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 03/03/2016

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MECKLENBURG HEALTH & REHABILITATION CENTER	2416 SANDY PORTER ROAD CHARLOTTE, NC 28273

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F 000	INITIAL COMMENTS An amended Statement of Deficiencies was provided to the facility on 03/18/16 to correct a clerical error in the facility's original CMS 2567 report. Event ID# O1T011.	F 000	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.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by Based on interviews and review of records the facility failed to develop a comprehensive care plan on 1 of 4 sampled residents (Resident #3). The findings included A review of the clinical record revealed Resident #3 had diagnoses including malnutrition and	F 279	F279 **How the corrective action will be accomplished for the resident(s) affected.** Specific measurable goals were added to care plan for Resident #3. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** The Director of Nursing/Unit Manager or designee will audit all current in house residents for Potential/Actual Skin Impairment by 3/31/16 and updated appropriately. Current residents Skin assessments and Wound Records updated to ensure accurate recording. MDS will review MDS's	3/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Carr — TITLE: Administrator — (X6) DATE: 3-30-16

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 279	Continued From page 1 anemia. A review of the Minimum Data Set (MDS) dated 10/12/2015 was coded as Resident #3 had a Stage 1 or greater pressure ulcer. It was coded for risk for pressure ulcers. An unhealed stage 4 pressure ulcer was present on admission. The pressure ulcer measured 4.5 cm length, 4.0 cm width, and 0. 5cm deep. There was granulation tissue present. A stage 4 pressure ulcer was documented on the previous MDS. The care plan dated 10/13/2015 was reviewed. It had no care plan for potential or actual skin breakdown. The quarterly MDS dated 01/08/2016 is coded in section M as Resident #3 having a Stage 1 or greater pressure ulcer. It documented Resident #3 had one or more unhealed pressure ulcers. There were no current pressure ulcers coded on M300. Pressure ulcers were present on the previous MDS. The comprehensive care assessment (CAA) for pressure ulcers for the MDS dated 01/22/2016 documented the resident continued to required assistance for all activities of daily living. She was at risk for pressure ulcers and had there was the presence of a pressure ulcer. Resident #3 was incontinent of bowel and bladder. She was bedfast per her choice. She had a chronic sacral ulcer being treated. It stated she was at risk for non-healing of her wound and future breakdown. They were proceeding to the care plan. Review of the record revealed no care plan update for the MDS dated 01/22/2016. An interview with the MDS coordinator conducted on 03/03/2016 at 3:30 PM revealed that she develops the resident's care plan. She stated she updated the care plan when the assessments were done and with changes. She stated she gets information from the morning meeting where	F 279	for all current residents to ensure that Section M is completed and accurate for patient status. **Measures in place to ensure practices will not re-occur.** All new admissions and readmissions will be reviewed for potential and actual wound care plans. The Director of Nursing/Unit Manager or designee will review the care-plan goals and interventions for wound prevention and actual wounds. Data Analyst Verification Specialists will check all care plans during the completion of Comprehensive Assessment to ensure Section M is accurate based on resident and care plan, weekly x 8 weeks, twice a month x 2 month, and monthly x 8 on 5 residents if applicable. Corporate Nurse Consultant and Data Analyst Verification Specialist reviewed audit requirements and ensuring all residents have a potential and or actual skin impairment care plan with MDS and DON. **How the facility plans to monitor and ensure correction is achieved and sustained.** The results of these audits will be reviewed during the Monthly QA meeting for a period of 12 months for review for compliance and revision as needed.	

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F 279	Continued From page 2 staff share what has happened and any interventions and she then updates the care plan. If some had skin breakdown she would document that in section M of the MDS. She got her information from the progress notes and wound assessments. She stated she does do a chart review for the look back period. The MDS coordinator stated if she wasn't aware of a wound if there was another way or system to know that and update the care plan she would have done so. An Interview with the Director of Nursing was conducted on 03/03/2016 at 3:30 PM revealed that it was her expectation that the MDS care plan would be inclusive. She stated they are putting things in place for this information to be available for staff including the MDS coordinator.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to utilize the correct size sling for the mechanical lift when transferring 1 of 4 sampled residents (Resident #2). Findings Included A review of Resident #2's clinical record history	F 323	F323 **How the corrective action will be accomplished for the resident(s) affected.** Resident #2 was successfully transferred without injury using the fitted sling selected by the CNA. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** The Director of Nursing/Unit Manager or designee will audit all current residents to determine that various sling sizes are available to accommodate manufacturers recommendation by 3/31/16.	3/30/16

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F 323	Continued From page 3 and physical dated 02/05/2016 revealed she was totally dependent for her activities of daily living including transfers. Her mobility status was bed to chair only. Her diagnoses included senile dementia, functional quad, pressure ulcer, adult failure to thrive, chronic kidney disease, diabetes with peripheral circulatory disorder. A review of Resident #2's weights from 10/01/2015-03/01/2016 revealed a weight range of 168.5-160.5 pounds. A review of Resident #2's care plan revised 01/25/2016 revealed for transfers she requires a mechanical lift with staff assistance for transfer to a broad chair. An observation of Resident #2 on 03/02/2016 at 11:30 AM revealed Nurse Aide #2 (NA) and NA #4 using the mechanical lift to transfer Resident #2 from her bed to the chair for lunch. Nurse Aide #2 chose to use the purple sling for the transfer. The purple sling was very large for the resident and during the transfer she slipped slightly in the sling. An interview with NA #4 on 03/02/2016 11:45 AM revealed that they usually use a smaller blue sling to transfer Resident #2 but one was not available. An interview with NA #5 on 03/03/2016 at 03:04 PM revealed she decided on the size of the sling she used for Resident #2 by holding it up and looking at its size. She stated she usually used a blue one and she liked that one since the size was better for the resident. She stated the purple one was too big for the resident. She stated she just holds up the sling to see if it is too big and if she thinks it is too big she gets another one. She stated it was not in their care guide which size to use for the resident. She stated using the right size sling was for safety because if it's was too big the resident could slip out or move more to one side and their body tipped. She stated	F 323	**Measures in place to ensure practices will not re-occur.** Staff Nurses and CNA's in-serviced on utilizing the appropriate size sling for patients and how to identify the correct sling for a patient, by SDC/DON and completed by 3/31/16. SDC will educate all new staff on how to identify the correct size sling for a patient and how to identify that sling. For Hoyer, they will be educated on the following criteria based on sling manufacturers recommendation, Sit to Stand Lift – the back belt should be wide enough to fit from the top of the gluteal fold (between the buttocks) to 2"-3" inches below the lower edge of the patients shoulder blades. The back belt should be long enough for belt fabric to fit around patients abdomen without loop fabric touching the patient, the sling may also have a thigh support which is placed under the buttocks. For the Hoyer utilizing also manufacturers recommendation, the sling should be long enough to fit from the bottom of the patient's coccyx to the top of, or a few inches above, the patient's head and wide enough for sling fabric to extend at least two inches in front of the patients anterior shoulder. The DON/Unit Manager or designee will watch 5 transfers a day for 3 days weekly times 4 weeks, then once a week x	

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F 323	Continued From page 4 sometimes they have to look for a sling or go to the laundry to get one. An interview with the Rehabilitation Director on 03/03/2016 at 04 30 PM revealed that nursing chooses the size of the transfer slings. She stated that staff had been in-serviced last fall in 2015 after the last recertification survey. The in-service occurred the last week of October 2015 and the first week of November 2015. It was conducted by the Staff Development Coordinator for staff as part of the plan of correction for the last recertification survey. She stated it was her understanding that the sling size went by the resident's weight. An interview with the Minimum Data Set (MDS) Coordinator on 03/03/2016 revealed she attended an in-service last October 2015 on use of a lift for transferring residents safely. It was required for all nursing staff. She could not remember any specific instructions about use of the slings or how the size sling to be used for a resident was determined. An interview was conducted with the Director of Nursing (DON) on 03/03/2016 at 03:30 PM revealed that the size of the sling to be used for transfers was documented for care staff on the electronic kardex. She pulled up Resident #2's kardex and there was no documentation of what sling size to use for Resident #2's transfers using the lift. A review of the manufacture's Uni-fit sling size to weight general reference guide indicated slings were color coded and a size were listed by weight range. The purple sling used by the staff to transfer Resident #2 on 03/02/2016 at 11:30 AM was purple XXL which was for someone who weighed between 450-600 pounds. The blue/L sling was for a patient weighing 180-250 pounds. The red/M size sling was to be used for someone	F 323	4 weeks, twice a month x 1 month, and monthly x 9. Audits will be completed and turned in to Administrator to ensure compliance. **How the facility plans to monitor and ensure correction is achieved and sustained.** The results of these audits will be reviewed in Monthly QA X 12 months for review for continued compliance and revision as needed.	

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F 323	Continued From page 5 110-190 pounds. An interview was conducted with the DON on 03/03/2016 at 6 04 PM revealed that it was her expectation the nursing staff follow the manufacturer's guidelines for use of the correct sling size for each resident being transferred by the mechanical lift. She stated that they need a system to communicate the correct sling size to the nursing staff.	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. This REQUIREMENT is not met as evidenced by Based on record review, observations and staff interviews the facility failed to maintain accurate medical records for weekly skin assessments for 3 of 4 sampled residents (Residents #1, #2 and #3). The findings included 1. Resident #1 was admitted to the facility on 01/04/2016 with diagnosis of adult failure to thrive, protein calorie malnutrition and pressure	F 514	F514 **How the corrective action will be accomplished for the resident(s) affected.** Skin assessment for residents was completed for residents #1, #2. #3. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** The Director of Nursing/Unit Manager or designee audited all current residents' skin assessments to ensure completion. Resident records not in compliance were updated. **Measures in place to ensure practices will not re-occur.** On 3/31/16, the nursing staff was educated on appropriate documentation Skin Assessment every 7 days, Wound Record every 7 days if applicable and Potential and Actual Skin Impairment Care Plans in place for skin integrity issues. The Director of Nursing/Unit	3/30/16

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F 514	Continued From page 6 area of sacral region. The quarterly Minimum Data Set (MDS) dated 01/04/2016 indicated Resident # 1 was moderately cognitively impaired and required extensive assistance from staff for bed mobility, locomotion, and toileting. Resident #1 required supervision with eating and was dependent for personal hygiene and bathing activities. The 01/04/2016 MDS also indicated that resident #1 had no pressure ulcers and was at risk for developing pressure ulcer. Review of the weekly skin assessments for Resident #1 for January, 2016, included a skin assessment completed on 01/04/2016 with a stage 2 open area to sacrum which measured 1 cm in length by 1 cm in width and 0.25 cm in depth. There was no weekly skin assessment completed for the week of January 10, 2016. Weekly skin assessments dated January 22, 2016 and January 29, 2016 respectively, noted that buttocks were red. Record review for Resident #1, revealed some weekly skin assessments for February, 2016 were completed. A weekly skin assessment dated 02/05/2016, revealed a stage 2 pressure ulcer of her sacrum which measured 1.2 cm in length with no width or depth documented. A weekly skin assessment dated 2/11/2016 revealed a stage 3 pressure area to her sacrum which measured 7.5 cm in length, 7.5 cm in width and no depth documented. An interview with the Director of Nursing (DON) on 03/03/2016 at 3:30 PM revealed that she was aware that weekly skin assessments were not being completed weekly and that she had started to implement the weekly skin check schedules. The DON was unable to provide information about quality monitoring to ensure assessments were complete and accurate. The DON stated	F 514	Manager will audit the completion of the weekly skin assessments for current residents by 3/31/16.The DON/Unit Manager or designee will audit 75 % of residents weekly x4 weeks, 50% of resident weekly x 4 weeks and 25% of residents x4 weeks. Audits will be completed and turned in to Administrator to ensure compliance. **How the facility plans to monitor and ensure correction is achieved and sustained.** The results of these audits will be reviewed during the Monthly QA meeting for a period of 3 months for review for compliance and revision as needed.	

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F 514	Continued From page 7 that her expectation was that all assessments be completed accurately and completely for each resident. An interview with the nurse consultant on 03/03/2016 at 4:00 PM revealed that they did not have a wound care or treatment nurse on schedule and that weekly skin assessments were to be completed by the nurse assigned to complete them as indicated by the alert in the electronic record system. The nurse consultant stated that he was aware that skin integrity areas had not been documented completely or consistently for any residents and his expectation was that with the new DON that all assessments would be scheduled and completed accurately and timely. 2. Resident #2 was admitted to the facility on 06/05/2012 with diagnoses including cerebrovascular disease, Alzheimer's disease, congestive heart failure, diabetes, anemia and chronic kidney disease. On 12/09/2015 a pressure ulcer Stage 2 on the sacral area was documented. The quarterly MDS dated 12/31/2015 indicated Resident #2 was severely cognitively impaired and required extensive assistance with bed mobility, transfers, bathing, dressing, toileting and eating. It indicated the use of a pressure relieving device on the bed mattress. Range of motion was impaired on both sides. Review of weekly skin assessments for Resident #2 from 11/09/2015-12/24/2015 were not in the resident's record. The skin assessment 11/02/2015 documented skin intact. The 12/31/2015 weekly skin assessment documented a left buttocks pressure ulcer Stage 2 length 2 centimeters (cm) X width 1cm. A weekly skin assessment indicated pressure	F 514		

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F 514	Continued From page 8 ulcer left buttocks length 2cm X width 1cm Stage 2 previously staged by RN. No skin assessments were available from Nov. 9, 2015- Dec. 24, 2015. An interview with Nurse #3 on 03/03/2016 3 30 PM revealed skin assessments were done weekly by the nurses and were documented in the electronic record. An audit done by the Nurse Consultant revealed that they were really far behind doing the weekly skin assessments. That is why weekly skin assessments were not available. An interview with the Director of Nurses (DON) on 03/03/2016 at 3 30 PM revealed that she was aware the skin assessments had not been completed weekly. She had begun to implement a weekly schedule to assure the weekly skin assessments were completed. She stated she had no information to provide that the weekly skin assessments were complete and accurate The DON stated her expectation was that all assessments be completed accurately and completely for each resident. An interview with the Nurse Consultant on 03/03/2016 at 4 00 PM revealed that the skin assessments were not in the clinical record for a number of weeks. He stated they did not have a wound care or treatment nurse at the facility and the weekly skin assessments were to be completed by the nurse assigned to complete the assessment as indicated by an alert in the electronic record system. He stated that he was aware that the skin assessments had not been documented completely or consistently for any residents and his expectation was that the new DON would have assessments scheduled and completed accurately each week. 3. Resident #3 was admitted to the facility on 02/09/2015 with diagnoses of dementia, asthma, emphysema, hypertension, adult failure to thrive	F 514		

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F 514	Continued From page 9 and anemia. The quarterly Minimum Data Set (MDS) dated 10/12/2015 documented an unhealed, Stage 4 pressure ulcer present on admission. It measured 4.5 centimeters (cm) in length x 4.0 cm width x 0.5 deep. There was granulation tissue. The care plan dated 10/13/2015 had no care plan for potential or actual skin breakdown. The care updated 01/08/2016 documented a chronic sacral ulcer. A review of the MDS dated 01/22/2016 indicated Resident #3 had a Stage 1 or greater pressure ulcer. There was no care plan update for the MDS dated 01/22/2016. A review of Resident #3 ' s weekly skin assessments revealed on 11/2/2015 she had a pressure ulcer on her sacrum. There were no weekly skin assessments available for the rest of November up until December 23, 2015. The skin assessment dated 12/23/2015 documented a pressure ulcer on her sacrum. Weekly skin assessments dated 12/30/2015, 01/04/2016, and 01/11/2016 documented " an open area " on the sacrum. The skin assessments 01/14/2016 -02/08/2016 documented an, " open area " on the coccyx. The skin assessment on 2/22/2016 documented a " pressure area on the sacrum ". There was nothing documented on the weekly skin assessment dated 2/25/2016. The weekly skin assessment documented " pressure " on the sacrum. There are no measurements documented for the " open " or " pressure " areas on the sacrum or coccyx area on the skin assessments reviewed after 11/02/2015 - 02/29/2016. An interview with Nurse #3 on 03/03/2016 03:30 PM revealed skin assessments were done weekly by the nurses and were documented in the electronic record. An audit done by the Nurse Consultant revealed that they were very far	F 514		

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F 514	Continued From page 10 behind doing the weekly skin assessments and that was why weekly skin assessments were not available. An interview with the Director of Nurses (DON) on 03/03/2016 at 3:30 PM revealed that she was aware the skin assessments had not been completed weekly. She had begun to implement a weekly schedule to assure the weekly skin assessments were completed. She stated she had no quality monitoring data to demonstrate that the weekly skin assessments were complete and accurate. The DON stated her expectation was that all assessment be completed accurately and completely for each resident. An interview with the Nurse Consultant on 03/03/2016 at 4.00 PM revealed that the skin assessments were not in the clinical for a number of weeks. He stated they did not have a wound care or treatment nurse at the facility and the weekly skin assessments were to be completed by the nurse assigned to complete the assessment as indicated by an alert in the electronic record system. He stated that he was aware that the skin assessments had not been documented completely or consistently for any residents and his expectation was that the new DON would have all assessments scheduled and completed accurately each week.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET 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.	F 520	F520 **How the corrective action will be accomplished for the resident(s) affected.** F279 Specific measurable goals were added to care plan for resident #3 and Resident #2 was safely transferred utilizing the sling that was utilized by the CNA for transfer. **How corrective action will be accomplished for those**	

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 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2416 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 11 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 review and 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 October of 2015. This was for two recited deficiencies which were originally cited in September of 2015. The deficiencies were in the areas of accident hazards and development of comprehensive care plans. The continued failure of the facility during two surveys shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings include This tag is crossed referenced to 1a. F323 Accidents/Hazards Based on observations, staff interviews and record review the facility failed to utilize the correct size sling for	F 520	**residents with the potential to be affected by the same practice.** Individual actions denoted on said area for citation F-279 & F-323. **Measures in place to ensure practices will not re-occur.** Individual actions denoted on said area for citation F279 & F-323. **How the facility plans to monitor and ensure correction is achieved and sustained.** The Results of audit will be reported during monthly QA specifically to discuss F 279 &F Tag 323 and first meeting will be the April meeting to discuss compliance with POC and	3/30/16

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F 520	Continued From page 12 the mechanical lift when transferring 1 of 4 sampled residents (Resident #2). During the survey of September 2015, the facility failed to use the correct method for transferring a resident causing an injury. The facility was recited at F 323 on the current survey for failing utilize the correct size sling when using a mechanical lift to transfer a resident. b. F279· Develop Comprehensive Care Plans Based on staff interview and review of records the facility failed to develop a comprehensive care plan that included a problem, goal and interventions for pressure ulcers. During the survey of September of 2015 the facility failed to develop a comprehensive care plan for a resident regarding psychotropic medication. On the current survey the facility also failed to develop a comprehensive care plan for a resident regarding treatment for actual or potential skin break down. During an interview on 03/03/2016 at 5 44 PM the Administrator stated the Quality Assessment and Assurance committee meets monthly. They look at their POC from former surveys to determine what drives the agenda for and any service items that came up. They do in services with staff to communicate the plan. He stated they do observations and audits to monitor progress. The Administrator added the facility ' s staff turnover rate was huge. The plan was to keep key positions filled. They have to standardized the QA process and hold staff to it. The key positions were department heads and the turnover had an exponential impact on their QA plan and process.	F 520		