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 04/11/2018

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

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F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health	F 622		5/9/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2018

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 622	Continued From page 1	F 622		

or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for

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F 622	Continued From page 2 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide accurate resident information to the acute care facility that was receiving 1 of 1 residents (Resident #5) for evaluation and treatment. Findings included: Resident #5 was admitted to the facility on 8/11/16. The most recent Minimum Data Set (MDS) dated 3/12/18 indicated Resident #5 was cognitively intact and required extensive assistance with bed mobility, transfer and Activities of Daily Living (ADL). Review of the medical record dated 3/28/18 revealed Resident #5 was lethargic and unable to communicate with nursing staff. Oxygen saturation ranged from 88-91% on a bipap mask. Nursing assessments revealed diminished lung sounds with rales auscultated in the left lower lobe. Per the Medical Doctor (MD) recommendation, Resident #5 was sent to the emergency room (ER) for acute care. An interview was conducted on 4/11/18 at 8:20am with the Director of Nursing (DON) who revealed she had printed the medication list and the face sheet for Resident #5 prior to Emergency Medical Services (EMS) arrival. She further stated there	F 622	The statements included in this plan of correction 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. F622 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The process that led to the citation was relying on EMS to verify the paperwork they picked up from the nursing station. The facility will provide accurate resident information to the receiving acute care facility by now providing the EMS worker who responds for the resident with the resident□s paperwork. The paperwork will be provided through a direct nurse to EMS worker handoff.	

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F 622	Continued From page 3 was another resident residing in the facility that had a doctor's appointment on 3/28/18 at 1:30pm and her paperwork was printed by Nurse #1. She reported both sets of paperwork were left on top of the nurse's station counter. The DON further stated she gave EMS face to face verbal report on Resident #5 when they arrived but did not hand them the paperwork. An interview was conducted on 4/11/18 at 8:39am with the hospital Social Worker (SW) who revealed Resident #5 was critical when she arrived to the ER. She stated she wanted to make sure family was made aware of Resident #5's condition. When she called the facility, she was told the resident named on the paperwork provided by EMS was still in the facility and was not in the ER. The hospital SW further stated it took approximately 15 minutes to confirm which resident was in the ER. She reported she gave the phone to the ER MD to get the correct medical history on the critical resident who was in the ER. A second interview was conducted on 4/11/18 at 9:22am with the DON who stated EMS had grabbed the paperwork left on the nurses' station counter. She further stated moving forward she felt paperwork needed to be handed to EMS in an envelope. She further stated she expected staff to look at the paperwork to make sure the correct resident was listed prior to handing it over. An interview was conducted on 4/11/18 at 10:18am with the EMS Risk and Safety Specialist who revealed it was EMS policy that medics do not grab paperwork off counters, it was handed to them when getting face to face report from staff.	F 622	The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The facility has in-serviced licensed nursing personnel on the expectation to provide all the necessary information to the receiving acute care facility by handing the resident□s paperwork directly to the EMS provider; completed May 8, 2018. The facility has also implemented a checklist for the nursing staff to guide them on the information to provide to the receiving facility. The checklist should be signed by the EMS worker accepting the paperwork. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. Nursing administration will review each resident discharged to an acute care facility by reviewing the copy of the checklist with the receiving EMS signature at the weekly quality meeting for 8 weeks. Any staff found to be noncompliant with using the checklist and handing the paperwork to EMS will be counseling using the progressive discipline process. The facility QAPI committee will review the discharge documentation for compliance x 2 months and make recommendations for systemic changes or further education as indicated. The title of the person responsible for implementing the acceptable plan of	

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F 622	Continued From page 4 An interview was conducted on 4/11/18 at 10:24am with the Administrator who revealed there were two sets of paperwork for two different residents left on the nurse's station counter. She stated she planned on talking with the QAPI committee in an upcoming meeting to come up with a solution to prevent this from happening in the future.	F 622	correction. The Director of Nursing.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident, staff, and nurse practitioner interviews, and record review, the facility failed to conduct a complete physical assessment after a resident fell for 1 of 3 sampled residents who fell (Resident #2). The findings included: Review of the facility's fall management program policy and procedure dated 02/01/15 revealed a licensed nurse should complete a physical and mental assessment immediately after a resident fall. The procedure included direction to evaluate, monitor and document resident response for 3 consecutive shifts post fall and include a neurological assessment if the fall was	F 684	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The process that led to the citation was that the nurse did not verify that the patient□s physical assessment was documented in the record. The facility nursing staff will provide a physical assessment after a resident fall and document it in the resident record. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The facility has in-serviced licensed nursing personnel on	5/9/18

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F 684	Continued From page 5 unwitnessed and/or the resident hit his/her head. Resident #2 was admitted to the facility on 12/15/16 with diagnoses which included hypertension and dementia. Review of Resident #2's annual Minimum Data Set (MDS) dated 12/08/17 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #2 ambulated independently and had no falls. Review of a Post Fall Assessment dated 02/28/18 at 3:36 PM, written by Nurse #1, revealed Resident #2 fell outside and received education to call for assistance. There was no documentation of a physical assessment. Review of Resident #2's care plan created on 01/03/17 revealed a revision dated 03/02/18 which stated "(2/28/18 minor injury-right forehead abrasion) unaware of safety needs." Interview with Resident #2 on 04/10/18 at 11:20 AM revealed he fell on the sidewalk in front of the facility. Resident #2 reported he became dizzy before the fall. Resident #2 explained he had no further falls. Interview with the nurse practitioner at 12:46 PM on 04/10/18 revealed he expected vital signs and a physical assessment to be completed when a resident fell. The nurse practitioner explained blood pressure should be measured especially if a resident reported dizziness prior to the fall. Telephone interview with the MDS consultant on 04/10/18 at 1:55 PM revealed he saw Resident #2 on the ground between the sidewalk and the	F 684	the policy and procedure for assessing a resident after a fall and the documentation steps for the resident record; completed May 8, 2018. The education includes providing a neurological assessment for a fall with an actual or suspected head injury. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. Nursing administration will review each resident fall for assessment and documentation at the weekly clinical quality meeting for 8 weeks. Any staff found to be noncompliant with completing and documenting the assessment of a resident post-fall will be counseling using the progressive discipline process. The facility QAPI committee will review the discharge documentation for compliance x 2 months and make recommendations for systemic changes or further education as indicated. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing.	

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facility's parking lot when he looked out the window on 02/28/18. The MDS consultant reported he and the facility's MDS nurse went outside to assist Resident #2 into a wheelchair. The MDS consultant explained Resident #2 told them he was not hurt and had lost his balance. The MDS consultant reported he and the MDS nurse brought Resident #2 back to the nursing in a wheelchair so the charge nurse could conduct the physical assessment. The MDS consultant reported Resident #2 did not complain of dizziness but did report a need to use the bathroom.

Interview with Nurse Aide (NA) #1 on 04/10/18 at 3:20 PM revealed she received report of Resident #2's fall when she came on duty at 3:00 PM on 02/28/18. NA #1 reported a small abrasion on the forehead did not cause Resident #2 pain.

Telephone interview with the charge nurse, Nurse #1, on 04/10/18 at 4:05 PM revealed the MDS consultant and the MDS nurse brought Resident #2 onto the nursing unit in a wheelchair and reported the fall. Nurse #1 explained she thought the MDS nurse conducted an assessment. Nurse #1 reported the fall occurred a few minutes before the shift ended at 3:00 PM. Nurse #1 explained she completed the post fall form and did not recall if an assessment was documented.

Telephone interview with the MDS nurse on 04/10/18 at 4:58 PM revealed she and the MDS consultant saw Resident #2 on the ground. The MDS nurse reported they assisted Resident #2 into a wheelchair. The MDS nurse explained she did not conduct a physical assessment of Resident #2. The MDS nurse reported Resident #2 appeared to have no injury.

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F 684	Continued From page 7 Telephone interview with Nurse #2 on 04/11/18 at 5:40 AM revealed she worked 3:00 PM to 11:00 PM on 02/28/18. Nurse #2 explained she received report of Resident #2 ' s fall and thought the day shift nurse conducted the post fall assessment. Nurse #2 reported Resident #2 informed her that dizziness caused his fall. Nurse #2 reported she did not measure Resident #2's blood pressure or conduct a physical assessment. Interview with the Director of Nursing on 04/11/18 at 8:59 AM revealed she expected staff to conduct and document a physical assessment when Resident #2 fell.	F 684		