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CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	**4801 RANDOLPH ROAD** **CHARLOTTE, NC 28211**

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E 000	Initial Comments An unannounced Recertification survey was conducted on 12/09/2019 through 12/13/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# D3FK11.	E 000		
F 000	INITIAL COMMENTS A Recertification Survey and Complaint Investigation was conducted from 12/09/2019 through 12/13/2019. There were 12 allegations investigated and 2 were substantiated. Event ID# D3FK11.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the area of Preadmission Screening and Resident Review (PASARR) to reflect Level II determination for 5 of 5 sampled residents (Resident #6, Resident # 36, Resident #48, Resident #53 and Resident #57). Findings included: 1. Resident #6 was admitted to the facility on 6/22/17 with medical diagnoses inclusive of unspecified sequelae of unspecified cerebrovascular disease and schizophrenia. A review of Resident #6's annual Minimum Data Set (MDS) dated 5/15/19, Section A 1500	F 641		

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

Electronically Signed

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

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revealed she was not screened for Level II PASRR determination. Resident #6's last quarterly MDS dated 10/1/19 revealed she was cognitively intact.

An interview was conducted on 12/10/19 at 3:32 PM with the MDS nurses. During the interview, MDS Nurse #1 reported she had completed Section A 1500 for Resident # 6's annual MDS assessment. MDS Nurse #1 stated she was not aware residents with a severe mental health disorder required screening and referral for Level II PASARR determination with each comprehensive assessment.

During an interview on 12/10/19 at 3:40 PM with the facility's Social Worker (SW), SW#1 indicated he was responsible for screening and referring residents for Level II PASARR determination. He also stated he was responsible for educating the MDS nurses regarding the process of screening and referring residents diagnosed with a severe mental health disorder. SW#1 reported he had not screened and referred Resident #6 for Level II PASARR determination.

An interview was conducted with the Director of Nursing (DON) on 12/12/19 at 2:25 PM. The DON reported the facility had a corporate MDS consultant that should review assessments and reports completed by the facility's MDS nursing staff. The DON indicated the consultant had conducted conference calls and weekly onsite visits to answer questions. The DON stated the MDS nurses had opportunities to ask questions when they were not knowledgeable of the process to complete MDS assessments.

During an interview with the facility's Administrator

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F 641	Continued From page 2 on 12/12/19 at 2:34 PM, she stated residents with a severe mental health disorder should be screened and referred for Level II PASARR to determine their eligibility for additional services. The Administrator identified the facility's Social Worker as having the responsibility of knowing the residents in the facility with a severe mental health diagnosis, screening and referring those residents for Level II PASARR determination at the time of their MDS comprehensive assessment. 2. Resident #36 was admitted to the facility on 5/31/19 with medical diagnoses inclusive of chronic kidney disease, schizoaffective disorder and bipolar disorder. A review of Resident #36's admission Minimum Data Set (MDS) dated 6/7/19, Section A 1500 revealed she was not screened for Level II PASARR determination. Resident #36's last quarterly MDS dated 11/22/19 revealed she was cognitively intact. An interview was conducted on 12/10/19 at 3:32 PM with the MDS nurses. During the interview, MDS Nurse #1 reported she had completed Section A 1500 for Resident #36's admission MDS assessment. MDS Nurse #1 stated she was not aware residents with a severe mental health disorder required screening and referral for Level II PASARR determination with each comprehensive assessment. During an interview on 12/10/19 at 3:40 PM with the facility's Social Worker (SW), SW#1 indicated he was responsible for screening and referring residents for Level II PASARR determination. He also stated he was responsible for educating the	F 641		

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F 641	Continued From page 3 MDS nurses regarding the process of screening and referring residents diagnosed with a severe mental health disorder. SW#1 reported he had not screened and referred Resident # 36 for Level II PASARR determination. An interview was conducted with the Director of Nursing (DON) on 12/12/19 at 2:25 PM. The DON reported the facility had a corporate MDS consultant that should review assessments and reports completed by the facility's MDS nursing staff. The DON indicated the consultant had conducted conference calls and weekly onsite visits to answer questions. The DON stated the MDS nurses had opportunities to ask questions when they were not knowledgeable of the process to complete MDS assessments. During an interview with the facility's Administrator on 12/12/19 at 2:34 PM, she stated residents with a severe mental health disorder should be screened and referred for Level II PASARR to determine their eligibility for additional services. The Administrator identified the facility's SW as having the responsibility of knowing the residents in the facility with a severe mental health diagnosis, screening and referring those residents for Level II PASARR determination at the time of their MDS comprehensive assessment. 3. Resident #48 was readmitted to the facility on 6/22/15 with medical diagnosis inclusive of chronic pain syndrome, type 2 diabetes mellitus and schizophrenia. A review of Resident #48's annual Minimum Data Set (MDS) dated 11/6/19 revealed he was moderately cognitively impaired, and Section A	F 641		

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1500 revealed he was not screened for Level II PASARR determination.

An interview was conducted on 12/10/19 at 3:32 PM with the MDS nurses. During the interview, MDS Nurse #1 reported she had completed Section A 1500 for Resident #48's annual MDS assessment. MDS Nurse #1 stated she was not aware residents with a severe mental health disorder required screening and referral for Level II PASARR determination with each comprehensive assessment.

During an interview on 12/10/19 at 3:40 PM with the facility's Social Worker (SW), SW#1 indicated he was responsible for screening and referring residents for Level II PASARR determination. He also stated he was responsible for educating the MDS nurses regarding the process of screening and referring residents diagnosed with a severe mental health disorder. SW#1 reported he had not screened and referred Resident #48 for Level II PASARR determination.

An interview was conducted with the Director of Nursing (DON) on 12/12/19 at 2:25 PM. The DON reported the facility had a corporate MDS consultant that should review assessments and reports completed by the facility's MDS nursing staff. The DON indicated the consultant had conducted conference calls and weekly onsite visits to answer questions. The DON stated the MDS nurses had opportunities to ask questions when they were not knowledgeable of the process to complete MDS assessments.

During an interview with the facility's Administrator on 12/12/19 at 2:34 PM, she stated residents with a severe mental health disorder should be

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screened and referred for Level II PASARR to determine their eligibility for additional services. The Administrator identified the facility's SW as having the responsibility of knowing the residents in the facility with a severe mental health diagnosis, screening and referring those residents for Level II PASARR determination at the time of their MDS comprehensive assessment.

4. Resident #53 was admitted to the facility on 2/16/17 with medical diagnosis inclusive of chronic atrial fibrillation, dementia, and schizophrenia.

A review of Resident #53's annual Minimum Data Set (MDS) dated 11/7/19 revealed she was cognitively intact, and Section A 1500 revealed she was not screened for Level II PASARR determination.

An interview was conducted on 12/10/19 at 3:32 PM with the MDS nurses. During the interview, MDS Nurse #1 reported she had completed Section A 1500 for Resident # 53's annual MDS assessment. MDS Nurse #1 stated she was not aware residents with a severe mental health disorder required screening and referral for Level II PASARR determination with each comprehensive assessment.

During an interview on 12/10/19 at 3:40 PM with the facility's Social Worker (SW), SW#1 indicated he was responsible for screening and referring residents for Level II PASARR determination. He also stated he was responsible for educating the MDS nurses regarding the process of screening and referring residents diagnosed with a severe mental health disorder. SW#1 reported he had

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not screened and referred Resident #53 for Level II PASARR determination.

An interview was conducted with the Director of Nursing (DON) on 12/12/19 at 2:25 PM. The DON reported the facility had a corporate MDS consultant that should review assessments and reports completed by the facility's MDS nursing staff. The DON indicated the consultant had conducted conference calls and weekly onsite visits to answer questions. The DON stated the MDS nurses had opportunities to ask questions when they were not knowledgeable of the process to complete MDS assessments.

During an interview with the facility's Administrator on 12/12/19 at 2:34 PM, she stated residents with a severe mental health disorder should be screened and referred for Level II PASARR to determine their eligibility for additional services. The Administrator identified the facility's SW as having the responsibility of knowing the residents in the facility with a severe mental health diagnosis, screening and referring those residents for Level II PASARR determination at the time of their MDS comprehensive assessment.

5. Resident #57 was readmitted to the facility on 9/27/19 with medical diagnoses inclusive of unspecified sequelae of cerebral infarction, unspecified dementia and schizophrenia.

A review of Resident #57's significant change Minimum Data Set (MDS) dated 11/6/19 revealed she moderately cognitively impaired, and Section A 1500 revealed she was not screened for Level II PASARR determination.

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An interview was conducted on 12/10/19 at 3:32 PM with the MDS nurses. During the interview, MDS Nurse #2 reported she had completed Section A 1500 for Resident # 57's Resident #57's significant change MDS assessment. MDS Nurse #2 stated she was not aware residents with a severe mental health disorder required screening and referral for Level II PASARR determination with each comprehensive assessment. MDS Nurse #2 reported she indicated in Section A 1500 on a comprehensive assessment, residents with PASARR Level II should be screened for continued services.

During an interview on 12/10/19 at 3:40 PM with the facility's Social Worker (SW), SW#1 indicated he was responsible for screening and referring residents for Level II PASARR determination. He also stated he was responsible for educating the MDS nurses regarding the process of screening and referring residents diagnosed with a severe mental health disorder. SW#1 reported he had not screened and referred Resident #57 for Level II PASARR determination.

An interview was conducted with the Director of Nursing (DON) on 12/12/19 at 2:25 PM. The DON reported the facility had a corporate MDS consultant that should review assessments and reports completed by the facility's MDS nursing staff. The DON indicated the consultant had conducted conference calls and weekly onsite visits to answer questions. The DON stated the MDS nurses had opportunities to ask questions when they were not knowledgeable of the process to complete MDS assessments.

During an interview with the facility's Administrator on 12/12/19 at 2:34 PM, she stated residents with

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F 641	Continued From page 8 a severe mental health disorder should be screened and referred for Level II PASARR to determine their eligibility for additional services. The Administrator identified the facility's social worker as having the responsibility of knowing the residents in the facility with a severe mental health diagnosis, screening and referring those residents for Level II PASARR determination at the time of their MDS comprehensive assessment.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		

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admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews and record review, the facility failed to develop a baseline care plan which included the minimum healthcare information necessary to properly care for a resident with a tracheostomy, feeding tube, indwelling urinary catheter and pressure ulcers for 1 of 3 sampled residents who required baseline care plans after admission (Resident #275).

The findings included:

Resident #275 was admitted to the facility on 12/06/19 with diagnoses which included chronic respiratory failure with tracheostomy, cerebral vascular accident, colostomy, diabetes mellitus, and pressure ulcers.

Review of a nursing admission assessment, written by Unit Manager #1, dated 12/06/19

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F 655	Continued From page 10 revealed Resident #275 was nonverbal. Resident #275's nursing assessment documented presence of a gastrostomy tube, indwelling urinary catheter, and pressure ulcers on both hips, sacrum and both heels. Review of Resident #275's electronic clinical record revealed there was no documentation of a baseline care plan. The electronic clinical record contained a statement; "Base Line Care Plan 5 days overdue." Observation of Resident #275 on 12/11/19 at 9:49 AM revealed Resident #275 received continuous tube feedings and used a tracheostomy without oxygen. Resident #275's legs were contracted and an indwelling urinary catheter drained clear, yellow urine to gravity. Resident #275 did not respond to verbal stimuli. Interview with Nurse #1 on 12/11/19 at 2:03 PM revealed Resident #275 required occasional suctioning and required total care by staff for all activities of daily living. Nurse #1 explained the admitting nurse had the responsibility of Resident #275's baseline care plan development within 48 hours. During an interview with Unit Manager #1 on 12/11/19 at 2:19 PM, Unit Manager #1 reported Resident #275 did not have a base line care plan. Unit Manager #1 explained the facility's software system did not trigger a pathway to write a base line care plan when she completed the admission nursing assessment. Interview with the Director of Nursing (DON) on 12/11/19 at 2:33 PM revealed Resident #275's height and weight were not documented on the	F 655		

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F 655	Continued From page 11 admission nursing assessment. The admitting nurse did not receive a message to complete a base line care plan due to the omitted data. The DON reported staff should complete all areas of an assessment and develop the base line care plan upon admission.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide nail care for 1 of 4 residents who were dependent on nursing staff for assistance with activities of daily living (Resident #19). Findings included: Resident #19 was readmitted to the facility on 4/8/19 with medical diagnoses inclusive of dementia and hypertension. Resident#19's annual Minimum Data Set (MDS) dated 10/18/19 identified he was severely cognitively impaired. The MDS also identified he was totally dependent of staff for bathing and required extensive assistance, two persons physical, with personal hygiene. Resident #19's care plan updated with the annual MDS identified a focus area for assistance with activities of daily living.	F 677		

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F 677	Continued From page 12 Observation on 12/10/19 at 9:33 AM revealed Resident #19 awake in his bed with food matter on his clothes, his arms crossed and resting on his abdomen. Resident #19's fingernails on both his hands were long, jagged with dried brown colored matter underneath the nails. An additional observation on 12/10/19 at 11:28 AM, Resident #19 was observed to be sitting in a wheelchair in his room. Resident #19 was wearing personal clothing and his facial hair was trimmed. Resident #19 also was observed to be attempting to move items in his reach. His fingernails were long and jagged. On 12/11/19 at 3:04 PM, Resident #19 was observed to be lying in bed. He was wearing a gown and appeared asleep. He had his hands resting on his abdomen. His fingernails were long and jagged. An additional observation was conducted on 12/12/19 at 11:15 AM, Resident #19's fingernails on both hands were long and jagged. During an interview with the Admissions Coordinator on 12/12/19 at 2:42 PM, the coordinator stated she was assigned to complete "angel rounds" in the morning for Resident #19 on 12/10/19 through 12/12/19. The Coordinator reported she had observed Resident #19's fingernails were long. The Coordinator stated she informed Nurse Aide (NA#1) Resident #19's nails were long, however, she was unable to recall the day and time she informed NA#1. The Coordinator also stated she had not informed the nurse assigned to Resident #19 of her observation of Resident #19's long fingernails during angel rounds.	F 677		

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An interview was conducted with NA #1 on 12/12/19 at 2:50 PM, she stated she had not observed Resident #19's long nails and had not been informed of any concerns made during angel rounds. NA #1 stated she would be responsible for notifying the assigned nurse for Resident #19 of the need to cut his nails.

On 12/12/19 at 3:23 PM, the Director of Nursing (DON) observed Resident #19's fingernails and confirmed his nails were long, jagged and dirty.

An interview was conducted with the Director of Nursing (DON) on 12/12/19 at 2:38 PM. The DON stated nail care should be performed daily by nurse aides and cut as needed by the assigned nurse and also stated nail care was performed by nurse aides while providing residents assistance with bed baths and showers. She also identified the facility had a process of completing "angel rounds" each morning by department managers and stated department managers were assigned to residents and angel rounds included greeting residents, inquiring of and observing for the residents' needs, and reporting to the nursing staff concerns observed and needs requested by the residents.

On 12/12/19 at 2:47 PM during an interview with the Administrator, she reported department managers were responsible for completing angel rounds each morning. The Administrator stated department managers should assess the overall status of assigned residents at the time of the round and report concerns to nursing staff and during stand-up meetings attend by the department managers. The Administrator had not conducted a formal process for department

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managers to report concerns during stand-up meetings following the morning angel rounds on 12/10/19 - 12/12/19.

F 695 SS=D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) F 695

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident and staff interview, and record review, the facility failed to provide oxygen therapy per physician order for 2 of 2 residents reviewed for respiratory care (Resident #56, #29).

Findings included:

1. Resident #56 was readmitted to the facility on 10/22/2019. His diagnoses were inclusive of acute and chronic respiratory failure with hypoxia, unspecified combined systolic (congestive) and diastolic (congestive) heart failure, and muscle weakness.

Resident #56's quarterly Minimum Data Set (MDS) dated 10/24/2019 revealed moderate cognitive impairment. Resident #56 was not indicated as exhibiting behavioral symptoms. Review of Section O- Special Treatments, Procedures, and Programs indicated Resident

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F 695	Continued From page 15 #56 received oxygen therapy. Resident #56 had a plan of care dated 10/24/2019 related to the use of a nasal cannula for oxygen support. Interventions were inclusive of alerting the physician of any new onset of respiratory issues. Review of Resident #56's electronic medical record revealed the following physician order: Continuous oxygen at 2 liters per minute via nasal cannula An observation was completed on 12/9/2019 at 12:14 PM of Resident #56. He was in bed asleep with his NC applied to his nares. His in-room oxygen concentrator was running and was observed to be set at 3 liters. Resident #56 did not appear to be in distress. Additional follow up observations revealed the following: 12/9/2019 at 2:44 PM Resident #56 observed in bed resting. In-room oxygen applied via nasal cannula to his nares. In-room oxygen concentrator observed to be set at 3 liters. No distress observed. 12/11/2019 at 10:07 AM Resident #56 was observed in bed. In-room oxygen applied via nasal cannula to his nares. In-room oxygen concentrator observed to be set at 2.5 liters. No distress observed. An additional observation and interview with Nurse #1 was completed on 12/12/2019 at 9:35 AM of Resident #56. He was in bed resting with	F 695		

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his nasal cannula applied to his nares. His in-room oxygen concentrator was set at 2.5 liters. Nurse #1 confirmed the observed in-room oxygen setting of 2.5 liters. Nurse #1 verified Resident #56's physician order for oxygen via the electronic mediation administration record (eMAR). Nurse #1 explained his in-room oxygen concentrator should be set at 2 liters per his physician order. Nurse #1 adjusted the in-room oxygen setting to 2 liters. She verbalized nurses should check oxygen settings every shift. She could not explain why the in-room concentrator was set at a different liter that what was ordered. Nurse #1 communicated Resident #56 would not have adjusted his own oxygen settings.

An interview was completed on 12/12/2019 at 9:39 AM with the Director of Nursing (DON). The DON expressed nurses should check oxygen orders to ensure residents received the ordered setting. The DON continued to communicate the process going forward would include nurses checking oxygen settings every shift and as needed.

2. Resident #29 admitted to the facility on 10/14/2019. His diagnoses included acute on chronic systolic (congestive) heart failure and pleural effusion.

Resident #29's admission Minimum Data Set (MDS) dated 10/16/2019 revealed he had intact cognition. Resident #29 did not have any behavioral symptoms indicated. Review of Section O- Special Treatments, Programs, and Procedures revealed he utilized oxygen therapy.

Resident #29 had a congestive heart failure plan of care in place with most recent revision dated

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11/17/2019. The interventions were inclusive of oxygen continuous at 4 liters/ minute via nasal cannula.

Review of Resident #29's electronic medical record revealed the following physician order:

Oxygen continuous at 4 liters/ minute via nasal cannula to maintain oxygen saturation (amount of oxygen in the blood stream) above 90%

An observation was completed on 12/10/2019 at 11:55 AM of Resident #29. He was in bed resting with his nasal cannula applied to his nares. His in-room oxygen concentrator was observed to be set at 3 liters. No distress observed.

A follow up observation and interview was completed on 12/10/2019 at 2:33 PM with Resident #29. He was awake and resting in bed. His nasal cannula was applied to nares. Observation of his in-room concentrator revealed a setting of 3.5 liters. Resident #29 verbalized "his oxygen setting should be on 4 liters". No distress observed.

An additional observation was completed on 12/12/2019 at 9:59 AM of Resident #29. He was sitting edge of bed with his nasal cannula applied to his nares. His in-room concentrator was observed to be set at 3.5 liters. No distress observed.

An observation and interview was completed on 12/12/2019 at 10:01 AM of Resident #29 with the Treatment Nurse. The Treatment Nurse confirmed the in-room concentrator was set at 3.5 liters. She was not certain of Resident #29's current physician order. The Treatment Nurse

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F 695	Continued From page 18 did state nurses should be checking oxygen settings frequently throughout the shift to ensure residents received the ordered amount of oxygen prescribed by the physician. The Treatment Nurse verbalized she would follow up with the hall nurse to ensure Resident #29 received his ordered amount of oxygen. An interview was completed on 12/12/2019 at 9:39 AM with the Director of Nursing (DON). The DON expressed nurses should check oxygen orders to ensure residents received the ordered setting. The DON continued to communicate the process going forward would include nurses checking oxygen settings every shift and as needed.	F 695		