 43 but would discuss ordering al supply. The DON also be a Respiratory Therapist would come out to the facility and service the facility 's ne RT company checked the bucheck the settings on the ake sure they were correct.	F	695		
F 756 SS=D	During an interview of 2/26/20 at 12:39 PM be following their policy: Respiratory Expectation was for policy regarding care CPAP machine. The was not information changing the filter fo would follow up with	with the Administrator on she stated the facility would licy titled, Infection Control Equipment, and her the facility staff to follow the e and filter changes for the e Administrator stated there in the policy regarding r a CPAP machine and she the nursing department.	F	756		3/23/20
	must be reviewed at licensed pharmacist. §483.45(c)(2) This re of the resident's med §483.45(c)(4) The plirregularities to the a facility's medical dire and these reports medical through that meets the (d) of this section for	rug regimen of each resident least once a month by a eview must include a review dical chart. narmacist must report any ttending physician and the ector and director of nursing,				

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	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	E .	02/20/2020
(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)	I SHOULD BE	(X5) COMPLETION DATE
F 756	separate, written reputattending physician and director and director and the irregularity the sident's medical regularity has been action has been take be no change in the rephysician should door the resident's medical selection has been take be no change in the rephysician should door the resident's medical selection has been take be no change in the rephysician should door the resident's medical selection has been take be no change in the rephysician should door the resident's medical selection has been take be no change in the rephysician should door the resident's medical selection has been take be no change in the rephysician should door the resident's medical selection has been take be no change in the rephysician should door the resident review limited to, time frame the process and step when he or she ident requires urgent action. This REQUIREMENT by: Based on record review pharmacist interviews consultant failed to idiregularity regarding Level during a reside of 4 residents review medications (Resident #145 was a 2/6/2020 with diagnormal directors and directors are rephysically selection.	ast be documented on a cort that is sent to the and the facility's medical of nursing and lists, at a nt's name, the relevant drug, we pharmacist identified. A spician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in all record. Collity must develop and procedures for the monthly that include, but are not is for the different steps in is the pharmacist must take iffies an irregularity that in to protect the resident. If is not met as evidenced item, and staff and is the facility's pharmacy dentify and report an a critically high Vancomycin int's medication review for 1 and for unnecessary int #145). I dmitted to the facility on sees of metabolic comyelitis, sepsis, diabetes kidney disease.	F 7	This Plan of Correction const facilities allegation of compliat deficiencies citied in the CMA statement made in the plan of are not admission to and do n an agreement with alleged de This Plan of Correction is write executed as to remain in com all Federal and State regulational alleged deficiencies cited h will be corrected by the date (Response to this statement of does not constitute an admission deficiency is accurate. Resident #145 was transferre	nce for the -2567. The forrection not indicate ficiencies. ten and pliance withons such that ave been os) indicated f Delicense sion that any	s n at or l.

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345130	B. WING			1	
NAME OF D		343130	D: W(0 _		TREET ARRESTO CITY OTATE ZIR CORE	02/	28/2020
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER			15 LAKE CONCORD ROAD NE		
				С	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	e 45	F7	756			
	"Vancomycin Hydrochloride Injection solution reconstituted 1 gram intravenously two times a day for Methicillin Resistant Staphylococcus Aureus (MRSA) until 3/2/2020" by the Primary				hospital for further evaluation and will not be readmitting.	iot	
					All residents on requiring medications t require lab monitoring have the potention to be affected. As a result, an audit on	al	
	Vancomycin Trough (ated 2/10/2020 specified a blood test to check the			residents on medications requiring additional lab assessments prior to		
	to be administered 30	Resident #145's blood) was I minutes prior to ration every Monday and the			administering medication will be conducted 2/27/20. All licensed nursing staff will be educated on reading labs a		
	results were to be fax	ed to the Infectious Disease tious Disease Center within			the reporting process for critical labs pr to administration of medications 2/26/2	ior	
	24 hours of drawing s				On 2/28/20 The pharmacist consultant was educated on reviewing labs during		
	marked reported by the	n collected on 2/10/2020 and ne laboratory on 2/10/2020 45's Vancomycin level was			her monthly review of the electronic medical record.		
	critical at 41.52 micro with a normal referen	grams/milliliter (mcg/ml) ce range of 10.00 to 20.00			The lab results for resident #145 were scanned into the medical record at the		
	mcg/ml.				time of the pharmacist consultant revie Labs for medication requiring lab	w.	
	Supervisor on 2/27/20	r stated Resident #145's			monitoring will be drawn per order and results scanned into medical records at review by facility physician.	fter	
	processed on 2/10/20	020 at 5:15 pm and was atory website at 6:19 pm on			The Director of Nursing Services, or designee, will audit all potentially affect	ed	
	2/10/2020. The Labo facility had access to	ratory Supervisor stated the the results at that time. The			residents□ lab results and documentation of communication between the facility a	ion and	
	laboratory level is not	r stated once a critical ed they immediately call the She stated the Laboratory			physician regarding critical labs 5 time week x 4 weeks, then 3 times a week x then weekly x 1 month or until corrective	4,	
	-	erous times but could not			action is achieved.	5	
	facility's phone. The stated on 2/10/2020 to	Laboratory Supervisor also			The pharmacy report along with a mon- lab order listing report will be reviewed monthly by the Director of Nursing, Uni Manager or Supervisor. Any labs for	-	

Facility ID: 953050

		(X3) DATE COMF	SURVEY				
		345130	B. WING			1	C / 28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE ONCORD, NC 28025	1 021	20/2020
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	2/10/2020 there was Disease Physician at Center or the resident the resident's criticall 41.52 milligrams/millino physician's order the administration of twice a day based on Vancomycin level. Review of the Pharm dated 2/12/2020 for Flaboratory results we irregularities were found.	ical record revealed on no indication the Infectious the Infectious Disease t's physician was notified of y high Vancomycin level of liter. Additionally, there was written on 2/10/2020 to stop the resident's Vancomycin the resident's critically high acist's Medication Review Resident #145 revealed the re reviewed and no und. The pharmacy review esident's 2/10/2020 critical	F	756	medication monitoring not identified on pharmacy report will be addressed. Findings will be reviewed with the administrator weekly. Results will be discussed and addressed as needed during the facility s monthly Quality Assessment and Performance Improvement (QAPI) meeting.		
F 757 SS=J	she reviewed Reside 2/12/2020, but was n a critical Vancomycin 2/10/2020. The Phar aware Resident #145 the pharmacy was not Resident #145's Vanc Disease Clinic was for Drug Regimen is Free CFR(s): 483.45(d) Unnecess Each resident's drug	2020 at 10:48 am revealed on the #145's medications on so to informed the resident had a Trough of 41.52 mcg/ml on smacist stated she was a was on Vancomycin, but so the involved in dosing comycin since the Infectious sollowing him. The from Unnecessary Drugs (6) The sary Drugs-General companies of the involved in	F	757			2/28/20

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN			DATE SURVEY COMPLETED	
		345130	B. WING _		1	2/28/2020	
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 757	Continued From page duplicate drug theral supplicate drug theral supplicate drug theral supplication supplica	the 47 by); or coessive duration; or cut adequate monitoring; or cut adequate indications for its presence of adverse indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or combinations of the reasons indicate the dose should be ued; or c	F 7	DEFICIENCY)	es the e for the orrections indicate encies. and ance with such that		
	to the hospital for every the hospital the residence Vancomycin Level of milliliters, a critically 7.07 milligrams per conclude a cute renal failure at Intensive Care Unit.	esident #145 was transferred aluation and treatment. At dent had a critically elevated f 87.3 micrograms per elevated Creatinine level of deciliter, was diagnosed with and placed in the hospital's At the time of the survey, ined in the hospital with upport.		will be corrected by the date (s) in Response to this statement of De does not constitute an admission deficiency is accurate. Resident #145 continued to receive Vancomycin intravenously after the drew a trough level on 2/10/20 we elevated levels reported to the fathe laboratory portal on 2/10/20 at to the laboratory and noted by the	elicense I that any ive he facility ith icility on according		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C 02/28/2020	
NAME OF P	ROVIDER OR SUPPLIER	2.2.2.2	<u> </u>	SI	TREET ADDRESS, CITY, STATE, ZIP CODE	1 027	20/2020
	101.52.1.01.100.1.2.2.1		515 LAKE CONCORD ROAD NE		, , ,		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER	CONCORD, NC 28025				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 757	Continued From page	e 48	F 7	757			
F /3/	Immediate Jeopardy the facility failed to im address Resident #14 Level and continued a Vancomycin until 2/19 Jeopardy was remove facility provided and i allegation of immediate facility remained out a scope and severity le potential for more that immediate jeopardy) systems were put into Findings included: Resident #145 was a 2/6/2020 with diagnose encephalopathy, oste and stage III chronic A physician's order da "Vancomycin Hydrocl reconstituted 1 gram day for Methicillin Reaureus (MRSA) until Physician. A Care Plan for Resides pecified, he had a direlated to Methicillin Faureus (MRSA) and in antibiotic therapy. The Resident #145's labo should be obtained a Resident #145's Febr	began on 2/10/2020, when aplement measures to 45's critical Vancomycin to administer the resident's 20/2020. The Immediate ed on 2/28/2020 when the implemented a credible the jeopardy removal. The for compliance at a lower evel of D (no actual harm with an minimal harm that is not to ensure monitoring to place are effective. In different to the facility on sees of metabolic comyelitis, sepsis, diabetes actioned intravenously two times a sistant Staphylococcus 3/2/2020" by the Primary I dent #145 dated 2/6/2020 agnosis of osteomyelitis required intravenous are Care Plan also stated aratory and diagnostic work and monitored as ordered.		757	of Nursing (DON) on 2/11/20 through the laboratory portal. The facility began having scattered problems with phone transmission on 2/10/20 but with a server reset, it appeared that faxes were being received and phones were working. On the ever of 2/11/20 the DON realized that no laboratory results had been received by fax on that day, 2/11/20, and DON ope the lab portal on the computer to pull a results for the day and identified the critical lab alert. In checking, the laboratory reported that multiple attems were made to reach the facility on 2/10 and were unsuccessful. Neither realized that fax reports were also not reaching facility. The DON pulled the critical alert from the laboratory portal, late in the day on 2/11/20 and due to the time of day, the DON did not call the Infectious Disease office who had ordered the Vancomycin trough until the morning or 2/12/20. When the DON attempted to reach the Infection Disease practice on 2/12/20 to report the result, the DON was unable to reach a person and left a message on the Nurse Line providing the name of resident #10 the resident □s date of birth, the critical value and informed them that the phone and faxes were not working consistent the facility at that moment and asked they contact the Director of Nursing, (DON) on the DON □s cell phone to give orders. When the DON had not receive a response from Infectious Disease physician by 2/13 DON again contacts.	ed ning y ned II ots /20 ed the ne es n nen ous ne se 45, lab es y in nat	
	Administration Recor	ruary 2020 Medication d noted from 2/6/2020 to nt received Vancomycin			a response from Infectious Disease physician by 2/13, DON again contacte the Infectious Disease office and left a	ed	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345130	B. WING _			l o:	2/28/2020	
NAME OF P	ROVIDER OR SUPPLIER	-	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				51	5 LAKE CONCORD ROAD NE			
CURIS AT	CONCORD NURSING	G & REHABILITATION CENTER		CC	ONCORD, NC 28025			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 757	Continued From p	age 49	F 7	757				
	Hydrochloride Inje	ection Solution Reconstituted 1			second message on the Nurse Line.	⊺he		
	gram two times a	day for Methicillin Resistant			Infectious Disease office nurse claims	to		
	Staphylococcus A	ureus (MRSA).			have attempted to call the facility on 2/	12		
					and 2/13 repeatedly but was unable to			
	_	lated 2/7/2020, written by the			reach the facility by phone. The Infect			
		r, stated Resident #145 was			Disease nurse did not attempt to reach			
		ission to the facility. The			the DON on the DON□s cell phone as			
	, , ,	o stated Resident #145 was			directed on the two messages left.			
		ycin intravenously until 3/2/2020			According to the DON the Nurse			
	_	lowed by the Infectious Disease			Practitioner (NP) was made aware of t			
		ess note also specified the			critical lab on 2/12/20 while in the facili	ty		
		ory results and dosing of the			and instructed the Nurse to notify			
	vancomycin would	d be done by the pharmacy.			Infectious Diseases. The NP has deni	ea		
	A physician's ords	or datad 2/10/2020 appointed			knowing about the critical lab.			
		er dated 2/10/2020 specified gh (a blood test to check the			The Vancomycin trough was again scheduled for 2/17/20 but as the 2/10/2	20		
		in Resident #145's blood) was			result remained unresolved, the Nurse			
		d 30 minutes prior to			not add the Vancomycin trough to the	uiu		
		nistration every Monday and the			laboratory requisition or draw it thirty			
		xed to the Infectious Disease			minutes prior to the next dose as would	d		
		nfectious Disease Center within			be required for a trough. According to			
	24 hours of drawir				record, the DON notified the Nurse			
	2 mouro or arawn	ig specimen.			Practitioner on 2/18/20 about the critic	al		
	A Vancomycin Tro	ough collected on 2/10/2020 and			value of 2/10/20 and the order was pla			
		by the laboratory on 2/10/2020			to discontinue the Vancomycin until the			
		t #145's Vancomycin level was			Infectious Disease practitioner could b			
		icrograms/milliliter (mcg/ml)			reached. Infectious Diseases and the			
		rence range of 10.00 to 20.00			DON finally made contact on 2/20/20 t	0		
	mcg/ml.	•			discuss the critical lab result of 2/10/20)		
					resulting in an order to send send			
	Resident #145's n	nedical record revealed on			Resident #145 to the hospital by the			
	2/10/2020 there w	as no indication the Infectious			Infectious Disease office.			
		n at the Infectious Disease			The DON failed to make contact with t	he		
		dent's physician was notified of			Nurse Practitioner or the Medical Direct			
		cally high Vancomycin level of			for instructions when the DON was una	able		
		lditionally, there was no			to contact the Infectious Disease			
	1	written on 2/10/2020 to stop the			doctor⊡s office and continued to			
		he resident's Vancomycin twice			administer the Vancomycin resulting in			
	a day based on th	e resident's critically high			toxic level of Vancomycin in the Reside	ent		

Facility ID: 953050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	3.0.00		ς.	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	28/2020	
NAME OF PI	ROVIDER OR SUPPLIER							
CURIS AT	CONCORD NURSING	& REHABILITATION CENTER			15 LAKE CONCORD ROAD NE			
				С	ONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 757	Continued From pa	nge 50	F 7	757				
	Vancomycin level.				#145. Resident #145 was hospitalized	on		
	,				2/20/20 with elevated Vancomycin leve			
	Review of the Phar	macist's Medication Review			and remains hospitalized as of 2/27/20			
		r Resident #145 revealed the			Any resident who is administered			
		vere reviewed and no			medications where doses and			
		ound. The pharmacy review			administration depend on blood levels,	(ie:		
	•	resident's 2/10/2020 critical			Coumadin and Levothyroxine) would h			
	Vancomycin level o	of 41.52 mcg/ml.			the potential to be affected by a failure			
	•	C			properly monitor those levels. To assu			
	A Progress Note da	ated 2/12/2020, written by the			no other residents were affected by the			
	Nurse Practitioner	(NP), specified Resident #145			same circumstances of telephone and	fax		
	was receiving Vano	comycin intravenously and the			issues and the decisions made around			
	Infectious Disease	Clinic and Pharmacy were			managing critical labs, on 2/26/20 and			
	monitoring the dose	e. The NP progress note did			2/27/20 the Staff Development			
	not mention the res	sident's 2/10/2020 critical			Coordinator, DON and Regional Direct	or		
	Vancomycin level o	of 41.52 mcg/ml.			of Clinical Services reconciled the last			
					thirty (30) days of lab listings from Poir	ıt		
	An Admission Minir	mum Data Set (MDS)			Click Care, compared these to the			
		2/12/2020 revealed Resident			laboratory requisitions used to draw			
	#145 was cognitive	intact. The Admission MDS			laboratory specimens and examined th	e		
		r revealed Resident #145 was			results received. No other laboratory			
	on antibiotics and h	nad diagnosis of septicemia.			orders had been missed and no other			
					critical labs had not been reported. her			
	•	ated 2/14/2020, written by the			are no other residents being administe	red		
		specified Resident #145 was			antibiotics that require laboratory			
	-	cin. The progress note also			monitoring by intravenous methods at	ihis		
	-	Disease was monitoring the			time			
		therapy. The NP progress			Specify the Action the Facility will take	to		
		on the resident's 2/10/2020			alter the process or system failure to			
	critical vancomycin	level of 41.52 mcg/ml.			Prevent a Serious Outcome from			
	On 0/47/0000 /: *4	anday) a Vanaanseelia Teereeli			occurring or reoccurring and when the			
	,	onday) a Vancomycin Trough			Action will be complete.			
		Resident #145 on this Monday			The facility had experienced telephone			
	as ordered on 2/10	/ZUZU.			and fax transmission inconsistencies a	na		
	A Drogress Note de	atod 2/17/2020 written by the			had contacted the telephone service			
	•	ated 2/17/2020, written by the			provider (Jetway) and the Information			
		stated Resident #145 was			Technology firm on 2/10/20 to forward			
		oost admission follow-up. The er specified Resident #145			calls to the facility cell phone number which was held by the Receptionist to			
	progress note fulfill	or opposition regulation # 170			willou was field by the Receptionist to			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		PLETED
		345130	B. WING			l	C / 28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING	& REHABILITATION CENTER		515	REET ADDRESS, CITY, STATE, ZIP CODE 5 LAKE CONCORD ROAD NE DNCORD, NC 28025	, <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 757	Continued From pa	ge 51	F	757			
	was tolerating intrav Vancomycin dose w disease clinic and p note did not mentio critical Vancomycin On 2/19/20 a physic Nurse Practitioner t Vancomycin. A Nurse's Note date written by Nurse #3 sent to the Emerge laboratory findings a with the Infectious I The hospital History 2/20/2020, stated th from the hospital to Creatinine of 1.47m to the hospital on 2 7.07 milligrams/decirange for Creatinine milligrams/deciliter) also stated Nephrol Resident #145's ac related to Vancomy hypotension. Resid Trough level was 8 he returned to the h range for a Vancom 20.00 mcg/ml). An interview was co pm with the Directo stated the resident's Trough Level that w to the Infectious Dis	venous Vancomycin and the vas managed by the infectious sharmacy. The NP progress in the resident's 2/10/2020 level of 41.52 mcg/ml. cian's order was written by the o hold the resident's ed 2/20/2020 at 12:45 pm , stated Resident #145 was incy Room for abnormal after Director of Nursing spoke			answer all incoming calls and faxes we forwarded to the email address of the Business Office Manager in effort to resolve the issue. The initial recommendation by Information Technology to reset the server appears to correct the problem which gave the facility a sense of confidence that the communication issues were resolved. On 2/11/20 the DON realized that the problem was occurring again, the telephone service provider (Jetway) and the IT firm were again notified. The problem was fully resolved on 2/17/20 at telephone and fax service has been consistent since that time. The Administrator□s and the Director of Nursing□s cell phone numbers as well the facility cell phone number have been provided to the laboratory, pharmacy, X-ray, Infectious Disease and Medical Director in order to provide a back up number for emergency contact in the event of if these providers are unable to reach the facility. As the DON was responsible for failing notify the Medical Director when the DON was unable to reach the prescribing physician immediately (within two hours receiving the Critical value), the DON were-educated by the Regional Director of Clinical Services on both 2/26 and 2/27 with an emphasis on the urgency of reporting Critical lab values and change in condition to the physician and the Medical Director if unable to reach the physician. The DON received a verbal counseling session that required a	d and of as en	

Facility ID: 953050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(C	
		345130	B. WING _			02/	28/2020	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
CUDIC AT	CONCODD NUIDSING 8	REHABILITATION CENTER		51	5 LAKE CONCORD ROAD NE			
CURIS AI	CONCORD NURSING 6	REHABILITATION CENTER		C	ONCORD, NC 28025			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 757	Continued From pag	e 52	F 7	757				
	Trough level was crit The DON also specif #145 was transferred Vancomycin Trough function. An interview was cor Disease (ID) Nurse of ID nurse stated she is message from the fa which stated Resides Level was 41.52 mod she immediately calle but no one answered stated she also calle 2/13/2020, but could	ne resident's Vancomycin ically high at 41.52 mcg/ml. fied on 2/20/20 Resident of to the hospital due to a high Level and poor kidney Inducted with the Infectious on 2/27/2020 at 8:58 am. The received a voice mail cility's DON on 2/12/2020 on #145's Vancomycin Trough of the facility on 2/12/2020, of the facility's phone. She of the facility several times on not reach anyone. She 8/2020 she called the facility			counseled on by the Regional Director Clinical Services on 2/27/20. On 2/26/20 the Administrator, DON and SDC began in-servicing all nurses on the importance of 1) informing the physicial about any significant changes in condit 2) the process for assuring order listing for lab draws are correctly entered in the lab draw book for the following morning 3) the process for assuring that blood is drawn as ordered, 4) the process for confirming that results are received. In-services of nurses include a clarified process by which the nurse will immediately contact the prescribing physician to report any abnormal lab values for medication monitoring. A message left must be returned within the	d ne n ion. s ne J,		
	nurse who was carin Infectious Disease N her she could not reather facility and would to call her back. The stated she called the (2/19/2020) and spol She said the DON in did not hear back fro Clinic on 2/12/2020, message about the r Vancomycin level, the administration of the medication until 2/19 Disease Nurse further informed her that the medication was not complete the service of the servi	#6 and asked to speak to the g for Resident #145. The urse stated Nurse #6 told ach anyone on that side of I ask the Director of Nursing Infectious Disease Nurse facility again on Wednesday are to the Director of Nursing. Informed her when the facility m the Infectious Disease after she left the voice esident's critically high e facility did not stop the resident's vancomycin /2020. The Infectious er stated after the DON er resident's Vancomycin discontinued on 2/12/2020 of Nursing that Resident immediately to the			hours or the nurse will call the facility — Medical Director to advise of the abnor value and get instructions for managing the elevated level. The nurse is instructed not to continue to administer the medication associated with the elevated blood level until the nurse has received clear instructions from the physician. In-servicing also stressed that nurses must inform the medical director about any significant changes in condition if unable to reach the attending or consulting physician who may have initially ordered medication or treatment and prior to administering any such medication or treatment. CNAs were in-serviced on the importance of report any changes in condition to the Nurse charge immediately both in writing/verb	mal g t t ing n		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG	, , ,	TE SURVEY MPLETED
		345130	B. WING			C 2/28/2020
NAME OF P	ROVIDER OR SUPPLIER	0.0.00	 	STREET ADDRESS, CITY, STATE, ZIP C	•	2/28/2020
TVAIVIL OF T	TOVIDER OR GOLT EIER			, , ,	OBL	
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER		515 LAKE CONCORD ROAD NE		
				CONCORD, NC 28025		
(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 (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 757	Continued From page	e 53	F 7	57		
	Emergency Room du	ie to renal failure.		through the Stop and Watch	h ticket as well	
	An interview with the			as placing a Nurse Alert on		
		20 at 9:19 am revealed with		Care wall kiosk system in w		
	_	n level of over 20 mcg/ml the		document care. Staff who		
	resident's Vancomyci			assigned to work on 2/26 o		
	_	ian stated continuing to		contacted by telephone and		
		nt's Vancomycin at the same		the requirement. Each will		
		ısed Resident #145's renal		in-serviced in person prior t		
	failure.			the floor.	Ü	
				The Administrator and the [Director of	
	An interview with the	Nurse Practitioner on		Nursing completed the in-se	ervice of all	
	2/27/2020 at 9:50 am	revealed he stated the		employed nurses and CNA	s on 2/27/20.	
	Infectious Disease C	linic was following Resident		In addition, the instruction h	nas been	
	#145's Vancomycin a	and he was not aware of the		added to the Nurse and CN	IA Orientation	
	Vancomycin trough b	eing elevated on 2/10/2020		programs to assure that fut	ure nursing	
		2020. The NP stated on		staff fully understands both		
	2/17/2020 he gave a	n order to stop the		importance and the process	s for reporting	
	-	otify the infectious Disease		changes in condition, abnor		
		levels, but he did not		other diagnostic findings im		
		se he spoke to regarding the		the physician or NP. The fa		
		actitioner stated he did not		contract with any outside st		
	_	as not written to stop the		or use agency or contract s		
	resident's Vancomyci	in until 2/19/2020.		future this occurs, the nursi		
				for that shift will be respons		
		resident's Primary Physician		providing written instruction	i to that agency	
		2 am revealed he saw		staff person.		
		10/2020, but was not aware		To assure that the complica		
		ated Vancomycin Trough		phones and faxes inconsist	•	
		aff had notified him of the		reoccur, the Administrator of		
		gh Vancomycin he would		Information Technology ser		
	have stopped the Vai	ncomycin.		worked with the telephone		
	An interview	dusted with The Laber-term		resolve the issues. Telepho		
		iducted with The Laboratory		services are working depen		
		020 at 1:45 pm. The lab		2/17/20. The back up cell		
	-	sident #145's 2/10/2020		has been established as ab		
		evel was processed on		extra measure in assuring t		
		and were released on the		from the facility who is in a	•	
		6:19 pm on 2/10/2020. The		responsibility can be reached		
	Laboratory Superviso	or stated the facility had		Immediate Jeopardy is rem	oved as of	

Facility ID: 953050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C 02/28/2020	
NAME OF P	ROVIDER OR SUPPLIER		· I	STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER	515 LAKE CONCORD ROAD NE				
oonio Ai	CONTOCKE NOROMO G	REHABIEHARION GENTER		CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
F 757	Continued From page		F 7				
	access to the results Supervisor stated one is noted they immedia facility. She stated the facility numerous time because no one was phone. The Laborator results to the facility at A second interview was conducted on 2/2 DON revealed she die #145's Vancomycin To 2/17/2020. The Direct normal procedure registre orders are entere Physician and Nurse shift supervisor prints fills out a laboratory relaboratory test ordere sheets are placed in the phlebotomist. The phlaboratory specimens Director of Nursing stare printed to the fax room. She stated if the working the supervisor results from the labor The Director of Nursing responsible for printing the fax machine was also the Unit Manager	at that time. The Laboratory ce a critical laboratory level ately call the Nurse at the le Laboratory called the les but could not get through answering the facility's but Supervisor also stated on ry faxed Resident #145's lab as well. Which the Director of Nursing 27/2020 at 2:00 pm. The dunct know why Resident frough was not drawn on ctor of Nursing stated the garding laboratory tests is duinto the computer by the Practitioner and the evening of the order listing report and request sheet for each led. The laboratory request the lab book for the laboratory results machine in the medication the fax machine is not or or unit manager prints the latory site on the computer.		2/28/20.			
	working properly from and Resident #145's print to the fax machi retrieve the results of	n 2/10/2020 to 2/17/2020 2/10/2020 lab results did not ne. She stated she did not the resident's 2/10/2020 drawn until 2/12/2020, but					

	IDENTIFICATION NUMBER:			RUCTION	(X3) DATE SURVEY COMPLETED	
	345130	B. WING _			1	C 28/2020
	REHABILITATION CENTER	•	515 LAKE	E CONCORD ROAD NE	,	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI TAG	Κ			(X5) COMPLETION DATE
confirmed the reside accessible on the lab Director of Nursing s Resident #145's Van 2/10/2020 to the Nur when she printed the website on the comp to hold the resident's An interview with the Pharmacist on 2/28/2 she reviewed Reside 2/12/2020, but was ra critical Vancomycir 2/10/2020. The Pha aware Resident #145's Van Disease Clinic was for An interview with the 2/28/2020 at 11:32 a notified of the Reside Vancomycin Trough Medical Director state the Vancomycin imm notified of the reside continuing to adminishave led to the reside continuing to	oratory's website. The tated she gave the results of comycin Trough drawn on se Practitioner on 2/12/2020 e results from the laboratory uter and the NP did not say a Vancomycin at that time. facility's Consultant 2020 at 10:48 am revealed ent #145's medications on not informed the resident had a Trough of 41.52 mcg/ml on reacist stated she was a was on Vancomycin, but not involved in dosing comycin since the Infectious collowing him. facility's Medical Director on me revealed he was not ent #145's 2/10/2020 critical drawn of 41.52 mcg/ml. The ed he would have stopped ediately if he had been not's critical level and ester the Vancomycin could ent's renal failure. The content stated the Infectious nanaging the dosing of comycin and they were of the laboratory result.	F	757			
stated the facility call	ed on 2/10/2020 to report					
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page confirmed the reside accessible on the lab. Director of Nursing seed Resident #145's Van 2/10/2020 to the Nurwhen she printed the website on the compto hold the resident's An interview with the Pharmacist on 2/28/2 she reviewed Reside 2/12/2020, but was notifical Vancomycin 2/10/2020. The Pharmacy was not Resident #145's Van Disease Clinic was for An interview with the 2/28/2020 at 11:32 a notified of the Reside Vancomycin Trough of Medical Director state the Vancomycin immedical Director state the Vancomycin immedical Director also Disease Clinic was notified of the resident #145's Van Disease Clinic was notified of the resident process of the Vancomycin immedical Director also Disease Clinic was notified by voicemail. An interview was continuing to administ have led to the resident #145's Van notified by voicemail. An interview was continuing to administ have led to the resident process of the resident #145's Van notified by voicemail. An interview was continuing to administ have led to the resident process of the resident pro	CORRECTION IDENTIFICATION NUMBER:	ROVIDER OR SUPPLIER CONCORD NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 55 confirmed the resident's lab results were accessible on the laboratory's website. The Director of Nursing stated she gave the results of Resident #145's Vancomycin Trough drawn on 2/10/2020 to the Nurse Practitioner on 2/12/2020 when she printed the results from the laboratory website on the computer and the NP did not say to hold the resident's Vancomycin at that time. An interview with the facility's Consultant Pharmacist on 2/28/2020 at 10:48 am revealed she reviewed Resident #145's medications on 2/12/2020, but was not informed the resident had a critical Vancomycin Trough of 41.52 mcg/ml on 2/10/2020. The Pharmacist stated she was aware Resident #145's Vancomycin since the Infectious Disease Clinic was following him. An interview with the facility's Medical Director on 2/28/2020 at 11:32 am revealed he was not notified of the Resident #145's 2/10/2020 critical Vancomycin Trough drawn of 41.52 mcg/ml. The Medical Director stated he would have stopped the Vancomycin immediately if he had been notified of the resident's critical level and continuing to administer the Vancomycin could have led to the resident's renal failure. The Medical Director also stated the Infectious Disease Clinic was managing the dosing of Resident #145's Vancomycin and they were notified by voicemail of the laboratory result. An interview was conducted on 2/28/2020 at 11:57 am with a representative of the phone company the facility utilizes. The representative stated the facility called on 2/10/2020 to report	ROVIDER OR SUPPLIER CONCORD NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 55 confirmed the resident's lab results were accessible on the laboratory's website. The Director of Nursing stated she gave the results of Resident #145's Vancomycin Trough drawn on 2/10/2020 to the Nurse Practitioner on 2/12/2020 when she printed the results from the laboratory website on the computer and the NP did not say to hold the resident's Vancomycin at that time. 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An interview was conducted on 2/28/2020 at 11:57 am with a representative of the phone company the facility cilled on 2/10/2020 to report	A BUILDING 345130 B WING STREET ADDRESS, CITY, STATE, ZIP CODE SIMMARY STATEMENT OF DEPTICENCIES (EACH DEPTICENCY) EACH DEPTICENCY WILL BE PERCECED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 55 confirmed the resident's lab results were accessible on the laboratory's website. The Director of Nursing stated she gave the results of Resident #145's Vancomycin Trough drawn on 2/10/2020 to the Nurse Practitioner on 2/12/2020 when she printed the results from the laboratory website on the computer and the NP did not say to hold the resident's Vancomycin at that time. An interview with the facility's Consultant Pharmacist on 2/28/2020 at 10-48 am revealed she reviewed Resident #145's medications on 2/12/2020, but was not informed the resident had a critical Vancomycin Trough of 41.52 mcg/ml on 2/10/2020. 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WING STREET ADDRESS, CITY, STATE, 2IP CODE \$15 LAKE CONCORD ROAD NE CONCORD NURSING & REHABILITATION CENTER CONCORD, NC 28025 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 55 confirmed the resident's lab results were accessible on the laboratory's website. The Director of Nursing stated she gave the results of Resident #145's Vancomycin Trough drawn on 2/10/2020 to the Nurse Practitioner on 2/12/2020 when she printed the results from the laboratory website on the computer and the NP did not say to hold the resident's Vancomycin at that time. An interview with the facility's Consultant Pharmacist on 2/28/2020 at 11:32 am revealed she reviewed Resident #145's vancomycin, but the pharmacy was not involved in dosing Resident #145's Vancomycin since the Infectious Disease Clinic was following him. An interview with the facility's Medical Director on 2/28/2020 at 11:32 am revealed he was not notified of the Resident #145's 2/10/2020 critical Vancomycin immediately if he had been notified of the resident's critical level and confining to administer the Vancomycin could have led to the resident's critical level and confining to administer the Vancomycin and they were notified by voicemail of the laboratory result. An interview was conducted on 2/28/2020 at 11:57 am with a representative of the phone company the facility villizes. The representative stated the wealth representative stated the secility called on 2/10/2020 to report

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING _				28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		51	REET ADDRESS, CITY, STATE, ZIP CODE 5 LAKE CONCORD ROAD NE ONCORD, NC 28025	1 02	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	on 2/17/2020. An interview with the conducted on 2/28/2 Administrator stated reported the resident laboratory result to the 2/12/2020 when they Infectious Disease Consection of the Apalliative care consections 2/27/2020 specified entity required verticular fibrillation currently required verticular for palliative were made aware of the Administrator was jeopardy on 2/27/2020 the facility provided the Allegation of Immedial Identify those recipies are likely to suffer, a a result of the noncoon Resident #145 continuous conducted in the conducte	Administrator was 020 at 2:42 pm. The the nursing staff should have it's critical Vancomycin he Medical Director on vidid not hear back from the linic. Sult from the hospital dated Resident #145 had a arrest on 2/26/2020 and ntilator support. The consult ident #145 was being ve care and family members his condition. as notified of immediate 20 at 4:11 pm. On 2/28/2020 he following Credible ate Jeopardy Removal: ation of Immediate Jeopardy onts who have suffered, or serious adverse outcome as mpliance nued to receive Vancomycin	F	757	DEFICIENCY)		
	on 2/10/20 with elevate facility on the laborate according to the laborate Director of Nursing (laboratory portal. The facility began ha	ne facility drew a trough level ated levels reported to the cory portal on 2/10/20 oratory and noted by the DON) on 2/11/20 through the aving scattered problems with on 2/10/20 but with a server					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _				C 28/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET	FADDRESS, CITY, STATE, ZIP CODE	1 02/	20/2020	
				515 LA	KE CONCORD ROAD NE			
CURIS AT	CONCORD NURSING	& REHABILITATION CENTER		CONC	ORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 757	and phones were we 2/11/20 the DON received a deep re 2/11/20, and DON of computer to pull all identified the critical laboratory reported made to reach the funsuccessful. Neith were also not reach the laboratory portal, lad ue to the time of definition of the DON pulled the laboratory portal, lad ue to the time of definition Diseases Vancomycin trough When the DON attention of the DON was unab message on the "Nof resident #145, the critical lab value and phones and faxes we in the facility at that contact the Director DON's cell phone to had not received a	anat faxes were being received forking. On the evening of alized that no laboratory ceived by fax on that day, opened the lab portal on the results for the day and I lab alert. In checking, the that multiple attempts were facility on 2/10/20 and were the realized that fax reports aing the facility. The critical alert from the te in the day on 2/11/20 and any, the DON did not call the strong of the facility of the reach the Infectious of 2/12/20 to report the result, the to reach a person and left a curse Line" providing the name the resident's date of birth, the dinformed them that the were not working consistently moment and asked that they for Nursing, (DON) on the progress of the response from Infectious of the response from Infectious of the providing from Infectious of the providing from Infectious of the providers.	F	757	DEFICIENCY)			
	the Infectious Disea message on the "N Disease office nurs call the facility on 2 was unable to reach Infectious Disease the DON on the DO the two messages I Nurse Practitioner (by 2/13, DON again contacted ase office and left a second curse Line". The Infectious e claims to have attempted to 1/12 and 2/13 repeatedly but in the facility by phone. The nurse did not attempt to reach by's cell phone as directed on left. According to the DON the NP) was made aware of the 20 while in the facility and						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345130	B. WING _			1	C 28/2020	
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		515 LA	ET ADDRESS, CITY, STATE, ZIP CODE AKE CONCORD ROAD NE CORD, NC 28025	, 02.		
(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 757	The NP has denied k The Vancomycin trou 2/17/20 but as the 2/ unresolved, the Nurs Vancomycin trough to draw it thirty minutes would be required for record, the DON noti on 2/18/20 about the the order was placed Vancomycin until the practitioner could be Diseases and the DO 2/20/20 to discuss th resulting in an order to to the hospital by the The DON failed to ma Practitioner or the Ma instructions when the the Infectious Disease continued to adminis in a toxic level of Van	to notify Infectious Diseases. nowing about the critical lab. gh was again scheduled for 10/20 result remained e did not add the to the laboratory requisition or prior to the next dose as a trough. According to the fied the Nurse Practitioner critical value of 2/10/20 and to discontinue the Infectious Disease reached. Infectious the finally made contact on the critical lab result of 2/10/20 to send send Resident #145 Infectious Disease office. The contact with the Nurse the contact with the Nurse the dical Director for The DON was unable to contact	F	757	DEFICIENCY)			
	Any resident who is a where doses and adr levels would have the failure to properly mono other residents we circumstances of tele the decisions made a labs, on 2/26/20 and Development Coord Director of Clinical Se	administered medications ministration depend on blood e potential to be affected by a mitor those levels. To assure ere affected by the same phone and fax issues and pround managing critical						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345130	B. WING_			C 02/28/2020	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	•	32/26/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC 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 757	and examined the relaboratory orders had critical labs had not other residents being require laboratory methods at this time. Specify the Action the process or system factor outcome from occur the Action will be confused the Action will be confused to the facility had expetransmission inconsist the telephone service information Technolocalls to the facility of held by the Reception calls and faxes were address of the Busing to resolve the issue. By Information Technology information Technology information Technology information Technology information Technology. Information Technology information the service occurring again, the and the IT firm were was fully resolved of fax service has been	draw laboratory specimens esults received. No other deen missed and no other been reported. There are no gradministered antibiotics that conitoring by intravenous. The Facility will take to alter the earliure to Prevent a Serious ring or reoccurring and when emplete. Berienced telephone and fax stencies and had contacted the provider and the logy firm on 2/10/20 to forward to answer all incoming to forwarded to the email these office Manager in effort. The initial recommendation the logy to reset the server the problem which gave the	F7	,			
	phone number have laboratory, pharmac in order to provide a emergency contact	as well as the facility cell been provided to the y, Xray and Medical Director back up number for n the event of if these to reach the facility effective					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345130	B. WING			C
	ROVIDER OR SUPPLIER	3 & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	ODE	02/28/2020
(X4) ID PREFIX TAG	(EACH DEFICI	(STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 757	the Medical Direct to reach the presco (within two hours of the DON was reed Director of Clinical 2/27 with an emphreporting Critical la condition to the properting a signature counseled on by the Services on 2/27/2 On 2/26/20 the Address on 2/27/2 On 2/26/20 the Address in condition order listings for lating the lab draw bothe process for as ordered, 4) the properting are received. Insclarified process by immediately contained and get instruction level. The nurse administer the me elevated blood lever instruction of the process of the proc	esponsible for failing to notify or when the DON was unable ribing physician immediately of receiving the Critical value), ducated by the Regional Services on both 2/26 and lasis on the urgency of lab values and changes in hysician and the Medical to reach the physician. The large acknowledging the failure large Regional Director of Clinical 20. In ministrator, DON and SDC all nurses on the importance of hysician about any significant on. 2) the process for assuring lab draws are correctly entered lock for the following morning, 3) suring that blood is drawn as locess for confirming that results ervices of nurses include a lab values for medication lab values for medication lab values for medication lasage left must be returned in the nurse will call the facility's lab draws as of the abnormal value as for managing the elevated is instructed not to continue to dication associated with the lel until the nurse has received	F 7	757		
	In-servicing also s inform the medica	rom the physician. tressed that nurses must I director about any significant on if unable to reach the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD			، ا	
		345130	B. WING				28/2020
NAME OF F	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
CLIDIS AT	CONCODD NITESING	& REHABILITATION CENTER		5	15 LAKE CONCORD ROAD NE		
CONIGAI	CONCORD NORSING	& REHABILITATION CENTER		C	CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	initially ordered med to administering any treatment. CNAs we importance of report to the Nurse in char writing/verbally thro as well as placing a Care wall kiosk syst care. Staff who was or 2/27 was contact of the requirement. in person prior to write The Administrator a completed the in-se and CNAs on 2/27/2 has been added to Orientation program nursing staff fully unimportance and the changes in condition diagnostic findings in or NP. The facility of outside staffing age contract staff. If, in the nursing supervisor for responsible for proving agency staff person To assure that the condition and faxes inconsisted Administrator contated Technology service telephone and faxes dependably as of 2/2 service has been estertal measure in as	ring physician who may have dication or treatment and prior of y such medication or tree in-serviced on the ting any changes in condition any changes in condition and the Stop and Watch ticket of Nurse Alert on the Point of the in which CNAs document as not assigned to work on 2/26 and by telephone and informed and Each will also be in-serviced orking on the floor. The individual of the Nurse and CNA are to assure that future inderstands both the process for reporting in, abnormal labs or other immediately to the physician does not contract with any incies or use agency or the future this occurs, the for that shift will be riding written instruction to that	F	757			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345130	B. WING				C 28/2020
NAME OF PI	ROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	20/2020
				515	LAKE CONCORD ROAD NE		
CURIS AI	CONCORD NURSING &	REHABILITATION CENTER		co	NCORD, NC 28025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 757	Continued From pag	e 62	F 7	757			
	Immediate Jeopardy	is removed as of 2/28/20.					
	Immediate Jeopardy						
		20 of the plan to ensure those					
		ent practice revealed the					
	facility had investigated the incident. The facility reconciled the last thirty days of resident with						
laboratory test and compared them to the							
	-	s used to draw laboratory					
	specimens to ensure no other residents were affected. The facility found that no other critical						
		d not been reported. The					
		ctor of Nursing's, and the					
		mbers were provided to the					
		y, x-ray, and Medical Director					
	in order to provide a	•					
	emergency contact in						
		ble to reach the facility The Director of Nursing was					
		rgency of reporting critical					
		the physician and Medical					
		rs of receiving a critical					
		e facility developed an audit					
	_	porting of critical laboratory					
		staff were in-serviced on the					
	_	ocess for assuring order					
		draws are correctly entered					
	_	the process for assuring					
	blood is drawn as ord	dered; and the process for					
	confirming the results						
	•	uded ensuring the physician					
		g any abnormal laboratory					
		Nursing staff from all three					
		ed regarding the in-services					
		standing. The facility will					
	-	service education to any new					
	nursing employees.]

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 02/28/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
CURIS AT	CONCORD NURSING 8	REHABILITATION CENTER		515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 835 SS=F	enables it to use its efficiently to attain or practicable physical, well-being of each retained to the REQUIREMENT by: Based on record recompany represents failed to ensure a wowhen the phone systaboratory results; results; and receiving infectious Disease Coreviewed for unnecessitation of the properties of the pro	ministered in a manner that resources effectively and r maintain the highest mental, and psychosocial	F 83	This Plan of Correction constitutes the facilities allegation of compliance for deficiencies citied in the CMA-2567 statement made in the plan of Correction are not admission to and do not indican agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance all Federal and State regulations such	the The tions ate es. with	
	Vancomycin level ar was unable to call in resident's Vancomyc failure to put an alter in place affected all Findings included:	nd Infectious Disease Clinic to the facility to ensure the sin was stopped. The facility's mate communication system residents in the facility.		all alleged deficiencies cited have be will be corrected by the date (s) indice Response to this statement of Delice does not constitute an admission that deficiency is accurate. No residents we named in the citation	en or ated. nse t any vere	
	Vancomycin Trough Vancomycin level in to be administered 3 Vancomycin adminis results were be faxe Physician at the Infe 24 hours of drawing A Vancomycin Troug marked reported by	stration every Monday and the d to the Infectious Disease ctious Disease Center within		and fax transmission inconsistencies had contacted the telephone service provider (Jetway) and the Information Technology firm on 2/10/20 to forward calls to the facility cell phone number which was held by the Receptionist to answer all incoming calls and faxes of forwarded to the email address of the Business Office Manager in effort to resolve the issue. The initial recommendation by Information Technology to reset the server appear	n d O vere	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345130	B. WING				0
		345130	D. WING _			02/	28/2020
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CURIS AT	CONCORD NURSING	& REHABILITATION CENTER			LAKE CONCORD ROAD NE		
		<u> </u>		co	NCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 835	Continued From pa	ge 64	F 8	335			
	critical at 41.52 mic with a normal reference/ml. An interview was composed to state the critically was not reported to until 2/12/2020 when the Infectious Disease telephone lines were did not realize the file 2/10/2020 and the Infectious and the Infectious Disease telephone lines were did not realize the file 2/10/2020 and the Infectious Disease telephone lines were did not realize the file 2/10/2020 and the Infectious Disease telephone lines were did not realize the file 2/10/2020 and the Infectious Disease telephone lines were did not realize the file 2/10/2020 and the Infection with a normal reference model of the control o	rograms/milliliter (mcg/ml) ence range of 10.00 to 20.00 onducted on 2/25/2020 at 3:42 or of Nursing (DON). The DON high Vancomycin Trough level the Infectious Disease Center en she left a voice message for ease Nurse. She stated the er down in the facility and she ax had not been working since aboratory results had not			to correct the problem which gave the facility a sense of confidence that the communication issues were resolved. 2/11/20 the DON realized that the problem was occurring again, the telephone service provider (Jetway) and the IT fir were again notified. The problem was resolved on 2/17/20 and telephone and fax service has been consistent since time. The Administrator s and the Director of Nursing s cell phone numbers as well the facility cell phone numbers have been consistent been been consistent as a service time.	olem rm fully d that of	
	stated she ran the I laboratory's comput had access to but of 2/12/2020. During an interview	ax as normal. The DON aboratory results from the ter website which the facility lid not run them until with the Infectious Disease			the facility cell phone number have bee provided to the laboratory, pharmacy, Xray and Medical Director in order to provide a backup number for emergen contact in the event of if these provider are unable to reach the facility effective 2/28/20.	cy rs	
	she received a voic facility's DON on 2/Resident #145's Va 41.52. The ID Nurs called back to the fa 2/12/2020 and also 2/13/2020 but could stated on 2/18/2020 spoke to Nurse #6 nurse that was takin The ID Nurse stated not reach anyone of she would ask the IN Nurse stated she ca 2/19/2020 and spoke ID Nurse stated the facility did not he	2020 at 8:58 am she stated to mail message from the 12/2020 that indicated the mail message from the 12/2020 that indicated the new stated she immediately acility several times on called several times on the new sees at a control of the new sees at			The maintenance director or maintenance assistant will test weekly 5 times a weekly 4 weeks then 3 times a times for 4 weeks then weekly times 1 month or user corrective action is achieved. Findings will be reviewed with the administrator weekly any issues will be addressed immediately. Results will be discussed and addressed as needed during the facility monthly Quality Assessment and Performance improvement meeting.	ek ntil	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345130	B. WING			1	C
NAME OF D	ROVIDER OR SUPPLIER	040100	1	CTD	REET ADDRESS, CITY, STATE, ZIP CODE	02/	28/2020
NAIVIE OF P	ROVIDER OR SUPPLIER						
CURIS AT	CONCORD NURSING 8	REHABILITATION CENTER		515 LAKE CONCORD ROAD NE CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From pag	e 65	F	335			
	Vancomycin Trough	bout the critically high Level, the facility did not stop the residents intravenous ion until 2/19/2020.					
	An interview was cor Supervisor on 2/27/2 supervisor stated Re Vancomycin Trough 2/10/2020 at 5:15 pm released on the labor for viewing by the fact Supervisor stated the numerous times but because no one was phone. The Laboratory had also results to the facility During a second inte 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes the machine in the medic stated she did not results or 2/27/2020 at 2:00 pm procedure regarding laboratory faxes at 2/27/2	nducted with the Laboratory 1020 at 1:45 pm. The sident #145's 2/10/2020 Level was processed on an and the results were ratory's website at that time cility. The Laboratory e Laboratory called the facility could not get through answering the facility's ory Supervisor stated the faced Resident #145's lab on 2/10/2020. rview with the DON on a she stated she the normal					
	2/12/2020 and then so the laboratory websit facility's telephone lir properly from 2/10/20 machine was not work. An interview with the representative on 2/20 facility called on 2/10 was not able to recei out of the facility. The phones were repaire	she printed the results from te. The DON stated the nes were not working 02 to 2/17/2020 so the fax rking. sphone company 28/2020 at 11:57 am revealed 0/2020 to report the facility ve calls in the facility or call he representative stated the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345130	B. WING		C 02/28/2020		
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	, G2/26/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION		
F 835	notified the phones	n she stated the facility had company of the issue with the 0 but the phones were not	F 83	5			
F 842 SS=D	Resident Records - CFR(s): 483.20(f)(5) §483.20(f)(5) Reside (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use or except to the extent to do so. §483.70(i) Medical resident must maintain medical that are-(i) Complete; (ii) Accurately docum (iii) Readily accessible (iv) Systematically of \$483.70(i)(2) The facall information contained regardless of the for records, except where (i) To the individual, representative where (ii) Required by Law (iii) For treatment, paceparations, as permit with 45 CFR 164.50	Identifiable Information (, 483.70(i)(1)-(5) ent-identifiable information. release information that is to the public. elease information that is to an agent only in contract under which the agent disclose the information the facility itself is permitted ecords. cordance with accepted dis and practices, the facility cal records on each resident enented; ble; and rganized cility must keep confidential ined in the resident's records, m or storage method of the n release is- or their resident e permitted by applicable law; cayment, or health care itted by and in compliance	F 84:		3/23/20		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		E SURVEY MPLETED
		345130	B. WING _			C 2/28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING	& REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	1 3.	2/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE
F 842	activities, judicial ar law enforcement purposes, research medical examiners, a serious threat to help by and in compliance §483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medic for- (i) The period of tim (ii) Five years from there is no requirem (iii) For a minor, 3 y legal age under State §483.70(i)(5) The model of the record of the rec	c violence, health oversight and administrative proceedings, rposes, organ donation purposes, or to coroners, funeral directors, and to avert lealth or safety as permitted se with 45 CFR 164.512. Incility must safeguard medical legainst loss, destruction, or all records must be retained le required by State law; or the date of discharge when lent in State law; or lears after a resident reaches	F8			
	provided; (iv) The results of all and resident review determinations cond (v) Physician's, nurs professional's progr (vi) Laboratory, radi services reports as This REQUIREMEN by: Based on medical linterviews, the facili administered medic Medication Adminis	ny preadmission screening evaluations and ducted by the State; se's, and other licensed ess notes; and ology and other diagnostic required under §483.50. IT is not met as evidenced		This Plan of Correction constitut facilities allegation of compliance deficiencies citied in the CMA-25 statement made in the plan of Coare not admission to and do not	e for the 567 . The orrections	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
			A. BUILDI	NG		Ι,	2	
		345130	B. WING				28/2020	
NAME OF P	ROVIDER OR SUPPLIER	•	,	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
CUDIC AT	CONCORD MURCINO	O DELLA DIL ITATIONI CENTED		51	15 LAKE CONCORD ROAD NE			
CURIS AI	CONCORD NURSING	& REHABILITATION CENTER		С	ONCORD, NC 28025			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 842	Continued From pa	F	842					
	medication adminis	=		072	an agreement with alleged deficiencies			
		stration.			This Plan of Correction is written and	•		
	Findings included:				executed as to remain in compliance w	ith		
	i mamgo moradoa.				all Federal and State regulations such			
	During a medicatio	n pass, which started on			all alleged deficiencies cited have beer			
	_	l, Resident #21 requested pain			will be corrected by the date (s) indicat			
	medication from Nเ	urse #2 and stated she had			Response to this statement of Delicens			
	received the last do	ose of pain medication in the			does not constitute an admission that a	iny		
		ırse #2 checked Resident #21			deficiency is accurate.			
		ed the resident was prescribed						
		tablet of hydrocodone 5			Nurse #5 initiated a late entry on the			
		etaminophen 325 mg (pain pill)			Electronic Medication Administration			
		needed, for pain. However, she			Record.(EMAR) that reflects the administration of medication given to			
		necked the EMAR there was ent had received the pain pill			resident #145.			
		ole day. The nurse checked			resident #140.			
		nitoring/control record or			All residents requiring a PRN (as Need	ed)		
		ed she saw where Nurse #5			medication have the potential to be			
		one-half pain pill earlier in the			affected. As a result, an audit on all			
	_	nd she believed the nurse had			residents on PRN medications will be			
	not signed off the p	pain pill as having been			conducted to ensure that proper			
	administered in the	EMAR. The resident stated if			documentation is completed post			
		the pain pill, she would like to			administration on 3-21-2020. All licensed			
		en for her pain. Nurse #2 was			nursing staff will be educated on prope	r		
	then observed adm				documentation regarding PRN			
	acetaminophen pill	to the resident.			administration 3-20-2020.			
	During a review of	Resident #21 ' s February			The Director of Nursing Services, or			
	_	on 2/25/20 it was observed			designee, will audit all potentially affect	ed		
		d for the administration of the			residents PRN narcotic records for pro			
	one-half tablet of hydrocodone 5 mg/acetaminophen 325 mg (pain pill) nor the 650				documentation on the EMAR 5 times a			
					week x 4 weeks, then 3 times a week x	: 4,		
	mg acetaminophen	n on 2/24/20.			then weekly x 1 month or until corrective action is achieved.	'e		
An interview was conducted		onducted on 2/25/20 at 11:15						
	AM with Nurse #5	and she stated she should			Findings will be reviewed with the	ĺ		
	have documented i	in the EMAR she had			administrator weekly. Results will be			
		ne-half tablet of hydrocodone 5			discussed and addressed as needed	ĺ		
	milligrams (mg)/ace	etaminophen 325 (mg) (pain			during the facility□s monthly Quality			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
		345130	B. WING_			C 02/28/2020
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	02/28/2020
				515 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION SACTION SHOULD BE TO THE APPROPRIATE SIENCY)	(X5) COMPLETION DATE
F 842	Continued From page	e 69	F 8	42		
	had not because it ha	sident #21. She stated she ad gotten really busy and she er resident from another hall		Assessment and Perfor Improvement (QAPI) m		
	on 2/25/20 at 11:20 A medication is adminis for the medication to 's EMAR and if the m	ng (DON) was interviewed M and she stated when a stered it was her expectation be signed off in the resident nedication is a narcotic it as well it should be signed of				
	on 2/25/20 at 4:32 PM documented in Resid administered the acei was confident becaus sequence, she had to administration information observed reviewing the and stated the information regarding the administration.	24/20 had not saved and it				
F 867	PM with the facility Administrator reveale a medication was adr documented in the EI accurate representati the medication. QAPI/QAA Improvem	d her expectation was when ministered it should be MAR so there would be an on of the administration of ent Activities	F 8	67		3/23/20
SS=D		sessment and assurance.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345130	B. WING _			C 02/28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	'	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI REGULATORY OR LSC IDENTIFYING INFORMATION) TAI		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 867	Continued From pag	e 70	F 8	67		
	assurance committee (ii) Develop and impl action to correct iden This REQUIREMEN by: Based on record rev facility's Quality Asse (QAA) Committee fai procedures and mon committee put into pl recertification and co This was for 2 recited Failure to complete a Set (MDS) assessme resident's admission complete quarterly M days of their Assessr (F-638). These deficit during the facility's co complaint investigatic continued failure of the	ement appropriate plans of tified quality deficiencies; is not met as evidenced iew and staff interviews the essment and Assurance led to maintain implemented itor the interventions the ace following their 4/18/19 mplaint investigation survey. d deficiencies in the areas of; in admission Minimum Data ents within 14 days of the date (F-636) and Failure to IDS assessments within 14 ment Reference Date encies were cited again urrent recertification and on survey of 02/28/20. The me facility during two federal nows a pattern of the facility's		This Plan of Correction constit facilities allegation of compliant deficiencies citied in the CMA-2 statement made in the plan of are not admission to and do not an agreement with alleged defi This Plan of Correction is written executed as to remain in compall Federal and State regulation all alleged deficiencies cited hawill be corrected by the date (so Response to this statement of does not constitute an admission deficiency is accurate. No resignamed in the citation	ce for the 2567 . The Corrections of indicate iciencies. en and diance with his such that ave been or) indicated. Delicense on that any dents were	
	The findings included This tag is cross refe			2/26/2020 resident #1 Compre Assessment dated 9/30/19 with completion date of 10/8/19 was and noted completed late by th Data Set Nurse.	n a s reviewed	
	interviews, the facility admission assessme admission date for 1 reviewed for timely c Minimum Data Set (N	ecertification survey of		On 3/19/2020, the Minimum Da Assessment Nurse performed Improvement monitoring for all residents with Comprehensive assessments in progress to ide late assessments. Any issues were addressed.	Quality current entify any identified	
		ailed to complete an annual num Data Set (MDS) and		On 3/18/2020, the Minimum Da Nurse S were re-educated by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345130	B. WING _				28/ 2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	, <u>02</u> 1	20/2020
					5 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING 8	REHABILITATION CENTER			ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 867	Continued From page Care Area Assessment referesidents reviewed for completion (Resident assessment and CA admission for 1 of 3 admission MDS completers and CA admission MDS completers and the Assessment Referesidents (Resident and the Assessment Referesident and the Assessment Referesidents (Resident and the Assessment Refe	per 71 ents (CAAs) within 14 days of rence date (ARD) for 1 of 5 or comprehensive MDS at #102) and failed to rensive admission As within 14 days of residents reviewed for apletion (Resident #57). dical record review and staff y failed to complete a resessment within 14 days of rerence Date (ARD) for 2 of 2 #26 and Resident #55) completion of quarterly		367		ent he for libe if i. ly and 3/19 ed	DATE
					On 3/19/2020, the Minimum Data Assessment Nurse performed Quality Improvement monitoring for all current residents with Quarterly assessments i progress to identify any late assessment Any issues identified were addressed.	n	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING				28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE ONCORD, NC 28025	1 02/	20/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	72	F	367	On 3/18/2020, the Minimum Data Set Nurse swere re-educated by the Regional Minimum Data Set Nurse on timeliness of Quarterly assessment completion. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS Quarterly assessments for timeliness of completion by reviewing the In Progres MDS list 3 times per week for four weethen twice weekly for two weeks, then time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020. The Director of Nursing will report on the Quality Assurance Performance Improvement Committee. Findings will reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. Date of Compliance is 3/23/2020.	f s ks, cone he s) be if s.	
F 880 SS=D	Infection Prevention & CFR(s): 483.80(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	(2)(4)(e)(f) ntrol blish and maintain an nd control program	F	380			3/23/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C 02/28/2020
NAME OF PROVIDER OR SUPPLIER CURIS AT CONCORD NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		02/20/2020
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	development and tra diseases and infection §483.80(a) Infection program. The facility must esta and control program a minimum, the follow §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visit providing services unarrangement based unconducted according accepted national states §483.80(a)(2) Written procedures for the procedure for the procedure of the procedure for the procedure fo	nent and to help prevent the insmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at wing elements: em for preventing, identifying, ing, and controlling infections is eases for all residents, tors, and other individuals inder a contractual upon the facility assessment to §483.70(e) and following andards; In standards, policies, and orgram, which must include, it is illance designed to identify ble diseases or y can spread to other organisms included in second precautions went spread of infections; olation should be used for a ut not limited to:	F8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 02/28/2020	
	NAME OF PROVIDER OR SUPPLIER CURIS AT CONCORD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	02/20/2020	
(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 APPROPF DEFICIENCY)	BE COMPLÉTION	
F 880	must prohibit employed disease or infected she contact with residents contact will transmit the (vi)The hand hygiene by staff involved in disease of involved involved in disease of involved involved involved involved involved involved involved in disease of involved involv	s under which the facility ees with a communicable kin lesions from direct for their food, if direct he disease; and procedures to be followed rect resident contact. In for recording incidents heility's IPCP and the een by the facility. It is, store, process, and to prevent the spread of It is It is not met as evidenced Ins, staff interviews and hility failed to clean and hometer (a device used to holood glucose or sugar er's recommendations after in one resident for 1 of 1 erved for blood sugar Exiculty It is not met as evidenced It is not met as evidenced It is not met as evidenced Ins, staff interviews and holood glucose or sugar er's recommendations after in one resident for 1 of 1 erved for blood sugar Exiculty It is not met as evidenced It is not met as evi	F 88	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 statement made in the plan of Correction are not admission to and do not indiction an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance all Federal and State regulations such all alleged deficiencies cited have been will be corrected by the date (s) indicated the corrected by the corrected by the correc	he The tions ate es. with n that en or ated. nse any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 50.25			(C
		345130	B. WING			02/	28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING 8	REHABILITATION CENTER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE ONCORD, NC 28025		
(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 880	(EPA) registered wip An observation was 2/24/20 during her mat 4:05 PM. She was glucometer check or removed a glucomet medication cart and Resident #32. When she stated she reme required their blood gbecause there was a container inside of thattempted to do a fin on the resident with resident 's room and the machine reading the glucometer, which storage container. Tresident having his of there was no need to on that resident. The FSBS on the resident which she had broug and it to read "error." check the resident 's proceeded to leave to room, the nurse open opened two alcoholowipe down the glucomed and placed the The nurse stated the cleaned and was rearesident. The nurse to clean the glucomed pad. An interview and observed and interview and observed and placed the cleaned and was rearesident. The nurse to clean the glucomed pad.	es for disinfecting the meter. conducted of Nurse #2 on ledication pass which started is observed performing a la Resident #32. The nurse ler which was stored in the brought it into the room of in the nurse entered the room, imbered each resident who glucose to be checked la glucometer in a storage leir room. The nurse ger stick blood sugar (FSBS) the glucometer inside of the la was unsuccessful due to lerror." The nurse returned th was in the room, to the line nurse stated due to the line nurse stated due to the line assigned glucometer, lo clean it prior to the next use le nurse then attempted an lat utilizing the glucometer lat into the resident 's room lat the nurse stated she would lat blood sugar later and late room. Upon leaving the lined the medication cart, line pads and proceeded to line pads and proceeded to line glucometer back in the cart. la glucometer back in the cart. la glucometer had been lady to be used on another later utilizing the alcohol wipe	F	8880	When the deficient practice was discovered, the nurse was in-serviced immediately on 2/24/2020 on the prope way, as defined by policy to clean the glucometer. The review of the procedur with licensed was completed by the state development coordinator and or Direct of Nursing on 3/23/2020. The staff development coordinator scheduled immediate in-service to reviet the policy and procedure for the cleaning of the glucometer. Each licenses nurse was schedule for the review. The in-serviced were completed on 3/23/20. The Director of Nursing Services, or designee, will audit all potentially affect residents that require the use of a glucometer that is not assigned to the resident 5 times a week x 4 weeks, the times a week x 4, then weekly x 1 monor until corrective action is achieved. Findings will be reviewed with the administrator weekly. Results will be discussed and addressed as needed during the facility smonthly Quality Assessment and Performance Improvement (QAPI) meeting.	re iff or ew ng 20 red	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345130	B. WING _	B. WING		C 02/28/2020	
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	•	02/20/2020	
(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 COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 883 SS=E	(DON) and Nurse #2 utilized disinfectant w glucometers between wipes would not suffi glucometer and their disinfectant wipes. T the disinfectant wipe the nurse informed h glucometer on any of had attempted to use DON stated it was he glucometer stored in disinfectant wipes. During an interview of 12:39 PM the admini expectation for the ni policy regarding clea administrator further provided training reg- glucometers 4 weeks aware of how importa the glucometers was each resident having matter of infection co- Influenza and Pneum CFR(s): 483.80(d)(1) §483.80(d) Influenza immunizations §483.80(d)(1) Influen- policies and procedu (i) Before offering the each resident or the	The DON stated the facility vipes for disinfecting in use. The DON said alcohol ciently disinfect the policy was to use the The DON proceeded to find on the medication cart and er she had not used the ther resident 's since she it in Resident #32. The er expectation for the the cart to be cleaned and each resident by using the conducted on 2/26/20 at strator stated it was her urses to follow the facility ning the glucometers. The stated the facility had arding how to clean the sago because she was ant of a matter disinfecting and she had also instituted their own glucometers as a portrol. Inococcal Immunizations of the influenza immunization, resident's representative egarding the benefits and of the immunization;		383		3/23/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345130		B. WING			C 02/28/2020	
	NAME OF PROVIDER OR SUPPLIER CURIS AT CONCORD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP C 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		02/20/2020	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 883	immunization Octobe annually, unless the i contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's medocumentation that infollowing: (A) That the resident was provided educati and potential side effeimmunization; and (B) That the resident immunization or did nimmunization due to refusal. §483.80(d)(2) Pneummust develop policies that- (i) Before offering the immunization, each representative receive benefits and potential immunization; (ii) Each resident is or immunization, unless medically contraindical ready been immunicial (iii) The resident or the has the opportunity to (iv)The resident's medocumentation that infollowing: (A) That the resident was provided educati	r 1 through March 31 mmunization is medically r resident has already been stime period; re resident's representative refuse immunization; and dical record includes redicates, at a minimum, the resident's representative regarding the benefits rects of influenza rective the influenza redical contraindications or receive the influenza redical contraindications or receive the resident's resident or the resident's rese education regarding the rect a pneumococcal redical contraindication is redical or the resident has red; resident's representative refuse immunization; and	F	383			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/28/2020	
				515 LAKE CONCORD ROAD NE		
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER	I	CONCORD, NC 28025		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 883	Continued From page	≥ 78	F 883			
F 003	immunization; and (B) That the resident pneumococcal immurthe pneu	either received the nization or did not receive munization due to medical fusal. is not met as evidenced lews and staff interviews, the le residents or their ducation regarding the laside effects of the influenza ccal immunization for 4 out led for immunizations for all residence of the control, our State and Local when managing an led for all residents with a first prior vaccination, refusal or list of date, time, response coines. The policy did not led bout educating a resident or entative regarding the laside effects of the led dmitted to the facility on loses to include chronic by disease, unspecified, type ithout complications.	F 883	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567. The statement made in the plan of Correction are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance we all Federal and State regulations such all alleged deficiencies cited have been will be corrected by the date (s) indicated Response to this statement of Delicent does not constitute an admission that a deficiency is accurate. No residents we named in the citation Based on Root cause analysis by the Administrative Nurses staff and facility administrator it was determine that the was a lack of clear understanding of the regulatory requirement to provide each resident or legal representative education for legal representative and Pneumococcal immunizations. Immunization Influenza and Pneumococcal immunization Influenza and Pneumococcal education for resident #64, #77 and #290 were giving. On 3-23-2020 all current residents or legal representative were giving education legal representative education legal representative education legal representative education legal representative education	e he ons de	
	Resident #9's Minimu	ım Data Set (MDS)		regarding the potential benefits and ris	k of	

Facility ID: 953050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER	0.0.00	 	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	02/	28/2020	
TWANE OF TH	TOVIDER OR GOLT EIER				15 LAKE CONCORD ROAD NE			
CURIS AT	CONCORD NURSING &	REHABILITATION CENTER						
				C	ONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 883	Continued From page	e 79	F8	883				
		nt dated 12/6/19 specified on as being cognitively intact.			influenza and Pneumococcal immunization.			
	consent for the influe and administration of There was no evident Resident #9. An interview was compevelopment Coording 2:51pm who stated, get the consent over representative's but we ducational sheet and educational sheet and oriented." An interview was compursing (DON) on 2/2 stated, "We do not give ask if they are alled the residents who are get the vaccine."	nator (SDC) on 2/26/20 at For the flu vaccines we will the phone with the we do not give out the diwe do not give out the the residents who are alert appleted with the Director of 26/2020 at 4:39 pm. She we out any formal education, ergic to eggs, but basically a cognitive will tell us if they			Annually each resident or legal representative will be provided educati regarding the potential benefits and ris immunizations between October 1 and March 31. Unless medically contraindicated or refused by the resid or residents representative. Residents admitted between October 1 and March 31 who were not previously immunized will receive education and offered immunization upon admission.	k of ent		
	immunization was to or representative prio consent form. 2. Resident #64 was 6/9/2017 with diagnost	20 at 2:45 pm who on regarding the influenza be provided to the resident r to signing the vaccination admitted to the facility on ses to include unspecified						
	disorder and major de	um Data Set (MDS) annual						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	· ,	(X3) DATE SURVEY COMPLETED	
		345130	345130 B. WING			C)2/28/2020	
NAME OF PROVIDER OR SUPPLIER CURIS AT CONCORD NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIF 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		212312323	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 883	Special Treatments a revealed the last influcompleted on 10/03/2 Resident #64's media signed consent for the and no evidence of e Resident #64's representative with unit 2/26/20 at 4:41pm stanot received any vacathe representative to once we get in touch. An interview was compevelopment Coording 2:51pm who stated, get the consent over representative 's but educational sheet an educational sheet to and oriented." An interview was computed in the residents who are get the vaccine." An interview was competed in the residents who are get the vaccine."	vas moderately impaired. Ind programs section Itenza vaccine was 2018. Cal record revealed no ite influenza immunization ducation provided to sentative. Itemanager #1 (UM) on ated that Resident #64 had cines and were waiting for sign the vaccination consent with her. Impleted with the Staff fractor (SDC) on 2/26/20 at For the flu vaccines we will the phone with the we do not give out the d we do not give out the d we do not give out the the residents who are alert Impleted with the Director of 26/2020 at 4:39 pm. She we out any formal education, regic to eggs, but basically a cognitive will tell us if they Impleted with the 3/20 at 2:45 pm who on regarding immunizations	F	383			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C 02/28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING	& REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	 	02/20/2020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 883	Continued From pa	ge 81	F 8	83		
	12/11/2019 with dia Thrombosis and Type complications. Resident #77's med #77 received the infloopital on 10/29/19 representative signed 12/12/19 for him to vaccine but there we provided regarding if Resident #77 received Resident #77's Miniassessment dated resident's cognition Special Treatments MDS revealed the prot offered and the	ed the consent form on receive the pneumococcal as no evidence of education the pneumococcal vaccine or eived it. mum Data Set (MDS) annual 12/13/19 specified the was moderately impaired. and programs section of the oneumococcal vaccine was influenza was completed				
	Coordinator (SDC) reviewed Resident signed on 12/12/19 status of the pneum form was signed up An interview with Ut 2/26/20 at 4:36 pm Resident #77's repr The representative to the role and was #77 has already had UM #1 stated, she was resident's represent	e Staff Development on 2/26/20 at 2:51 pm who #77's consent form which was . SDC was not sure as to the lococcal vaccine. The consent				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 02/28/2020		
NAME OF PROVIDER OR SUPPLIER CURIS AT CONCORD NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		, E. E. G. E	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 883	stated, "We do not give ask if they are alled the residents who are get the vaccine." 4. Resident #290 was 2/15/2020 with diagn Diabetes mellitus with Resident #290's mediagned consent form pneumococcal vaccina administration of the vaccines on 2/25/202 education provided to benefits and potential and the pneumococcal Resident #290's Miniadmission assessmenthe resident's cognition. An interview was corn Development Coordial 2:51pm who stated, get the consent over representative's but we ducational sheet an educational sheet to and oriented." An interview was corn Nursing (DON) on 2/stated, "We do not give ask if they are alled."	26/2020 at 4:39 pm. She ve out any formal education, ergic to eggs, but basically e cognitive will tell us if they s admitted to the facility on oses to include Type 2 hout complications. lical record revealed a for the influenza and ne on 2/21/2020 and influenza and pneumococcal 20. There was no evidence of to Resident #290 about the I side effects of the influenza al immunization. mum Data Set (MDS) nt dated 2/17/20 specified on was moderately impaired. Inpleted with the Staff nator (SDC) on 2/26/20 at For the flu vaccines we will	F8	83			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 02/28/2020
	ROVIDER OR SUPPLIER CONCORD NURSING &	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	02/20/2020
(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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETION
F 883	An interview was cor Administrator on 2/28 indicated the educati immunization was to	npleted with the	F 88	33	