STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# 405P11.	F 000		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow a physician's order to give a fortified nutritional supplement to a resident at risk for weight loss and the resident lost weight; and the facility failed to implement a weight loss intervention to prevent further weight loss for a resident that lost weight (Residents #90 and #178) for 2 of 3 sampled residents. The findings included: 1. Resident #90 was admitted to the facility on 07/10/14 with diagnoses that included dementia, pneumonia, metabolic encephalopathy, dysphagia, Diabetes Mellitus, hypertension and others. On 07/17/14 a physician's order was	F 325	1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice. An order for Med Plus, 4 ounces twice a day, was placed into the medication administration record (MAR) for resident # 90 on 12/4/14. Resident # 178 was discharged from the facility on 12/3/14 the day the observation was made. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. All nutritional supplement orders were reviewed and crosschecked with previous	12/26/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/23/2014

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F 325	Continued From page 1 written for Med Plus (a fortified nutritional supplement) to be given twice daily for weight loss prevention due to fluctuating intake. Review of Resident #90's Medication Administration Record (MAR) dated 07/14, 08/14, 09/14 and 10/14 revealed the fortified nutritional supplement was given as ordered. The most recent Minimum Data Set (MDS) dated 10/02/14 specified the resident had moderately impaired cognitive skills, required limited assistance with eating, received a mechanically altered diet but had not lost weight. Resident #90's care plan dated 10/17/14 specified she was at risk for weight fluctuation related to confusion and fluctuating intake. The care plan identified an intervention to avoid significant weight change was to provide diet as ordered, monitor intake and offer a substitute when intake was less than 50%. Review of the MAR for the month of November revealed the Med Plus was not given to Resident #90. Further review of the medical record revealed there was no physician's order to discontinue the Med Plus. Resident #90's weights were: 07/10/14 120.6 pounds (lbs) 08/07/14 127.5 lbs 09/01/14 129.3 lbs 10/17/14 128.8 lbs 11/05/14 128.0 lbs 12/01/14 122.1 lbs On 12/04/14 at 10:40 AM nurse aide (NA) #2 was interviewed and reported that she regularly cared	F 325	electronic system to ensure all orders were entered into the new computer system on 12/4/14. All residents with nutritional supplement orders that were admitted after the new computer transition were verified to have the correct order in place on 12/4/14. All nursing staff to be in-serviced on the proper procedures regarding nutritional supplement intake and documentation by 12/25/14. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur. Nutritional supplement accuracy and intake audits will be completed weekly x 4 weeks and monthly x3 for residents those residents whom are at risk for weight loss, by Corporate Dietician or designee, and discussed weekly during Risk Management Meeting to ensure all supplements are being administered and the intake of the supplement is documented correctly. Any lack of compliance noted with result in re-education or disciplinary action as indicated. All significant weight changes to be discussed in weekly risk meetings for possible interventions and further required monitoring were a member of dining services and nursing will be present. All new nurse hires will receive in-service education on proper procedures for ordering supplement and recording supplement intake upon hire. 4. How facility will monitor corrective action(s) to ensure deficient practice will	

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F 325	Continued From page 2 for Resident #90. The NA stated that Resident #90's intake varied day to day but on average was less than 50%. The NA added that she felt the resident had lost weight and voiced concerns to the nurse. NA #2 reported that Resident #90 did not receive nutritional supplements. On 12/04/14 at 10:55 AM nurse #2 was interviewed and reported that she worked all over the building and had cared for Resident #90 at times. Nurse #2 stated she recalled that Resident #90 received a nutritional supplement but stated Resident #90 was not given one on 12/04/14 because she did not have a physician's order. Nurse #2 reviewed current physician's orders for Resident #90 and confirmed that there was no order for a nutritional supplement to be given in the facility's new electronic computer system. On 12/04/14 at 12:30 PM the Corporate Consultant was interviewed and reported that the facility recently underwent a change in computer systems. He explained that this required all current physicians' orders to be electronically entered into the new computer system. He also added that the Dietary Department was responsible for entering all dietary related orders including nutritional supplements. The Corporate Consultant stated it was possible that a nutritional supplement order was omitted because of the large volume of orders that had to be entered into the new computer system. He stated that he would have expected Resident #90's order for a nutritional supplement to have been continued per the physician's orders but felt it was an oversight. On 12/04/14 at 1:30 PM the Registered Dietitian	F 325	not re-occur. Results of audits will be presented to Quarterly Quality Assurance meeting x 3 to ensure compliance and modification of plan if needed. 5. Date of Compliance: 12/26/14	

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(RD) was interviewed and reported that Resident #90 was at risk for weight loss and required a nutritional supplement to avoid weight loss. The RD reviewed Resident #90's medical record and confirmed that she should have been receiving the nutritional supplement and that there was not an order to discontinue the supplement.

2. Resident #178 was readmitted to the facility on 10/29/14. Diagnoses included dementia, chronic kidney disease stage 4, diabetes mellitus II, and cerebrovascular disease. Resident #178 received a renal diet on admission.

Review of the Resident's weight history revealed the following weight data:
· 10/29/14 - 106.3 pounds (readmission weight)
· 11/06/14 - 102.2 pounds (4.1 pound or 3.9% loss since admission)
· 11/10/14 - 102.5 pounds
· 11/11/14 - 101.9 pounds
· 11/17/14 - 104.1 and 106.5 pounds
· 11/24/14 - 104.3 pounds
· 12/01/14 - 101.2 pounds (5.1 pound or 4.8% loss since readmission)

Review of Resident #178's 10/30/14 care plan revealed the Resident was at risk for weight loss due to a recent hospitalization and stroke. Weight loss interventions included to provide diet and nutritional supplements as ordered.

A dietary progress note dated 11/04/14 written by the registered dietitian (RD) assessed Resident #178 with an average meal intake of less than or equal to 50% of meals since readmission. The

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F 325	Continued From page 4	F 325		

progress note recorded a recommendation to resume a renal mechanical soft diet as ordered for a recent previous admission and to add four ounces of a high calorie supplement twice daily for weight loss prevention.

A physician's order dated 11/04/14 was written for four ounces of a high calorie nutritional supplement to be given twice daily.

Resident #178's November 2014 medication administration record (MAR) recorded the nutritional supplement was accepted by the Resident twice daily 11/04/14 - 11/16/14. The MAR also recorded the supplement was administered once on 11/17/14 and refused once on 11/17/14.

A weight committee meeting progress note written by the RD dated 11/12/14 recorded Resident #178 lost 3.8 pounds since the addition of a nutritional supplement on 11/04/14. The progress note recorded that Resident #178 received a four ounce nutritional supplement twice daily, had a meal intake of 50-75% and recommended an increase of the nutritional supplement from twice daily to three times daily due to continued weight loss.

On 11/19/14 a physician's order was written to discontinue the nutritional supplement due to refusals with an additional 3 pounds of continued weight loss.

Resident #178 was observed on 12/03/14 from 08:45 - 09:20 AM with her breakfast meal. She received oatmeal, a boiled egg, toast, four ounces of apple juice, butter, and jelly. Resident

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#178 fed herself and ate approximately 25% of her meal.

An interview with nurse aide #1 (NA#1) on 12/03/14 at 09:20 AM revealed the meal intake for Resident #178 varied. NA #1 stated Resident #178 typically ate more for lunch and dinner than she did for breakfast.

Resident #178 was observed eating lunch on 12/03/14 from 12:57 - 1:30 PM. Resident #178 received a turkey sandwich, green peas, roll, and lemonade. The Resident fed herself, was encouraged by staff to eat, but ate approximately less than 25% of her meal.

An interview with nurse #1 occurred on 12/04/14 at 12:20 PM. Nurse #1 stated she was the primary nurse for Resident #178 and the Resident "always refused to take the nutritional supplement". The nurse stated she documented acceptance of the supplement on the Resident's MAR in error due to adjusting to the facility's new electronic medication recording system. The nurse stated she was not aware if the dietary department had been informed that Resident #178 refused to take the supplement, but she informed the nurse practitioner around 11/19/14 that Resident #178 routinely refused the supplement.

The director of nursing (DON) revealed in an interview on12/04/14 at 12:41 PM that the weight committee included staff from the dietary department (manager or RD), therapy, staff development, DON and administrator. The meeting was held to discuss meal intake, food preferences, medications that could contribute to weight fluctuations and interventions for residents

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F 325	Continued From page 6	F 325		

who trended for weight loss or gain. The DON stated either she or dietary staff made any recommendations for supplements and if the physician or nurse practitioner agreed they wrote an order or the RD would write the order. Review of Residents medical record during the interview revealed a physician's order for a nutritional supplement to be administered three times daily had not been written.

An interview with the RD occurred on 12/04/14 at 1:20 PM which revealed that he assessed Resident #178 with weight loss during an initial nutritional assessment dated 11/04/14 and recommended a four ounce supplement to be given twice daily. The interview continued that despite the supplement, Resident #178 lost an additional 3.8 pounds after the 11/04/14 initial dietary assessment and so the weight committee discussed the continued weight loss during a meeting on 11/12/14. The RD stated the committee wasn't sure where the weight loss was coming from since the Resident's average meal intake was 50-75% and she received a supplement twice daily. The RD stated that during the meeting he recommended to increase the supplement to three times daily, which he stated "was a pretty typical response to weight loss when a supplement was accepted." The RD further stated that if a supplement was not accepted by a resident, nursing would be expected to advise the physician/NP or dietary so that another intervention could be tried. The RD further stated that he reviewed the Resident's medical record and saw no indication that the supplement was not working so he made a recommendation to increase the supplement to three times daily, but that he would not have recommended to increase the supplement if he

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F 325	Continued From page 7 had been aware that the Resident refused it. The RD further stated that his recommendation to increase the supplement to three times daily did not get written as an order, it was missed. A follow-up interview with the DON on 12/4/14 at 1:30 PM revealed that at the time of the weight committee meeting on 11/12/14, the committee was not aware that Resident #178 had been refusing the supplement. The DON stated the facility was in transition between two electronic systems and there may have been some confusion as to whether or not nursing would take the recommendation to increase Resident #178's supplement to three times daily to the physician/NP or if the RD would have written this recommendation as an order.	F 325		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of facility records, the facility failed to serve pureed green peas, mashed potatoes, green beans, cauliflower and zucchini in portions according to the menu for 28 residents who ate in 2 of 4 dining areas observed. (Residents # 7, 13, 20, 25, 32, 37, 41, 45, 47, 56, 64, 69, 77, 80, 82, 92, 94, 99, 121, 122, 125, 143, 144, 146, 158,	F 363	1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice. At time of the notification of incorrect portion sizes of Pureed green beans, mashed potatoes, green beans, cauliflower and zucchini the serving	12/26/14

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F 363	Continued From page 8 151, 172, and 228) The findings included: An observation of the lunch meal tray line occurred on 12/03/14 from 11:14 - 11:50 AM. Lunch trays were prepared by the kitchen supervisor for Residents 7, 13, 20, 25, 32, 37, 41, 45, 47, 56, 64, 69, 77, 80, 82, 92, 94, 99, 121, 122, 125, 143, 144, 146, 158, 151, 172, and 228 who ate in the main dining room and the 100 hall. The Residents received pureed green peas, mashed potatoes, green beans, cauliflower or zucchini. Review of the menu revealed the following menu items and portions: · Pureed green peas, 4 ounce portion · Mashed potatoes, 4 ounce portion · Green beans, 4 ounce portion · Cauliflower, 4 ounce portion · Zucchini, 4 ounce portion Observation of the lunch meal tray line on 12/03/14 revealed Residents 7, 13, 20, 25, 32, 37, 41, 45, 47, 56, 64, 69, 77, 80, 82, 92, 94, 99, 121, 122, 125, 143, 144, 146, 158, 151, 172, and 228 received 2.5 ounces pureed green peas, 2.5 ounces mashed potatoes, 2 ounces zucchini, 2 ounces green beans or 2 ounces of cauliflower instead of the 4 ounce portion required according to the menu. During an interview with the kitchen supervisor on 12/03/14 at 12:10 PM, he stated that he used the therapeutic spreadsheet as his guide for serving residents the correct portions of food. He stated the wrong serving utensils were being used because he did not have the correct sizes in stock. He further stated he placed an order for more serving utensils a week prior and was	F 363	utensils were immediately replaced with the correct 4 oz. portion size for above items. Completion date 12/3/14 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. Dining Services Manager placed an order for additional serving utensils to Direct Supply on 12/3/14. In-service completed for all dining services staff on, reading diet guides, proper portion sizes and correlating utensils on 12/3/14. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur. Dietary Manager or designee, will complete portion size/scoop size audit weekly x 4 and monthly x 3 thereafter to ensure compliance with proper portion sizes for served items. All new hires in dining services will receive in-service education on proper portion sizes for all food items upon hire. Any deficient practice identified through the tray accuracy audits will result in reeducation or disciplinary action as indicated. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur. Results of audits will be presented to Quarterly Quality Assurance meeting x 3 to ensure compliance and modification of plan if needed. 5. Date of Compliance: 12/26/14	

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F 363	Continued From page 9 awaiting receipt of the order he placed. He stated he informed the dietary manager of the order he placed for additional serving utensils. An interview with the dietary manager (DM) occurred on 12/03/14 at 12:15 PM. During the interview, the DM stated she spot checked the meal tray line for accuracy usually for the lunch and supper meals and occasionally for breakfast. The DM stated that the she had not noticed a concern with portion sizes. The DM stated that the kitchen supervisor completed food/supply orders, but serving utensils had not been ordered and would be ordered that day. The DM stated she completed an inventory that day of serving utensils and noted the facility had enough 4 ounce serving utensils to serve the lunch meal and as a result she was not sure why smaller serving utensils were used to serve vegetables for the lunch meal. An interview with the registered dietitian (RD) occurred on 12/04/14 at 1:20 PM. The interview revealed that the RD provided clinical support one and a half days per week and dietary support as needed. The RD stated he was not aware of a previous concern related to residents receiving incorrect portions of foods, but the menu should be followed with foods served according the approved portions.	F 363		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		12/26/14

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F 371	Continued From page 10 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to utilize beard restraints during food handling and preparation for 4 of 4 dietary staff observed with facial hair. The findings included: Kitchen observations were conducted on 12/01/14 and 12/03/14 and revealed the following concerns with the use of beard restraints: a. Dietary staff #1 was observed on 12/01/14 from 9:44 AM until 10:00 AM to prepare foods for the lunch meal. Dietary staff #1 was also observed on 12/03/14 from 11:27 AM - 12:10 PM to remove uncovered lunch trays from the steam table for delivery to residents. During these observations, dietary staff #1 was noted with facial hair to his cheeks, chin and above his lips. Dietary staff #1 was not wearing a beard restraint. During an interview on 12/03/14 at 12:19 PM, dietary staff #1 stated he was not wearing a beard restraint and was not aware that he was required to wear one when handling food. b. The kitchen supervisor was observed on 12/03/14 from 11:12 AM until 12:10 PM removing lunch food items from the oven, setting up the lunch tray line and serving the lunch meal. During this observation, the kitchen supervisor was noted with long facial hair to his chin. He did not have on a beard restraint. During an interview on	F 371	1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice. At the time of observation all dietary staff with facial hair immediately placed hair nets over facial hair (12/3/14). Dining services manager located the appropriate beard guards and instructed staff to wear beard guards (12/3/14) 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. All dining services employees were in-serviced regarding proper personal hygiene requirements during food handling and storage (12/3/14) Position job responsibilities regarding sanitation standards were reviewed with each Dining services employee. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur. Dietary Manager, or designee will conduct a personal hygiene audit daily X 5 days every shift, then weekly x 2 weeks and monthly x3 thereafter to ensure compliance with corrective actions and personal hygiene standards. All new dietary employees will receive	

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CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 12/03/14 at 12:10 PM, the kitchen supervisor stated he was aware that beard restraints should be worn and typically wore one, but the kitchen staff had been without beard restraints for about 1 week. The kitchen supervisor stated he was responsible for placing orders for beard restraints, but they were currently out of them. c. Dietary staff #2 was observed on 12/03/14 from 11:23 - 11:27 AM to bag cookies, plate peaches and make peanut butter and jelly sandwiches. Dietary staff #2 was noted with facial hair to his cheeks, chin and above his lip. During an interview on 12/03/14 at 12:18 PM dietary staff #2 stated he did not wear a beard restraint because he usually did not have facial hair. d. Dietary staff #3 was observed on 12/03/14 at 11:27 AM to make and pour coffee for the lunch meal. He was noted with long facial hair to his chin and facial hair above his lip. During an interview on 12/03/14 at 12:20 PM he stated he was aware that beard restraints should worn, but stated he thought the restraints were not available and needed to be ordered. An interview with the dietary manager on 12/03/14 at 12:15 PM confirmed that beard restraints should be worn by dietary staff with facial hair. The interview revealed the kitchen staff had been without beard restraints for a couple of weeks because they were not available from one of the vendors. The DM further stated that in the past if beard restraints were not available, she instructed staff with facial hair to use hair nets to cover their facial hair until an order for beard restraints was placed and received, but she did not instruct her staff to do so this time.	F 371	in-service education regarding proper personal hygiene requirements during food handling and storage upon hire. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur. Findings will be reviewed at the Quarterly Quality Assurance meeting x 3 to ensure compliance and modification of plan if needed. 5. Date of Compliance: 12/26/14	