STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 02/19/2016

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WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigation. Event ID # SGKW11.	F 000	Preparation on and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156	F156 1. Resident #10 was discharged from the facility on 11-24-2015. Resident #3 was discharged from the facility the facility on 10-15-2015. 2. Current residents receiving Medicare services were audited as 3-1-2016 by the business office manager. 3. The business office manager (BOM), and MDS Coordinator received education by the executive director on 3-9-16, regarding Notice of Medicare Non Coverage letters. Monthly audits to be conducted on residents' receiving Medicare services monthly X 3 months.	3-18- 2016

DHSR NHL&C Black Mountain WRO Received MAR 16 2016 by: vcl

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

Executive Director 3-11-16

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 156	Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and	F 156	4. A QI tool will be utilized by the social services director, and or designee monthly X 3 months for residents receiving Medicare services, to ensure Medicare non coverage letters are issued timely prior to services being stopped. The results of the audit will be forwarded to the quality assurance committee on a monthly basis X 3 months, then ongoing as needed to sustain compliance.	

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F 156	Continued From page 2 applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide 2 of 3 sampled resident (#10 and #3) with the Notice of Medicare Non-Coverage. Resident #10 did not receive the letter and right to appeal Medicare Non-Coverage until after coverage of services ended. The facility could not verify through documentation in writing Resident #10 had received the letter and right to appeal the Notice of Medicare Non-coverage. Findings Included: 1. Review of the records revealed Resident #10 had signed the letter of Medicare Notice of Non Coverage and right to appeal 11/24/2015, the day after coverage ended on 11/23/2015. An interview with the Social Worker (SW) on 02/18/2016 at 11:20 AM revealed she could not verify the specific date Resident #10 had signed the letter and right to appeal Notice of Medicare Non-Coverage. An interview with the Director of Nursing (DON) on 02/19/2016 at 08:10 AM revealed that the date on the letter and right to appeal Notice of Medicare Non-coverage was after services were discontinued on 11/24/2015. 2. On 02/18/2016 at 11:20 AM the Social Worker was asked to provide a letter and right to appeal the Notice of Medicare Non-coverage for Resident #3. An interview with the SW on			

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F 156	Continued From page 3 02/18/2016 at 11:20 AM revealed she could not provide a letter and right to appeal the Notice of Medicare Non-coverage for Resident #3. She stated the letter would have been provided to the resident prior to her being employed by the facility. She stated that every resident needed to receive the letter before Medicare covered services end. An interview with the Director of Nursing (DON) on 02/19/2016 at 8:10 AM revealed that he was not employed by the facility at the time the Notice of Medicare Non-coverage would have been provided to Resident #3. He was aware the letter and right to appeal the Notice of Medicare Non-coverage are required to be provided to residents. He stated he would follow up and try to locate the letter and right to appeal the Notice of Medicare Non-coverage. The letter was not provided.	F 156		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272	F272 1. For resident #53, the MDS coordinator documented the findings with a description of problem, causes, contributing factors and risk related to falls. The MDS coordinator will open a new annual assessment with CAAs for residents' #20 and #25 by 3-18-16. The CAA will include the documentation of the problem, findings, causes and contributing factors.	3-18-2016

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F 272	Continued From page 4 Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to the risk for falls, psychoactive medication and urinary incontinence for 3 of 11 sampled residents (Residents #20, #25 and #53). The findings included: 1. Resident #53 was admitted to the facility on 03/07/15 with diagnoses which included anxiety and dementia.	F 272	2. By 3-14-16 The MDS Coordinator will view CAAs for the month of February 2016, to determine if residents at risk for falls, residents with incontinence or residents with the use of psychotropic medication have documentation of the problems, findings, causes, and contributing factors. Residents affected will have new annual assessments, if eligible. New annual assessments will begin the week of March 14th until completed. The MDS Coordinator will complete at least 1 per week until completed. 3. On 2-19-16, the MDS coordinator received education by the regional MDS Nurse regarding CAAs. 4. A QI tool will be utilized by the director of clinical services and or designee monthly X 3 months, for a maximum of 5 residents, to ensure CAAs include documentation of the problem, findings, causes and contributing factors. The results of the audit will be forwarded to the quality assurance committee on a monthly basis X 3 months, then ongoing as needed to sustain compliance.	

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F 272	Continued From page 5 Review of a nursing note dated 01/29/16 revealed Resident #53 fell at 8:35 PM with an elbow abrasion. Review of Resident #53's annual Minimum Data Set dated 02/09/16 revealed an assessment of short and long term memory loss and one fall since the prior assessment. Review of Resident #53's Fall Care Area Assessment (CAA) dated 02/10/16 revealed no documentation of findings with a description of the problem, causes, contributing factors and risk factors related to a fall risk. There was no description of the fall which occurred on 01/29/16. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Interview with Nurse #1 on 02/18/16 at 9:15 AM revealed Resident #53 required the assistance of one person with transfers. Nurse #1 explained Resident #53 occasionally became resistant during the transfers which caused a fall risk. Interview with Nurse Aide #1 on 02/18/16 at 2:25 PM revealed Resident #53 received assistance with transfers and occasionally became resistant during the transfers. Interview with the MDS Coordinator on 02/18/16 at 3:47 PM revealed the CAA did not contain documentation of findings and analysis regarding Resident #53's risk for falls. The MDS Coordinator explained she did not realize a documented analysis was required on the CAA. Interview with the Director of Nursing (DON) on 02/18/16 at 4:19 PM revealed he recently became	F 272		

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F 272	Continued From page 6 the Registered Nurse with MDS responsibility. The DON explained he did not realize a documented analysis was required on the CAA. 2. Resident #20 was admitted on 08/31/2015 with diagnoses that included Chronic Obstructive Pulmonary Disease, Diabetes, morbid obesity, anxiety, and depression. The Care Area Assessment (CAA) for Resident #20 for psychotropic medication use dated 09/11/2015 was reviewed. There was no documentation of the problem, findings, causes and contributing factors related to psychotropic medications. An interview conducted on 02/19/2016 at 02:15 PM with the Minimum Data Set (MDS) Coordinator revealed she tried to address the issue on the care plan and was not aware that the CAA needed to be completed and comprehensively reflect an analysis of the findings before doing the care plan. An interview with the Regional MDS Nurse on 02/19/2016 at 02:17 PM revealed that the MDS Coordinator was expected to follow the guidelines in the Resident Assessment Instrument (RAI)) that a comprehensive assessment and analysis (CAA) drove the care plan for each resident. The Regional MDS Nurse described the CAA for the MDS coordinator as the need to tell the story and tie everything together in the analysis. The Regional MDS nurse stated she and the Director of Nursing, as registered nurses, were responsible for signing off on the MDS. The CAA for Resident #20 for use of psychotropic medications was reviewed. The Regional MDS nurse stated that the resident needed a CAA completed before proceeding to develop the care plan. 3. Resident #25 was admitted 08/15/2015 with diagnoses that included irritable bowel, muscle	F 272		

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F 272	Continued From page 7 weakness, acute pain, and trauma and fracture to the neck. An interview with Resident #25 on 02/18/2016 at 08:30 AM revealed she wore a brief and they helped her change it. She stated she called them when she needed her brief changed. An interview on 02/18/2016 at 08:35 AM with Nurse #1 revealed Resident #25 was incontinent. She wore briefs. At times she was continent but usually she was incontinent. She stated that Resident #25 was checked every two hours to see if she needed to be changed. She stated Resident #25 was able to ring her bell and would let you know she needed assistance. She had no skin breakdown. An interview on 02/18/2016 09:40 AM with Nurse Aide # 2 revealed Resident #25 wore a brief. She was able to ring the call bell and would let them know if she had been incontinent. She stated they check on her and offer her to be changed or to go to the bathroom. She has no skin breakdown or redness. Nurse aide #2 stated Resident #25 was incontinent at times of bowel movement and would say she had made a mess. She stated they cleaned her up. A review of the nurse aide documentation revealed that Resident #25 needed assistance of one person for incontinence care. It was documented that she received assistance on each shift with toileting and incontinence care. The CAA dated 08/26/2015 for Resident #25 for incontinence was reviewed. There was not documentation of the problem, findings, causes contributing factors related to incontinence. An interview conducted on 02/19/2016 at 02:15 PM with the MDS Coordinator revealed that she was not aware that the CAA need to include a comprehensive analysis before developing the care plan.	F 272		

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F 272	Continued From page 8 An interview with the Regional MDS Nurse on 02/19/2016 at2:17 PM revealed that she was not aware that the MDS coordinator was developing the care plan without doing a CAA. She stated the CAA drove the care plan. She stated she expected CAAs to be completed for each resident before developing their care plan. The Regional MDS Nurse described the CAA for the MDS nurse as the need to tell the story and tie everything together in the analysis. The Regional MDS nurse stated she and the Director of Nursing, as registered nurses, were responsible for signing off on the MDS.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 1. On 2-29-16, resident #81 received an invitation to the next scheduled care plan meeting. 2. On 3-4-16, current residents were audited by the social services director regarding most recent and upcoming care plan meetings. 3. On 3-9-16, the executive director educated the Social Services director and the MDS Coordinator on regulation F280 regarding residents' participating in their plan of care. Beginning on 3-11-16 and thereafter, the social services director will audit 5 residents, monthly X 3 months, to ensure residents received invitations.	3-18-2016

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F 280	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to provide for resident participation in planning care and treatment for 1 of 3 sampled residents (Resident #81). The findings included: Resident #81 was admitted to the facility on 09/14/15. Review of Resident #81's quarterly Minimum Data Set dated 12/18/15 revealed an assessment of intact cognition. Interview with Resident #81 on 02/16/16 at 8:49 AM revealed staff did not include him in decisions regarding medications and treatments. Resident #81 reported he did not receive invitations to care plan meetings. Interview with the facility's social worker on 02/19/16 at 10:22 AM revealed she coordinated care plan meetings with residents and family members. The social worker reported Resident # 81's family member received notification and invitations regarding care plan meetings. The social worker explained Resident #81 did not receive invitations to care plan meetings. The social worker reported Resident #81 should be included in care plan meetings and the omission was an oversight. Interview with the Administrator on 02/19/16 at 10:44 AM revealed residents should participate in care plans and decisions regarding care and treatment.	F 280	4. A QI tool will be utilized by the business office manager, and or designee monthly X 3 months, to ensure that care plan invitations are received. The results of the audit will be forwarded to the quality assurance committee on a monthly basis X 3 months, then ongoing as needed to sustain substantial compliance.	

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F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, the facility failed to ensure call bells in 1 of 35 sampled resident rooms were functioning properly (Room 108). The findings included: On 02/16/16 at 9:39 AM, three attempts to activate the call bell in room 108 were unsuccessful. An interview with Resident #93 revealed he was a short-stay resident, and "had only been at the facility a few days or a week". During the interview, Resident #93 stated he "tried to use the call bell in his room, but nobody ever came". Resident #93 stated he "thought the staff just wasn't responding to his call bell". He had only used his call bell that one time and had never attempted to use it since. On 02/17/16 at 4:19 PM, three attempts to activate the call bell in room 108 were unsuccessful. On 02/18/16 at 8:36 AM, an interview was conducted with the Maintenance Director. The Maintenance Director stated he was unaware the call bell was not working in Room 108 and no one had reported any non-functioning call bells. During the interview, the Maintenance Director was asked what procedures were in place to address maintenance issues. The Maintenance Director advised work orders were utilized and	F 463	F463 1. On 2-18-16, call bell and cable were replaced in room 108 by maintenance director. 2. On 3-4-16, maintenance director conducted an audit of each call bell system to ensure that each call bell is functioning properly. 3. The maintenance director, and or designee will educate current staff on the protocol for submitting work orders, to ensure malfunctioning equipment are identified and addressed. The maintenance director will conduct weekly audits of each call bell system, to ensure call bells remain working properly. 4. A QI tool will be utilized by the maintenance director on a weekly basis X 12 weeks, to document the functional status of each call bell. The results of the audit will be forwarded to the quality assurance committee on a monthly basis X 3 months, then ongoing as needed to sustain substantial compliance.	3-18-2016

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F 463	Continued From page 11 submitted for equipment or items needing repair. He stated blank work order forms were obtained by staff from a box located at (or near) all nurse's stations. Staff then completed and submitted the work orders by placing them back in one of the boxes at the nurse's station. The work order boxes were checked for completed work orders approximately every hour by Maintenance personnel (usually the Maintenance Director). When asked what was done with the work orders which had been completed, he advised the completed work orders were "just scattered out on his desk". On 02/18/16 at 9:05 AM, the Maintenance Director had been observed replacing the call bell and cable in Room 108. Check of the call bell revealed the call bell was working properly.	F 463		