STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING ______ B. WING ______	C 08/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation. Event ID BZ5F11.	F 000		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to deliver mail on Monday, Thursday and Saturday. The findings included: Interview with the resident council president, Resident #63, on 08/04/16 at 10:14 AM revealed residents did not receive mail daily during the week and on Saturday. Resident #63 explained it would be nice to receive mail six days a week but the activity department could not deliver it every day. Interview with the activity director (AD) on 08/04/16 at 11:44 AM revealed the business office sorted the mail and gave it to the activity department for delivery. The AD reported the residents received mail on Tuesday, Wednesday and Friday. Interview with the business office manager (BOM) on 08/04/16 at 11:48 AM revealed mail distribution to the residents occurred on Tuesday,	F 170	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F170 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: All mail will be delivered 6 days a week to residents by close of business Monday through Saturday. How corrective action will be accomplished for those residents having	9/2/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/26/2016

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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F 170	Continued From page 1 Wednesday and Friday. Interview with the administrator on 08/04/16 at 11:51 AM revealed residents should receive mail Monday through Saturday.	F 170	the potential to be affected by the same deficient practice: All mail will be delivered 6 days a week to residents by close of business. BOM, activities director, and receptionist are to be educated by administrator on mail delivery process. Measures to be put in place or systemic changes made to ensure practice will not re-occur: BOM, or designee upon BOM absence, will conduct audit of daily mail delivery for completeness weekly for 4 weeks; every other week for 4 weeks and monthly X 1. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on 2 of 2 dining observations, a resident	F 242	F242 How corrective action will be	9/2/16

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F 242 Continued From page 2

interview, staff interviews and review of the medical record, the facility failed to honor a resident's food preferences for 1 of 4 sampled residents observed during dining (Resident #114).

The findings included:

Resident #114 was re-admitted to the facility on 07/26/16. Diagnoses included type 2 diabetes mellitus.

An admission nursing assessment dated 07/26/16 assessed Resident #114 as alert, oriented to person, place, time, and situation, with intact cogntion and without difficulty understanding others or being understood.

A care plan updated July 2016 identifed Resident #114 was at nutritional risk regarding possible weight fluctuations. Interventions included to honor meal preferences, monitor food intake and offer substitute foods.

Resident #114 had a physician's order dated 08/02/16 for a regular texture, diabetic diet.

On 08/04/16 at 08:47 AM Resident #114 was observed in his room eating breakfast. Resident #114 received 1 slice of toast, 1 sausage patty, Confetti scrambled eggs, milk, water, and juice. Resident #114 ate the eggs and drank his juice and milk. He did not eat the sausage patty. Review of Resident #114's breakfast tray card revealed he also selected to receive hasbrown potatoes and preferred bacon for breakfast. Resdient #114 did not receive the hasbrown potatoes or bacon as requested. During the observation, Resident #114 stated that he prefered bacon, but got sausage which he did not

F 242

accomplished for each resident found to have been affected by the deficient practice: Resident #114: On 8/4/2106, Director of Nursing (DON) was present at time of lunch service and retrieved requested items from dietary per resident request. On 8/5/2016 DON visited resident #114 to confirm resident was aware that he had the choice of requesting alternate meal items.

How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current residents with BIMS score of 12 or greater to be educated on the selective menu process, available alternates, and ala carte menu items to ensure residents are aware of choices. All dietary and nursing staff were in-serviced on: 1) The selective menu process, available alternates, ala carte menu items, and the importance of honoring resident requests and food choices. 2) The importance of checking meal tickets for resident food preferences to ensure patient satisfaction through accurate delivery of listed meal ticket preferences.

Measures to be put in place or systemic changes made to ensure practice will not re-occur: All new dietary and nursing staff will receive education in orientation on the selective menu process, available alternates, ala carte menu items, and the importance of honoring resident requests and food choices. Dietary and/or designee will conduct tray accuracy audits

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F 242	Continued From page 3 like and that he did not receive the hashbrown potatoes he wanted. On 08/04/16 at 1:36 PM Resident #114 was observed in his room eating lunch. Resident #114 received tea, chicken parmesan, green peas, pasta, and cake. Review of his tray card revealed no menu items were selected and garlic bread, pimento cheese sandwich and soup were also available menu options. Resident #114 did not receive garlic bread, a pimento cheese sandwich or soup. During the observation, Resident #114 stated that he completed a select menu ticket for lunch, but did not know why the menu ticket on his tray was not complete. He also stated that he selected garlic bread, a pimento cheese sandwich and soup for lunch, but did not receive those items and that he did not always get the foods he asked for. On 08/04/16 at 4:28 PM the Certified Dietary Manager (CDM) stated that bacon was recorded on Resident #114's breakfast tray card as a preferred menu item and that he should have received bacon for breakfast on Thursday, 08/04/16 per his preference. The CDM further stated that the facility offered a select menu system for lunch and dinner and residents should receive the foods they selected for those meals. The CDM stated that Resident #114's original lunch tray card for 08/04/16 with his selected menu items was misplaced and the dietary staff just plated the main menu items for him. The CDM went on to explain that was why the tray card Resident #114 received with his lunch meal on 08/04/16 was blank and did not record the foods he selected. The CDM stated that once the dietary staff realized his select menu ticket was misplaced, dietary staff should have gone back to	F 242	for 5 residents weekly for 4 weeks; 1 resident weekly for 4 weeks and monthly X 10. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Quality Assurance Meeting and Quarterly Quality Assurance meeting X 4 for further resolution if needed.	

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F 242	Continued From page 4 Resident #114 and asked him what he wanted for lunch. During an interview on 08/05/16 at 4:26 PM with the Administrator and Director of Nursing, the interview revealed that the facility would have to review current practices and re-educate staff to ensure food preferences were honored and educate residents that they could ask for any foods they did not receive.	F 242		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		9/2/16

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F 278	Continued From page 5 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to accurately assess a stage 4 left heel pressure ulcer on an admission Minimum Data Set for 1 of 3 sampled residents reviewed with pressure ulcers (Resident #96). The findings included: Resident #96 was admitted to the facility on 06/27/16. Diagnoses included a left heel stage 4 pressure ulcer and type 2 diabetes mellitus. A care plan dated 06/28/16 identified Resident #96 with actual and the potential for skin impairment. Resident #96 was initially evaluated by a wound care specialist on 06/29/16 and assessed with one stage 4 pressure ulcer of the left plantar heel, with necrotic/eschar tissue and measured 6.3 cm by 5.0 cm by 0.5 cm. An admission Minimum Data Set dated 07/04/16 documented the following errors in the assessment for Resident #96's stage 4 left heel pressure ulcer: · Section M 0210, documented that she did not have a stage 1 or higher unhealed pressure ulcer · Section M 0300 D did not record that she had a stage 4 pressure ulcer or that it was present on admission · Section M 0610 did not record the length, width or depth of the stage 4 pressure ulcer	F 278	F278 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: MDSC modified resident�s #96 MDS, Section M, on 8/9/2016 to correct coding of their pressure ulcer. Resident #96�s Admission MDS ARD 7/4/16 was modified to remove diabetic ulcer and code stage IV pressure ulcer as documented on the 6/29/16 wound documentation from the wound specialist. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: The Nurse Consultant and MDSC Consultant provided education to the MDSC on items coded in section M. All current residents with a documented pressure ulcer will be reviewed along with the most recent MDS to ensure Section M was coded accurately. Any issues identified as being coded incorrectly, will be modified by the MDSC. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Any new MDSC hires will receive the same coding education upon hire. The MDS Consultant or designee will audit 5 residents� MDS who are coded as having a pressure ulcer once weekly for 4 weeks, twice a month for one	

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F 278	Continued From page 6 · Section M 0700 did not record the most severe tissue type of the stage 4 pressure ulcer · Section M 1040 documented that she had a diabetic foot ulcer During an interview on 08/05/16 at 3:27 PM, the MDS Coordinator stated that the admission MDS dated 07/04/16 for Resident #96 was completed by a traveling MDS nurse. The MDS Coordinator reviewed the MDS and initial wound care specialist evaluation dated 06/29/16 for Resident #96 and stated that the admission MDS should have indicated Resident had an unhealed stage 4 pressure ulcer that was present on admission, recorded the measurements, and the most severe tissue type. The MDS Coordinator stated that the indication of a diabetic foot ulcer was an error. During an interview on 08/05/16 at 4:25 PM with the Director of Nursing (DON) and the Nurse Consultant, the interview revealed that the admission MDS dated 07/04/16 for Resident #96 was completed by a traveling MDS nurse who visited the facility to assist with timely completion of the MDS. The interview revealed that the MDS nurse covered a multi-state territory, but was not aware that Resident #96 was referred to a wound physician or how to access the physician's progress notes. The interview also revealed that the DON expected the MDS to accurately assess Resident #96's stage 4 pressure ulcer based on the wound physician's 06/29/16 initial evaluation.	F 278	month, and monthly x 1 month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	F 311		9/2/16

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F 311	Continued From page 7 specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide nail care to 2 of 3 sampled residents reviewed for provision of care with activities of daily living (Resident #100 and Resident #121). Findings included: 1. Resident #100 was admitted to the facility on 05/12/2014 with diagnoses included Diabetes Mellitus (DM), atrial fibrillation, and high blood pressure. Review of the latest Minimum Data Set (MDS) dated 04/21/2016 revealed that the resident was cognitively intact, adequate hearing and vision, and clear speech. The MDS also coded Resident #100 as requiring limited assistance with personal hygiene with one person physical assist. Review of Resident #100's care plan dated 03/10/2016 revealed that the Resident required attention to nail care due to the diagnosis of DM. Review of the nursing notes for the past 3 months revealed that Resident had no records of refusals of care or any other behaviors. On 08/02/2016 at 12:38 PM, Resident #100 was observed in her wheelchair with long jagged fingernails approximately 3-4 millimeters (mm) extended beyond her fingertips. Some of her fingernails were observed with brownish substance underneath. In an interview with Resident #100 on 08/02/2016 at 12:40 PM, she recalled it had been at least 2 months she had not received any nail care from the staff. She stated that the nurses were busy most of the time. She did not request nail care in the recent months as she did not want to bother	F 311	F311 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #100 and #121 nails were assessed and trimmed. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: 100% audit of nails were completed for all current residents in the facility and corrections and/or referrals made as needed. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Nursing staff in-serviced on steps to take if they identify any resident with long nails. The Charge Nurse and Unit Manager to be notified immediately and communication will be provided to MD/NP for evaluation as needed. DON and/or designee for each unit will conduct audit of nail care for 10% of resident population weekly for 4 weeks; every other week for 4 weeks and monthly x 1 month. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further	

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F 311	Continued From page 8 the nurses frequently. She would like her fingernails properly trimmed and stayed clean all the time. She had been thinking of trimming her fingernail herself lately but she did not have a nail clipper. On 08/03/16 at 10:42 AM, Resident #100 was observed sitting in her wheelchair chatting with another resident outside her room. Her fingernails remained long, jagged with brownish substance visible under the nail. On 08/04/16 at 8:31 AM, Resident #100 was observed sitting in the wheelchair in her room. Her fingernails were remained long, jagged with brownish substance under the nail. Resident #100's nails remained long and jagged when observed again on 08/04/16 at 3:20 PM, and on 08/05/16 at 10:49 AM. In an interview conducted on 08/04/16 at 3:31 PM, Nurse Aide #3 stated that she was not allowed to cut diabetic resident's finger or toe nails. However, she was responsible to observe resident's finger and toe nails daily or at least during the shower day. She would report to the nurse if nail care for diabetic resident was needed. She acknowledged that it was her oversight that she did not identify Resident #100's nail care needs. On 08/05/2016 at 11:00 AM, an interview with Nurse #2 revealed that for diabetic residents, the toe nails had been trimmed by the foot doctor and the fingernails by the nurses. She acknowledged that resident's nails should be checked daily and nail care should be provided as needed. Nail care should be offered by the staff, residents did not have to ask for it. She admitted that she had not observed Resident #100's fingernails in the past few weeks. She agreed that Resident #100's fingernails were long and dirty and they should be trimmed and cleaned.	F 311	resolution if needed.	

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F 311	Continued From page 9 An interview was conducted with the Director of Nursing on 08/05/2016 at 11:47 AM. She stated it was her expectation that the care staff observed residents' personal hygiene needs every shift, including nail care, and proactively addressed those needs as necessary in a timely manner. The residents were not obligated to ask for nail care. Instead, it should be offered by the appropriate staff. 2. Resident #121 was admitted to the facility on 02/04/2016 with diagnoses included Diabetes Mellitus (DM), rheumatoid arthritis (RA), and muscle weakness. Review of the latest Minimum Data Set (MDS) dated 05/13/2016 revealed that the resident was cognitively intact, adequate hearing and vision, and clear speech. The MDS also coded Resident #121 as requiring limited assistance with personal hygiene with one person physical assist. Review of Resident #121's care plan dated 02/18/2016 revealed that the Resident required attention to nail care due to the diagnosis of DM and RA. Review of the nursing notes since Resident #121's admission to the facility revealed he had no records of refusals of care or any other behaviors. On 08/04/2016 at 8:33 AM, Resident #121 was observed sitting in the wheelchair in his room with long jagged fingernails extended approximately 4-5 millimeters (mm) beyond his fingertips. Some of the fingers had visible yellowish substance underneath the nails. In an observation conducted on 08/04/2016 at 3:53 PM, Resident #121's fingernails remained long, jagged, and dirty. Resident #121 was observed having long, jagged, and dirty fingernails again on 08/05/2016 at 10:56 AM. Interview with Resident #121 on 08/04/2016 at	F 311		

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F 311	Continued From page 10 3:53 PM revealed that he had not received any nail care in the past 2 months. He would like to have his fingernails trimmed in order to stay clean and comfortable. No one had offered to provide the nail care he needed in the past 2 months. He had not made any requests as the nurse were too busy and he did not want to keep bothering them. In an interview conducted on 08/04/16 at 3:31 PM, Nurse Aide #1 stated that she was not allowed to cut diabetic resident's finger or toe nails. However, she was responsible to observe resident's finger and toe nails daily or at least during the shower day. She would report to the nurse if nail care for diabetic resident was needed. She acknowledged that it was her oversight she did not identify Resident #121's nail care needs. On 08/04/2016 at 3:48 PM, an interview with Nurse #4 revealed that for diabetic residents, the toe nails had been trimmed by the foot doctor and the fingernails by the nurses. She acknowledged that resident's nails should be checked daily and nail care should be provided as needed on a timely manner. Nail care should be offered by the staff, residents did not have to ask for it. She admitted that she had not observed Resident #121's fingernails in the past few weeks. She agreed that Resident #121's fingernails were long and it should be trimmed and cleaned. An interview was conducted with the Director of Nursing on 08/05/2016 at 11:47 AM. She stated it was her expectation that the care staff observed residents' personal hygiene needs every shift, including nail care, and proactively addressed those needs as necessary in a timely manner. The residents were not obligated to ask for nail care. Instead, it should be offered by the appropriate staff.	F 311		

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(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 314	Continued From page 11	F 314		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on an observation, physician's interview, staff interviews and medical record review, the facility failed to apply a protective/adhesive barrier, as ordered by the physician, to the periwound of a deteriorating infected left heel stage 4 pressure ulcer for 1 of 3 sampled residents observed for wound care (Resident #96). The findings included: Resident #96 was admitted to the facility on 06/27/16. Diagnoses included a left heel stage 4 pressure ulcer and type 2 diabetes mellitus. A care plan dated 06/28/16 identified Resident #96 with actual and the potential for skin impairment. Interventions included wound care specialist referral, the application of a moisture barrier to areas as needed for protection of skin and to complete wound care as ordered. Resident #96 was initially assessed by a wound	F 314	F314 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Nurse #4 corrected treatment on resident #96 at time of observation during survey. No adverse effects noted for resident #96. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current nurses have received education on reviewing treatment orders and gathering all necessary supplies before providing treatment. Measures to be put in place or systemic changes made to ensure practice will not re-occur: All new Licensed Nurses will receive education in orientation on wound care and treatments. DON and/or designee for each unit will conduct treatment observation for 2 residents	9/2/16

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	345471	A. BUILDING ______ B. WING ______	C 08/05/2016

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F 314	Continued From page 12 care specialist on 06/29/16 and presented with a stage 4 pressure ulcer of the left plantar heel. An admission Minimum Data Set and Care Area Assessment dated 07/04/16 assessed Resident #96 at risk for developing pressure ulcers and current skin breakdown/foot ulcer to the left heel. Resident #96's most recent wound care specialist assessment was completed on 08/03/16. The stage 4 left heel pressure ulcer was assessed with moderate serosanguinous exudate (bloody drainage), 50% necrotic (dead) and 50% granulated (viable) tissue and measured 7.0 cm by 3.8 cm x 1.0 cm. The wound measurements were increased due to surgical excisional debridement of tissue. The wound progress was documented as deteriorated due to a Methicillin-resistant Staphylococcus aureus infection which was being treated by antibiotic therapy. Resident #96 had a physician's order dated 08/04/16 to clean the wound with normal saline, apply Skin Prep (protective/adhesive barrier) to the surrounding tissue, then apply silver alginate dressing and cover with foam daily. On 08/04/16 at 04:32 PM, Nurse #4 was observed to complete wound care for Resident #96's stage 4 left heel pressure ulcer. Observation of the wound care supplies revealed Skin Prep was not included in the supplies collected by Nurse #4 to complete the wound care. The wound was observed with moderate serosanguinous drainage and the wound edges were macerated. Nurse #4 completed the wound care, but did not apply the Skin Prep to the surrounding tissue (periwound). At the completion	F 314	weekly for 4 weeks; 1 resident weekly for 4 weeks and monthly X 1. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed.	

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F 314	Continued From page 13 of the wound care, Nurse #4 was interviewed and asked to review the physician's order for the stage 4 left heel pressure ulcer. In review of the physician's order, Nurse #4 stated that she did not apply the Skin Prep to the surrounding wound tissue when she completed the wound care, she stated she missed that part of the physician's order, but that she would go and apply the Skin Prep immediately. During an interview on 08/04/16 at 5:30 PM the Nurse Practitioner stated that all physician's orders should be followed as written. He stated that the Skin Prep was a significant part of the physician's order, it was in place to prevent the surrounding tissue from breaking down and should be applied according to the doctor's order. During an interview on 08/04/16 at 5:40 PM, the Director of Nursing (DON) stated that she expected all physician's orders to be followed as written. The DON stated the Skin Prep should be applied as ordered because "We don't want the surrounding skin to breakdown." During a telephone interview on 08/05/16 at 1:41 PM, the Wound Care Physician (WCP) stated that Resident #96 had a moist infected wound. He stated that he ordered the calcium alginate to absorb some of the drainage and the Skin Prep because he did not want the periwound (surrounding tissue) to become macerated. The WCP further stated that the Skin Prep served as a protective barrier and help to ensure that the calcium alginate would adhere to the wound bed. The WCP stated that he did not want the calcium alginate with silver to shift, and further stated "it needs to stay in the wound bed" and that he wanted the Skin Prep used as part of the wound	F 314		

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F 314	Continued From page 14 care.	F 314		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on an observation, resident interview, staff interviews and medical record review, the facility failed to make a referral for dental services when a resident expressed tooth pain and requested a dental consult for 1 of 4 sampled residents reviewed for dental services (Resident #19). The findings included: Resident #19 was admitted to the facility on 08/04/15. Diagnoses included dysphagia, chronic pain, atherosclerotic heart disease, and major depressive disorder. Review of a nurse's progress note dated 02/09/16 and the February 2016 Medication Administration Record revealed Resident #19 complained of tooth pain, received pain medication and requested a dental consult.	F 412	F412 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #19 was seen by in-house dentist on 8/5/16 with no adverse complications. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current nurses will receive education on appropriate dental referral procedures: when change of condition warrants a dental referral, notify discharge planning of need for appointment. All current residents were audited to ensure all referrals have been completed. Measures to be put in place or systemic	9/2/16

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F 412	Continued From page 15 A care plan dated 05/31/16 identified Resident #19 was at risk for oral/dental health problems due to having only 6 natural teeth, with a goal to include freedom from pain, and an intervention to coordinate arrangements for dental care. An annual Minimum Data Set dated 06/08/16 assessed Resident #19 with intact cognition and obvious/likely cavity or broken natural teeth. On 08/03/16 Resident #19 was interviewed and stated that she had problems with her teeth due to missing teeth and difficulty chewing her foods. Resident #19 stated that she had tooth pain in the past and the facility staff informed her family that a dentist was coming, but that no one had looked at her teeth. Resident #19 stated she was missing teeth for at least 2 years and she wanted to see a dentist. Resident #19 was observed with missing teeth and a broken tooth. Review of the facility's documentation of monthly dental referrals and the medical record for Resident #19 revealed there was no documentation of a referral for a dental consult for Resident #19. An interview on 08/05/16 at 03:55 PM with the Director of Nursing (DON) revealed that the nurse who wrote the 02/16/16 progress note regarding Resident #19's tooth pain was no longer employed by the facility and was unavailable for interview. The DON stated that Resident #19 had recent complaints of tooth pain and was seen by the dentist for the first time on 08/05/16. The DON stated that when Resident #19 complained of tooth pain on 02/16/16 and requested a dental consult, the nurse should have reported the	F 412	changes made to ensure practice will not re-occur: All new Licensed Nurses will receive education in orientation on appropriate dental referral procedures. DON and/or designee for each unit will conduct audit of dental referrals for 2 residents weekly for 4 weeks; 1 resident weekly for 4 weeks and monthly X 1. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed.	

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F 412	Continued From page 16 request to the unit manager for further assessment and to the physician for a dental referral. The DON stated that the dentist came to the facility monthly and dental services could have been provided to Resident #19 before now had the Resident been further assessed regarding her 02/16/16 complaint of tooth pain. The DON stated that the prior unit manager, DON and physician were no longer employed by the facility and were not available for interview.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		9/2/16

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F 431	Continued From page 17 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of the manufacturer's specification, the facility failed to label and date a canister of opened, partially used inhaler on one of five medication carts (Medication Cart #5). The findings included: Observation of medication cart on 08/04/2016 for residents at 200 Hall revealed the following: At 12:24 PM, Medication Cart #5 contained one opened, partially used canister of Ventolin Hydrofluoroalkane (HFA) without labels and opening date. Further observation of this inhaler revealed that the inhaler was an 8 grams canister that contained 60 actuations, of which 34 actuations had been used. Review of the manufacturer's product storage information for Ventolin HFA inhaler indicated, "Throw the inhaler away when the counter reads 000 or 12 months after you opened the foil pouch, whichever comes first." During an interview on 08/04/2016 at 12:24 PM, Nurse #1 stated that she was unable to identify the name of the resident, directions of administration, and the opening date for the Ventolin HFA inhaler found in the Medication Cart #5. She agreed that the Ventolin HFA inhaler which was not labeled with resident's name, directions, and opening date should be discarded.	F 431	F431 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Nurse #1 removed unlabeled med from med cart #5 during findings. Nurse #1 educated on proper storage and labeling of medications. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: 100% audit of medication carts were completed in the facility with no other issue noted on medication storage and labeling. All nurses were in-serviced on the proper labeling and storage of medication. Measures to be put in place or systemic changes made to ensure practice will not re-occur: All new nurses hired will be educated/in-serviced on the protocol for medication storage and labeling. DON and/or designee will conduct audit of 2 med carts weekly for 4 weeks; every other week for 4 weeks and monthly x 1 month. How facility will monitor corrective	

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F 431	Continued From page 18 She added that all the nurses were responsible for ensuring proper labeling on the medication and writing an opening date on the medication label immediately when the medication was opened. She stated that the third shift nurse normally checked the medications in the medication carts thoroughly for expiration and proper labeling at least once daily. She acknowledged that the unlabeled partially used Ventolin HFA inhaler was missed and she would discard it immediately. An interview was conducted with Director of Nursing on 08/04/2016 at 4:49 PM. She stated that it was her expectation for all the medications to be labeled minimally with the name of resident, directions of administration, and expiration/opening date. She further stated that the facility policy required the nurse to ensure proper labeling of all medication before administering it to a resident and discard any unlabeled medications.	F 431	action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		9/2/16

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F 514	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to accurately assess and record the height on the nursing admission assessment and accurately assess and record the height and ideal body weight on a nutrition assessment for 1 of 22 sampled residents reviewed (Resident #114). The findings included: Resident #114 was re-admitted to the facility on 07/26/16. Diagnoses included type 2 diabetes mellitus, obesity and spinal stenosis. An admission nursing assessment dated 07/26/16 assessed Resident #114 as alert, oriented to person, place, time, situation and had intact cognition with no difficulty understanding others or being understood. His weight was assessed as 199 pounds and his height was assessed as 61 inches. A care plan updated July 2016 identified Resident #114 was at nutritional risk regarding possible weight fluctuations and obesity. A nutrition assessment dated 08/02/16 completed by the Registered Dietitian (RD) recorded that Resident #114 received a diabetic diet, weighed 201.5 pounds and had a height of 61 inches. The RD assessed the Resident's ideal body weight (IBW) as approximately 112 pounds based on a height of 61 inches (5 feet 1 inch). Resident #114 was observed on 08/04/16 at 08:47 AM seated on his bed in his room eating	F 514	F514 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Correct height placed in record for Resident #114 and new nutrition assessment completed based on new height and ideal body weight. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Audit completed for all new admissions during the month of July and August to ensure accurate height in patient record. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Regional Dietician and/or designee will conduct audit of admission heights for 5 new admissions weekly for 4 weeks; every other week for 4 weeks and monthly x 1 month. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Quality Assurance Meeting and Quarterly Quality Assurance meeting X 1 for further resolution if needed.	

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F 514	Continued From page 20 breakfast. When asked how tall he was, he stated he was about 6 feet tall. During an interview on 08/05/16 at 11:46 AM the RD stated that he completed a nutrition assessment for Resident #114 dated 08/02/16 and used the height of 61 inches that was documented in the computer from the admission nursing assessment to asses Resident #114's IBW of 112 pounds. The RD further stated that when he completed the nutrition assessment, he did not actually visit Resident #114, but rather based the assessment on data that was in the computer to include the height and weight, the physician's prescribed diet (diabetic), treatment for a surgical wound, average meal intake (50-75%) and determined that it was not necessary to see the Resident at that time. The RD also stated that Resident #114 was assessed as obese due to the weight and height data documented in the computer. The RD stated that the computer software the facility used calculated a resident's IBW based on the height and weight data entered and that's how the IBW of 112 pounds was determined for Resident #114. The RD stated that Resident #114 was actually 73 inches tall with an IBW of 184 pounds instead of 112 pounds. During an interview on 08/05/16 at 11:55 AM Nurse #5 stated she obtained the height and weight for Resident #114 on re-admission and recorded his height in error in the computer. Nurse #5 stated she just reassessed the Resident's height that day (08/05/16) to be 73 inches instead of 61 inches.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		9/2/16

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F 520	Continued From page 21 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in October of 2015. This was for 3 recited deficiencies which were originally cited in September of 2015 on a recertification and complaint investigation survey and on the current recertification and complaint investigation survey.	F 520	F520 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: F 242 Resident #114: On 8/4/2106, Director of Nursing (DON) was present at time of lunch service and retrieved requested items from dietary per resident request. On 8/5/2016 DON visited resident #114 to confirm resident was aware that he had the choice of	

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F 520	Continued From page 22 The deficiencies were in the areas of right to make choices, assessment accuracy and quality assurance. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1. F 242: Right to Make Choices: Based on 2 of 2 dining observations, a resident interview, staff interviews and review of the medical record, the facility failed to honor a resident's food preferences for 1 of 4 sampled residents observed during dining (Resident #114). F 242 was originally cited during a recertification and complaint investigation survey in September 2015 for the facility's failure to honor a resident's food preferences. During the current recertification and complaint investigation survey, the facility was recited for failure to honor a resident's food preferences. During an interview on 08/05/16 at 4:26 PM with the Administrator and Director of Nursing (DON), the interview revealed that neither of them were in their respective roles at the facility during the September 2015 annual survey. The Administrator stated that the facility's Quality Assurance Program (QAP) met at least quarterly and discussion was based on plans of correction and any new concerns identified. He stated that monitoring of concerns was discussed daily during morning meetings and then quarterly during QAP meeting. The interview revealed that the facility would have to review current practices	F 520	requesting alternate meal items. F278 □ MDSC modified resident□s #96 MDS, Section M, on 8/9/2016 to correct coding of their pressure ulcer. Resident #96□s Admission MDS ARD 7/4/16 was modified to remove diabetic ulcer and code stage IV pressure ulcer as documented on the 6/29/16 wound documentation from the wound specialist. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Individual actions denoted on said area for citation F-242 & F-278. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Individual actions denoted on said area for citation F-242 & F-278. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the weekly audits will be reviewed at Weekly Risk Meeting and Quarterly Quality Assurance meeting X 4 for further resolution if needed.	

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MECKLENBURG HEALTH & REHABILITATION CENTER	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

(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 520	Continued From page 23	F 520		

and re-educate staff to ensure food preferences were honored. The DON stated that residents would also have to be educated that they could ask for any foods they did not receive.

2. F 278: Assessment Accuracy: Based on staff interviews and medical record review, the facility failed to accurately assess a stage 4 left heel pressure ulcer on an admission Minimum Data Set for 1 of 3 sampled residents reviewed with pressure ulcers (Resident #96).

F 278 was originally cited during a recertification and complaint investigation survey in September 2015 for failure to accurately assess a stage 2 pressure ulcer and excoriated peri area. The facility was recited during the current recertification and complaint investigation survey for failure to accurately assess a stage 4 pressure ulcer.

During an interview on 08/05/16 at 4:26 PM with the Administrator and Director of Nursing (DON), the interview revealed that neither of them were in their respective roles at the facility during the September 2015 annual survey. The Administrator stated that the facility's Quality Assurance Program (QAP) met at least quarterly and discussion was based on plans of correction and any new concerns identified. He stated that monitoring of concerns was discussed daily during morning meetings and then quarterly during QAP meeting. The interview revealed that the facility would have to review current practices and re-educate staff to ensure accuracy of the Minimum Data Set.

3. F 520: QA: Based on observations, record reviews, staff and resident interviews the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING ______ B. WING ______	C 08/05/2016

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F 520	Continued From page 24 Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in October of 2015. This was for 3 recited deficiencies which were originally cited in September of 2015 on a recertification and complaint investigation survey and on the current recertification and complaint investigation survey. The deficiencies were in the areas of right to make choices, assessment accuracy and quality assurance. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. F 520 was originally cited during a recertification and complaint investigation survey in September 2015 for failure to maintain implemented procedures and monitor these interventions related to dignity with wound care and the use of disposable cups and feeding residents at eye level during dining. F 520 was recited on the current recertification and complaint investigation survey related to right to make choices, accuracy of the Minimum Data Set (MDS) and an effective Quality Assurance Program (QAP). During an interview on 08/05/16 at 4:26 PM with the Administrator and Director of Nursing (DON), the interview revealed that neither of them were in their respective roles at the facility during the September 2015 annual survey. The Administrator stated that the facility's QAP met at least quarterly and discussion was based on plans of correction and any new concerns identified. He stated that monitoring of concerns was discussed daily during morning meetings and then quarterly during QAP meeting. The interview revealed that the facility would have to review current practices and re-educate staff to ensure	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 25 food preferences were honored and accuracy of the MDS. The DON stated that residents would also have to be educated that they could ask for any foods they did not receive.	F 520		