STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		11/1/18

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

Electronically Signed | 10/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review resident, and staff interviews the facility failed to maintain a resident's dignity by turning off the call light and not returning for an extended period of time to provide incontinent care as requested by the resident for 1 of 1 of residents sampled for dignity (Resident #35). The findings included: Resident #35 was readmitted to the facility on 09/09/18 with diagnoses that included: weakness, dysphagia, severe protein calorie malnutrition, chronic obstructive pulmonary disease, and diabetes. Review of a comprehensive minimum data set (MDS) dated 07/23/18 revealed that Resident #35 was cognitively intact and required limited assistance of one staff member with toileting. No rejection of care was noted on the MDS. A continuous observation was made of Resident #35 on 10/01/18 at 2:15 PM through 3:27 PM. Resident #35 turned the call light on and the Director of Housekeeping (DOH) immediately entered her room and was informed by Resident #35 that she needed some incontinent care. The DOH stated to Resident #35 that she was going to leave the call light on and let one of the Nursing Assistants (NAs) know. As the DOH was exiting Resident #35's room she ran into the Director of Nursing (DON), the DOH pointed at the call light that was still illuminated in the hallway and stated Resident #35 "needs some	F 550	1. Corrective action has been accomplished for the alleged deficient practice regarding #35 which failed to be toileted in a timely manner resulting in a dignity issue. Resident #35 was toileted by the Certified Nursing Assistant 10/1/2018 at 3:19pm. 2. Current facility residents have the potential to be affected by the alleged deficient practice. All facility residents have the potential to be affected. The Director of Nursing/Nurse Management initiated In-Service on 10/04/2018 on Quality of Life: Dignity on all current facility staff. New employees and agency personnel will be in-serviced on Quality of Life: Dignity, during orientation process. 3. Measures put in place to ensure the alleged deficient practice does not recur include: Departmental Heads will complete Angel Care Round Communication Sheets which includes all residents three times per week for 4 weeks than 2 times a week for 4 weeks than 1 time a week for 4 weeks to ensure Dignity of residents. 4. The Director of Nursing will analyze audits/review for patterns/trends and report in the Quality Assurance committee meeting for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 550	Continued From page 2	F 550		

incontinent care." The DON entered Resident #35's room and turned the call light off without providing incontinent care and stated he would send someone back to assist her. At 2:49 PM Resident #35 confirmed that she was still waiting for incontinent care and the call light was again turned on by Resident #35. At 3:15 PM the call light remained on and Resident #35 again confirmed that she was waiting for incontinent care and that a man had come in and told her he would be back, and he never returned. At 3:19 PM NA #1 entered Resident #35's room and provided incontinent care and exited Resident #35's room at 3:27 PM.

An interview was conducted with NA #1 on 10/01/18 at 3:27 PM. NA #1 stated that she had been providing care to another resident and when she exited that room she noted Resident #35's call light and went to see what she needed. NA #1 confirmed that Resident #35 needed incontinent care and that she provided the care. She added that she was not aware that her call light had been on earlier as she was working with another resident and no one informed her that Resident #35 needed some assistance.

An interview was conducted with the DOH on 10/02/18 at 2:38 PM. The DOH stated that she observed Resident #35's call light come on and she went into to see what she needed. She stated that Resident #35 informed her that she needed her brief changed. The DOH stated she informed Resident #35 she would go and let someone know and was going to leave the call light on. She added that she ran into the DON on the way out of Resident #35's room and informed the DON that she needed to be changed and pointed to the call light that was on. The DOH stated that the identified.

5. The Administrator will be the person responsible for implementing the acceptable plan of correction.

6. Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 550	Continued From page 3 DON stated he would take care of it and she left the room. An interview was conducted with Resident #35 on 10/03/18 at 9:54 AM. Resident #35 confirmed that NA #1 had finally provided incontinent care to her on 10/01/18 and she was very grateful. She added that she tried not to use the call light very often but when she did it seemed to take a while for the staff to come and help. Resident #35 stated that turning the call light off without helping her "was just unnecessary and was very embarrassing to sit in a wet brief" for a long time. Resident #35 stated that she tried to be a very independent person, but this was one thing she could not do for herself and relied on the staff to help her and was very bothered and upset that she had waited for over an hour for incontinent care on 10/01/18. An interview was conducted with the DON on 10/04/18 at 11:25 AM. The DON confirmed that he had entered Resident #35's room and turned the call light off on 10/01/18. He stated he could not recall if he told anyone to assist Resident #35 or not. The DON stated that he should not have turned the call light off without providing the care and that it was unacceptable to have Resident #35 wait for over an hour for incontinent care.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		11/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 656	Continued From page 4 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan with measurable goals and implement	F 656	1. The comprehensive care plan for resident #76 has been updated to include hospice care with resident centered and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 656	Continued From page 5 identified care plan interventions for 1 of 1 resident reviewed for hospice (Resident #76) and 2 of 3 residents reviewed for activities of daily living (Resident #35 and Resident #68). The findings included: 1. A review of the hospice benefit period indicated Resident #79 was certified for hospice care from 05/25/18 to 07/23/18. Resident #76 was admitted to the facility on 06/08/16 with diagnoses which included atrial fibrillation, heart failure, hypertension, and renal insufficiency. A physician's order dated 06/08/18 indicated Resident #76 was under services of a Local Health Hospice and Palliative Care. A review of a care plan with an initiation date of 06/08/18 revealed there was no comprehensive care plan with measurable goals and identified care plan interventions implemented for hospice care for Resident #76. A review of the admission Minimum Data Set (MDS) dated 06/15/18 indicated under Section J1400. Prognosis that Resident #76 had a chronic disease that indicated a life expectancy of less than 6 months and under Section O0100 Special Treatments, Procedures, and Programs as receiving hospice care. On 10/03/18 at 11:46 AM an interview was conducted with the Reginald Minimum Data Set (MDS) Consultant who stated she had completed an audit of hospice residents in the facility on 10/03/18 and determined that Resident #76 did	F 656	measurable goals. The comprehensive care plan for resident #35 and #68 have been updated to address the current ADL status of the residents. 2. All residents receiving hospice services have been reviewed to ensure their care plans are complete with determination of hospice services. 3. All Comprehensive care plans are currently in review to ensure that their current ADL status has been addressed in the individual care plans and will be completed by 11/01/2018. 4. Staff education pertinent to the management of all identified hospice residents has been provided on 10/04/2018. 5. Minimum Data Set Coordinators will perform routine audits for comprehensive care plans for both accuracy and completion. This audit will be conducted weekly for one month. After that monthly audits will continue for a period of 3 months under the supervision of the Director of Nursing. Evaluation and Monitoring 1. Minimum Data Set Coordinators will audit residents receiving hospice services monthly to ensure comprehensive care planning is complete. 2. Minimum Data Set Coordinators will audit care plans to ensure Activities of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 656	Continued From page 6 not have a comprehensive hospice care plan in place with measurable goals and identified care plan interventions. The Reginald MDS Consultant stated the prior MDS Reginald Consultant who was responsible for creating a comprehensive care plan for Resident #76 was no longer employed at the facility. The Reginald MDS consultant stated the admission MDS assessment dated 06/15/16 indicated Resident #76 received hospice care and a comprehensive care plan with goals and interventions should have been created by 06/21/18 to reflect Resident #76 required hospice care. The Reginald MDS Coordinator stated the comprehensive care plan was never created to reflect Resident #76 was receiving hospice care. The Reginald MDS Coordinator stated a comprehensive plan of care with goals and interventions would be created immediately to reflect Resident #76 was receiving hospice care. On 10/03/18 at 11:51 AM an interview was conducted with the Director of Nursing (DON) who stated his expectation was that a comprehensive care plan for hospice care would have been created for Resident #76 by the MDS Coordinator who completed the admission MDS assessment dated 06/15/18. On 10/03/18 at 11:57 AM an interview was conducted with the facility Nurse Consultant who stated the MDS Coordinator who was responsible for coding the admission MDS assessment dated 06/15/18 should have created a comprehensive care plan to indicate Resident #76 was receiving hospice care. On 10/03/18 at 12:06 PM an interview was conducted with the administrator who sated her	F 656	Daily Living care interventions are personalized and accurate with each Minimum Data Set Coordinator completing audits of 5 residents each month for 2 months, then monthly for 2 months. The Director of Nursing will analyze/review for patterns/trends and report in the Quality Assurance meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 656	Continued From page 7	F 656		

expectation was that a comprehensive care plan for hospice would have been created for Resident #76 by the MDS Coordinator who coded the admission MDS assessment dated 06/15/18. The Administrator stated it was her expectation that a comprehensive care plan for hospice care would be created immediately for Resident #76.

On 10/04/18 at 10:03 AM an interview was conducted with the MDS Coordinator #1 who stated she was responsible for coding Resident 76's admission MDS assessment dated 6/15/28. The MDS Coordinator #1 stated she should have created a comprehensive hospice care plan for Resident #76 by 6/21/18 and she missed creating a comprehensive hospice care plan with goals and interventions for Resident #76.

Resident #35 was readmitted to the facility on 09/09/18 with diagnoses that included: weakness, dysphagia, severe protein calorie malnutrition, chronic obstructive pulmonary disease, and diabetes.

Review of a comprehensive minimum data set (MDS) dated 07/23/18 revealed that Resident #35 was cognitively intact and required limited assistance of one staff member with toileting. No rejection of care was noted on the MDS.

Review of an activities of daily living (ADL) care plan dated 08/29/18 and revised 10/02/18 read in part, Resident #35 had an activity of daily living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 656	Continued From page 8	F 656		

(ADL) self-care deficit. Further review revealed the ADL care plan had not been finalized with measurable goals and interventions that were specific to Resident #35 and the care she required.

A continuous observation was made of Resident #35 on 10/01/18 at 2:15 PM through 3:27 PM. Resident #35 turned the call light on and the Director of Housekeeping (DOH) immediately entered her room and was informed by Resident #35 that she needed some incontinent care. The DOH stated to Resident #35 that she was going to leave the call light on and let one of the Nursing Assistants (NAs) know. As the DOH was exiting Resident #35's room she ran into the Director of Nursing (DON), the DOH pointed at the call light that was still illuminated in the hallway and stated Resident #35 "needs some incontinent care." The DON entered Resident #35's room and turned the call light off without providing incontinent care and stated he would send someone back to assist her. At 2:49 PM Resident #35 confirmed that she was still waiting for incontinent care and the call light was again turned on by Resident #35. At 3:15 PM the call light remained on and Resident #35 again confirmed that she was waiting for incontinent care. At 3:19 PM NA #1 entered Resident #35's room and provided incontinent care and exited Resident #35's room at 3:27 PM.

An interview was conducted with NA #1 on 10/01/18 at 3:27 PM. NA #1 stated that she had been providing care to another resident and when she exited that room she noted Resident #35's call light and went to see what she needed. NA #1 confirmed that Resident #35 needed incontinent care and that she provided the care. She added

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 656	Continued From page 9	F 656		

that she was not aware that her call light had been on earlier as she was working with another resident and no one informed her that Resident #35 needed some assistance.

An interview was conducted with Resident #35 on 10/03/18 at 9:54 AM. Resident #35 confirmed that NA #1 had finally provided incontinent care to her on 10/01/18 and she was very grateful. She added that she tried not to use the call light very often but when she did it seemed to take a while for the staff to come and help.

An interview was conducted with MDS Regional Nurse Consultant who stated that the facility had gone a period with no MDS coordinator and that was the reason Resident #35's care plan had not been finalized and individualized to the needs of Resident #35. She stated that she expected all care plans to be completed and individualized with measurable goals and for the staff to implement the care plan daily.

3. Resident #68 was admitted to the facility on 07/31/17 with diagnoses that included atrial fibrillation and Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) dated 09/07/18 specified the resident's cognition was intact, he did not reject care and could make himself understood. The MDS also specified the resident required one-person assistance with personal hygiene.

A care plan revised on 07/04/18 for activities of daily living specified the resident required assistance with personal hygiene.

On 10/01/18 at 10:10 AM Resident #68 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 656	Continued From page 10	F 656		

interviewed in his room and reported he was waiting on his nurse aide to assist him with shaving. During the interview, Resident #68 had a razor and shaving cream in his hand. Observations of Resident #68 revealed he had facial stubble and the resident reported he had not been shaved for three days.

On 10/01/18 at 10:12 AM nurse aide (NA) #2 was notified by the State Agency that Resident #68 was requesting to be shaved. NA #2 asked Resident #68 if he could shave himself and he explained to the nurse aide he was not supposed to for safety reasons. NA #2 did not accommodated Resident #68's request to be shaved.

On 10/01/18 at 12:09 PM Resident #68 had his razor in his hand and asked NA #2 for assistance with shaving. NA #2 replied to Resident #68 that she was too busy passing meal trays, and replied, "I got you."

On 10/01/18 at 2:00 PM observations were made of Resident #68 in the front lobby at the receptionist desk. The resident had not received assistance with shaving. Resident #68 was interviewed and reported he was still waiting to be shaved.

On 10/01/18 at 3:00 PM Resident #68 was observed with a shaved face and stated he felt better and reported that it was his usually routine to shave daily and often he went days without being shaved.

On 10/03/18 at 3:49 PM the MDS Regional Consultant was interviewed and reported care plans were developed to meet the needs of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 656	Continued From page 11 residents and staff were expected to follow the interventions.	F 656		
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 observations, record review, resident, and staff interview the facility failed to provide incontinent care when requested by the resident (Resident #35) and failed to shave a resident when request by the resident (Resident #68) for 2 of 3 residents sampled for activities of daily living. The findings included: Resident #35 was readmitted to the facility on 09/09/18 with diagnoses that included: weakness, dysphagia, severe protein calorie malnutrition, chronic obstructive pulmonary disease, and diabetes. Review of a comprehensive minimum data set (MDS) dated 07/23/18 revealed that Resident #35 was cognitively intact and required limited assistance of one staff member with toileting. No rejection of care was noted on the MDS. Review of an activities of daily living (ADL) care plan dated 08/29/18 and revised 10/02/18 read in part, Resident #35 had an ADL self-care deficit. Further review revealed that the ADL care plan had not been finalized with measurable goals and interventions that were specific to Resident #35	F 677	1. Corrective action has been accomplished for the alleged deficient practice in regard to Resident #35 for failing to provide incontinent care when requested. Resident #35 was provided incontinent care on 10/1/2018 at 3:19pm. Resident #35 for failing to shave when requested. Resident #68 for failing to shave when requested. Resident #68 was shaved by the Unit Manager on 10/1/2018 at 2:01 pm. 2. Current facility residents have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. Director of Nursing/Nurse Management initiated In-Service on 10/17/2018 to all current Licensed Nursing Staff and Certified Nursing Assistants on Activities of Daily Living to include incontinent care and shaving of residents. All new Licensed Nursing Staff, Certified Nurses Assistants and Agency Personnel will be in-serviced during orientation. 3. Measures put in place to ensure the	11/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 677	Continued From page 12 and the care she required. A continuous observation was made of Resident #35 on 10/01/18 at 2:15 PM through 3:27 PM. Resident #35 turned the call light on and the Director of Housekeeping (DOH) immediately entered her room and was informed by Resident #35 that she needed some incontinent care. The DOH stated to Resident #35 that she was going to leave the call light on and let one of the Nursing Assistants (NAs) know. As the DOH was exiting Resident #35's room she ran into the Director of Nursing (DON), the DOH pointed at the call light that was still illuminated in the hallway and stated Resident #35 "needs some incontinent care." The DON entered Resident #35's room and turned the call light off without providing incontinent care and stated he would send someone back to assist her. At 2:49 PM Resident #35 confirmed that she was still waiting for incontinent care and the call light was again turned on by Resident #35. At 3:15 PM the call light remained on and Resident #35 again confirmed that she was waiting for incontinent care and that a man had come in and told her he would be back, and he never returned. At 3:19 PM NA #1 entered Resident #35's room and provided incontinent care and exited Resident #35's room at 3:27 PM. An interview was conducted with NA #1 on 10/01/18 at 3:27 PM. NA #1 stated that she had been providing care to another resident and when she exited that room she noted Resident #35's call light and went to see what she needed. NA #1 confirmed that Resident #35 needed incontinent care and that she provided the care. She added that she was not aware that her call light had been on earlier as she was working with another	F 677	alleged deficient practice does not recur include: The Director of Nursing/Nurse Management will audit 5 residents 5 times a week for 4 weeks, then 5 residents 3 times a week for 4 weeks, then 5 residents 1 time a week for 4 weeks to ensure compliance of Activities of Daily Living Care to include shaving and incontinent care. 4. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. 5. The Administrator will be the person responsible for implementing the acceptable plan of correction. 6. Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 677	Continued From page 13	F 677		

resident and no one informed her that Resident #35 needed some assistance.

An interview was conducted with the DOH on 10/02/18 at 2:38 PM. The DOH stated that she observed Resident #35's call light come on and she went into to see what she needed. She stated that Resident #35 informed her that she needed her brief changed. The DOH stated she informed Resident #35 she would go and let someone know and was going to leave the call light on. She added that she ran into the DON on the way out of Resident #35's room and informed the DON that she needed to be changed and pointed to the call light that was on. The DOH stated that the DON stated he would take care of it and she left the room.

An interview was conducted with Resident #35 on 10/03/18 at 9:54 AM. Resident #35 confirmed that NA #1 had finally provided incontinent care to her on 10/01/18 and she was very grateful. She added that she tried not to use the call light very often but when she did it seemed to take a while for the staff to come and help.

An interview was conducted with the DON on 10/04/18 at 11:25 AM. The DON confirmed that he had entered Resident #35's room and turned the call light off on 10/01/18. He stated he could not recall if he told anyone to assist Resident #35 or not. The DON stated that he should not have turned the call light off without providing the care and that it was unacceptable to have Resident #35 wait for over an hour for incontinent care.

2. Resident #68 was admitted to the facility on 07/31/17 with diagnoses that included atrial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 677	Continued From page 14	F 677		

fibrillation and Alzheimer's disease. The most recent quarterly Minimum Data Set (MDS) dated 09/07/18 specified the resident's cognition was intact, he did not reject care and could make himself understood. The MDS also specified the resident required one-person assistance with personal hygiene.

A care plan revised on 07/04/18 for activities of daily living specified the resident required assistance with personal hygiene.

On 10/01/18 at 10:10 AM Resident #68 was interviewed in his room and reported he was waiting on his nurse aide to assist him with shaving. During the interview, Resident #68 had a razor and shaving cream in his hand. Observations of Resident #68 revealed he had facial stubble and the resident reported he had not been shaved for three days.

On 10/01/18 at 10:12 AM nurse aide (NA) #2 was notified by the State Agency that Resident #68 was requesting to be shaved. NA #2 asked Resident #68 if he could shave himself and he explained to the nurse aide he was not supposed to for safety reasons. NA #2 did not accommodated Resident #68's request to be shaved.

On 10/01/18 at 12:09 PM Resident #68 had his razor in his hand and asked NA #2 for assistance with shaving. NA #2 replied to Resident #68 that she was too busy passing meal trays, and replied, "I got you."

On 10/01/18 at 2:00 PM observations were made of Resident #68 in the front lobby at the receptionist desk. The resident had not received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT CHARLOTTE TRANSITIONAL CARE & REHAB CNTR	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 677	Continued From page 15	F 677		

assistance with shaving. Resident #68 was interviewed and reported he was still waiting to be shaved.

On 10/01/18 at 2:10 PM the Unit Supervisor shaved Resident #68.

On 10/01/18 at 2:31 PM the Unit Supervisor was interviewed and reported she was told Resident #68 needed to be shaved and she assisted the resident. The Unit Supervisor explained that shaving was part of morning ADL care and was expected to be provided upon request.

On 10/01/18 at 3:00 PM Resident #68 was observed with a shaved face and stated he felt better and reported that it was his usually routine to shave daily and often he went days without being shaved.

On 10/01/18 at 3:04 PM NA # 2 was interviewed and stated she did not assist Resident #68 with shaving in the morning because she was bust getting residents out of bed. She reported that she did not honor Resident #68's second request to be shaved at lunch because she had to pass lunch trays. The NA added that she was having a "slow" day and usually worked faster.

On 10/04/18 at 10:52 AM the Director of Nursing (DON) was interviewed and explained he expected staff to provide shaving assistance upon request and shaving should be included with morning care. He added that a request for ADL care during a meal should be accommodated.