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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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
E 000	Initial Comments An unannounced recertification survey was conducted from 03/05/19 through 03/08/19. The facility is in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event T1V611.	E 000		
F 550 SS=E	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	F 550		4/5/19

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

Electronically Signed | 03/28/2019

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 550	Continued From page 1 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 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to provide a dignified dining experience regarding use of disposal tableware for 5 of 5 sampled residents (Residents #16, #37, #45, #52 and #136). The findings included: Interview with dietary aide #1 on 03/05/19 at 9:01 AM revealed residents received meals plated on disposable trays and used plastic utensils when two staff members worked in the kitchen. Interview with the day cook on 03/05/19 at 9:03 AM revealed disposable items were required to reduce the time of dishwashing. The day cook explained the lunch meal would be delayed should non-disposable items be used. Observation of Resident #52's breakfast meal tray on 03/05/19 at 11:56 AM revealed plastic utensils and a disposable container which contained scrambled eggs, grits and potatoes. Resident interviews revealed:	F 550	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. F550 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents #16, #37, #45, #52, and #136 received apologies from the dietary manager regarding the use of disposable tableware. How the facility will identify other residents having the potential to be affected by the	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 550	Continued From page 2 a) Review of Resident #37's significant change Minimum Data Set (MDS) dated 12/25/18 revealed an assessment of intact cognition. Interview with Resident #37 on 03/05/19 at 10:41 AM revealed the facility used plastic utensils and food containers frequently on weekends. Resident #37 reported the use of disposable items was undignified and preferred non-disposable utensils and plates. b) Review of Resident #52's significant change MDS dated 01/16/19 revealed an assessment of intact cognition. Interview with Resident #52 on 03/05/19 at 11:46 AM revealed the facility served meals with disposable trays and plastic utensils on several occasions. c) Review of Resident #136's entry MDS revealed an admission date of 02/20/19. Interview on 03/05/19 at 3:25 PM with Resident #136 revealed disposable meal trays and plastic utensils were used frequently since his admission to the facility. d) Review of Resident #16's annual MDS dated 12/17/18 revealed an assessment of intact cognition. Resident #16 estimated the facility used disposable items on the meal trays once or twice weekly during an interview on 03/06/19 at 10:36 AM. Resident #16 explained he did not like to use plastic utensils. e) Review of Resident #45's quarterly MDS dated 01/25/19 revealed an assessment of intact cognition. Interview with Resident #45 on 03/06/19 at 10:37 AM revealed she preferred to receive meals without disposable items. Interview with the evening cook on 03/07/19 at	F 550	same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Dietary staff educated, by the Registered Dietician and Dietary Manager, on when the use of disposable tableware was appropriate, not for staff convenience, and only when approved by facility leadership; completed by April 4, 2019. The dietary manager, supervisor, or designee will monitor meal service, including at least one evening and one weekend meal, at least 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 1 time per week for 4 weeks to ensure staff compliance with the non-use of disposable tableware without appropriate authorization. The administrator will validate the non-use of disposable tableware through resident council interviews for 3 months. How the facility plans to monitor its performance to make sure that solutions are sustained. The findings of all audits will be shared with the QAPI committee for review of any further education or systemic changes needed. Staff found to be non-compliant with the expectation not to use disposable tableware will receive progressive discipline.	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 550	Continued From page 3 3:23 PM revealed residents received disposable food containers and plastic utensils when the shift did not have 2 dietary aides. The evening cook explained the use of disposable items decreased the time required to wash dishes. Interview with the dietary manager on 03/07/19 at 3:47 PM revealed disposable plates and utensils were used approximately 5 times in the past two months. The dietary manager reported the use occurred rarely and he was not aware of resident complaints regarding disposable use. The dietary manager reported the kitchen staff should not use disposable items for convenience. Interview with the Administrator on 03/07/19 at 4:57 PM revealed residents should receive non-disposable plates and utensils.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to place a call light within reach for 1 of 1 residents (Resident #69) reviewed for accommodation of needs. Findings included: Resident #69 admitted to the facility on 7/18/2018 which included diagnoses of aphasia following	F 558	F558 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #69 call light clip was replaced with a stronger clip to assist in securing it to his bed or wheelchair.	4/5/19

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 558	Continued From page 4 other non-traumatic intracranial hemorrhage, abnormal posture, and contracture of left and right hand. Review of the Significant Change Minimum Data Set (MDS) dated 2/5/2019 revealed Resident #69 has some cognitive impairments. Resident #69 was coded as having unclear speech. Resident #69 was coded as not having behavioral symptoms or refusing care. Resident #69 required total assistance from staff for bed mobility, transfers, and personal hygiene. Review of the care plan dated 6/26/2018 with a revision date of 7/25/2018 revealed Resident #69 had an ADL self-care deficit with a goal identified to maintain his current level of function. The interventions included Resident #69 to use his call bell to call for assistance. On 3/5/2019 at 10:18 AM Resident #69 was observed in bed with his eyes closed. Resident #69's call bell was observed to the right of his bed, on the floor, underneath the call bell panel located on the wall. On 3/5/2019 at 11:31 AM Resident #69 was observed in bed with his eyes open. Resident #69's call bell remained on the floor, to the right of his bed, underneath the call bell panel located on the wall. On 3/5/2019 at 1:42 PM Resident #69 was observed up in his wheelchair with family present. Resident #69's call bell was observed slightly behind the resident, on the floor, underneath the call bell panel located on the wall. On 3/6/2019 10:53 AM Resident #69 was	F 558	How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Facility nursing staff educated by the Administrator and Director of Nursing on monitoring residents call bell placement during rounds and resident care; completed by April 4, 2019. The director of nursing or designee will monitor residents rooms for call bell placement within reach of the residents, at least 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 1 time per week for 4 weeks to ensure staff compliance. How the facility plans to monitor its performance to make sure that solutions are sustained. The findings of all audits will be shared with the QAPI committee for review of any further education or systemic changes needed. Staff found to be non-compliant with the expectation to ensure call bell placement within reach of the resident will receive progressive discipline.	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 558	Continued From page 5	F 558		

observed in bed with his eyes open. Resident #69's call bell remained on the floor, to the right of his bed, underneath the call bell panel located on the wall.

On 3/6/2019 at 3:42 PM Resident #69 was observed in bed with his eyes closed. Resident #69's call bell was observed to the right of his bed, on the floor, underneath the call bell panel located on the wall.

On 3/7/2019 at 10:09 AM an interview with Nurse #1 was completed. Nurse #1 stated Resident #69 used his call light when he needed assistance. Nurse #1 explained Resident #69 was able to manipulate his fingers and normally rested his fingers on his call bell. Nurse #1 further explained she did not monitor Resident #69's call bell placement when she worked with him in the room. Nurse #1 stated Resident #69 had no behavioral symptoms and would not have thrown call bell on the floor or moved it. Nurse #1 could not explain why Resident #69's call bell was not within reach.

On 3/7/2019 at 11:05 AM an interview with Nurse Aide (NA) #2 was completed. NA #2 stated see has not seen Resident #69 use his call bell. NA #2 stated that she checked the resident frequently and anticipated his needs. NA #2 stated "he may hit the call bell with his fingers, that's probably the reason why he had the flat/circle call bell instead of the push call button". NA #2 indicated that Resident #69 would notify staff of any needs by using his call bell. NA #2 stated she has seen his call bell on when family has been in the room visiting. NA #2 was not sure if family pressed the call bell or Resident #69. NA #2 stated that Resident #69's call bell

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 558	Continued From page 6 needed to be within reach. On 3/8/2019 at 11:31 AM an interview was completed with Director of Nursing (DON). The DON stated her expectation of staff would be to ensure that the resident's call bells were within reach.	F 558		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		4/5/19

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 561	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to provide a choice of eating in the main dining room for 5 of 5 sampled residents who want to eat in the main dining room (Residents #16, #45, #51 #57, and #78). The findings included: During a resident council group interview conducted on 03/06/19 at 10:30 AM, Resident #16, the Resident Council President, reported residents could not eat in the main dining room when the facility did not have enough staff in the kitchen. Interviews conducted from 10:30 AM to 11:00 AM on 03/06/19 revealed the following: a) Review of Resident #16's annual Minimum Data Set (MDS) dated 12/17/18 revealed an assessment of intact cognition. Resident #16 explained the main dining room was a meeting and social place. Resident #16 stated the closure of the dining room occurred primarily on the weekend. b) Review of Resident #45's quarterly MDS dated 01/25/19 revealed an assessment of intact cognition. Resident #45 reported she wanted to eat in the main dining room to socialize. Resident #45 explained she looked forward to getting out of her room for lunch and dinner. c) Review of Resident #51's quarterly MDS dated 01/30/19 revealed an assessment of intact cognition. Resident #51 reported she liked to eat	F 561	F561 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Administrator met with resident council, which included the presence of residents #16, #45, #51, #57, #78, on March 25, 2019 and discussed the expectation for the dining room to be available to residents for meals. The residents had no further complaints regarding the dining room and reported that it had not been closed to them since March 3, 2019. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Administrator, Director of Nursing, and Dietary Manager provided Dietary and Nursing staff education on when the closing of the dining room was appropriate, not for staff convenience, and only when approved by facility leadership; completed by April 4, 2019. The dietary manager, supervisor, or designee will monitor meal service, including at least one evening and one weekend meal, at least 5 times per week for 4 weeks, 3 times per week for 4	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 561	Continued From page 8 in the dining room and missed the conversation with others when it closed. Resident #51 estimated residents could not eat in the dining room approximately 3 to 4 times a month. d) Review of Resident #67's annual MDS dated 01/16/19 revealed an assessment of intact cognition. Resident #67 agreed with Residents #16, #45 and #51's above-mentioned statements. e) Review of Resident #78's quarterly MDS dated 02/15/19 revealed an assessment of intact cognition. Resident #78 reported it was important to be able to choose to eat in the main dining room. Interview on 03/06/19 at 3:21 PM with Nurse Aide (NA) #3 revealed residents could not eat the dinner meal in the dining room when the 200 unit had 3 NAs. NA #3 explained 2 NAs were required to serve in the dining room which would leave only 1 NA on the unit. NA #3 estimated residents could not eat in the dining room approximately twice a month. Interview on 03/06/19 at 3:25 PM with NA #4 revealed residents could not eat in the main dining room approximately once a month. NA #4 explained the closure occurred when 2 NAs could not be sent to the main dining room. Interview with Nurse #4 on 03/07/19 at 12:04 PM revealed the dining room required closure the prior Sunday (03/03/19) for the noon meal. Nurse #4 explained the facility's usual practice was to close the dining room when the 200 unit could not send 2 NAs to assist in the main dining room. Nurse #4 explained the 200 unit usually had 4 to 5 NAs. Nurse #4 reported the main dining room	F 561	weeks, and 1 time per week for 4 weeks to ensure staff compliance with the non-closing of the dining room without appropriate authorization. The administrator will validate the non-closing of the dining room through resident council interviews for 3 months. How the facility plans to monitor its performance to make sure that solutions are sustained. The findings of all audits will be shared with the QAPI committee for review of any further education or systemic changes needed. Staff found to be non-compliant with the expectation not close the dining room will receive progressive discipline.	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 561	Continued From page 9	F 561		

closure usually occurred on Sundays approximately twice each month.

Interview with NA #5 on 03/07/19 at 12:10 PM revealed residents could not eat in the main dining room when the 200 unit had 3 NAs.

Interview with NA #6 on 03/07/19 at 12:15 PM revealed residents could not eat in the main dining room when the 200 unit had 3 NAs. NA #6 estimated the main dining room closure occurred once a month.

The weekend supervisor was not available for interview.

Interview with the evening cook on 03/07/19 at 3:23 PM revealed the supper meal was not served in the main dining approximately once a month. The evening cook reported the closure of the main dining room occurred on a weekend.

Interview with the dietary manager on 03/07/19 at 3:54 PM revealed he was not aware residents were not able to eat in the main dining room. The dietary manager reported the main dining room would be closed only if directed for infection control purposes such as a flu outbreak or a planned closure for floor stripping.

Interview with the Administrator on 03/07/19 at 4:57 PM revealed residents should be able to eat meals in the main dining room. The Administrator was not aware staff closed the main dining room when the 200 unit had 3 NAs. The Administrator explained other staff in the facility would be able to assist in the dining room.

Interview with the Director of Nursing (DON) on

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 561	Continued From page 10 03/08/19 at 2:27 PM revealed she was not aware residents could not eat in the main dining room when the 200 unit had 3 NAs. The DON reported staff on other units were available to assist in the main dining room.	F 561		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of	F 576		4/5/19

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 576	Continued From page 11 electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to provide residents with the right to receive mail when delivered on Saturdays. The findings included: Interview with Resident #16, the Resident Council President, on 03/06/19 at 10:41 AM revealed residents received unopened mail Monday through Friday but not on Saturdays. Interview with Resident #45, the Resident Council Vice-President, on 03/06/19 at 10:42 AM revealed residents did not receive mail on Saturdays. Interview with the Activity Director on 03/07/19 at 12:55 PM revealed the activity department staff delivered mail to the residents Monday through Friday. The Activity Director explained the receptionist on duty Saturday delivered mail to the residents. Interview with the Medical Records Coordinator on 03/07/19 at 1:15 PM revealed she worked as receptionist every other Saturday. The Medical Records Coordinator explained residents received Saturday delivered packages; but mail was set aside for the Business Office Manager to	F 576	F576 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #16 and Resident #45 had no undelivered mail identified by a review of unopened mail in the business office on March 20, 2019. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Business office, medical records, and receptionist staff educated by the Administrator on how to sort facility mail and ensure resident mail delivered within twenty-four hours of receipt, including weekends; completed by April 4, 2019. Administrator or designee will review the unopened mail and mail log each Monday for eight weeks to confirm resident mail delivery on the weekend.	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 576	Continued From page 12 sort before delivery to the residents. Residents did not receive mail delivered on Saturday. Interview with the Administrator on 03/07/19 at 3:42 PM revealed residents should receive mail on Saturady's when it was delivered.	F 576	How the facility plans to monitor its performance to make sure that solutions are sustained. The findings of all audits will be shared with the QAPI committee for review of any further education or systemic changes needed. Staff found to be non-compliant with the expectation of weekend mail delivery will receive progressive discipline.	
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 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	F 656		4/5/19

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 656	Continued From page 13 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 observations, resident and staff interviews, and record review, the facility failed to develop an individualized plan of care for a left resting hand splinting device recommended by Occupational Therapy to be worn daily for up to 8 hours for 1 of 3 residents (Resident #28) reviewed for range of motion. Findings included: Resident #28 was admitted to the facility on 3/4/2015, with the most recent readmission being 12/7/2018. Resident #28's diagnoses included muscle weakness, hemiplegia and hemiparesis affecting left dominant side, and chronic pain. Review of Resident #28's plan of care revised on 3/28/2018 revealed no care plan in place for left resting hand splinting device. Review of the Therapy Restorative Nursing	F 656	F656 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #28 care plan was updated as presented during survey. How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of residents with a splinting, braces, or orthotic devices completed by April 4, 2019 with immediate corrections to the care plan as indicated. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Rehabilitation provided education to the	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 656	Continued From page 14 Referral dated 4/17/2018, with the most recent review being 12/7/2018, revealed Resident #28 had a referral in place for splinting to the left hand/ wrist up to 8 hours per day. Splinting device was to be applied in the mornings per the Therapy Restorative Nursing Referral. Review of the Quarterly Minimum Data Set (MDS) dated 1/2/2019 revealed Resident #28 was cognitively intact. Resident #28 required extensive assistance with bed mobility and personal hygiene. Resident #28 was coded as having functional limitation in range of motion to upper and lower extremities on one side. On 3/5/2019 at 10:07 AM an observation of Resident #28's night stand revealed a blue splinting device. Resident #28 was observed in bed with left hand/ arm resting by his side. Resident #28 stated he was unable to move his left hand/ arm due to having a stroke. Resident #28 verbalized he had a splint near the television. Resident #28 further stated he could not recall the last time he had his splinting device applied by staff. Follow up observations were completed on 3/5/2019 at 11:33 AM, 3/5/2019 at 4:55 PM, 3/6/2019 at 9:52 AM, and 3/6/2019 at 3:43 PM which revealed the blue splint remained on the night stand in Resident #28's room. On 3/7/2019 at 12:15 PM an interview and observation was completed with the Rehab Manager and Occupational Therapist in Resident #28's room. The Occupational Therapist verbalized she had not discontinued the splinting device for Resident #28's hand/ wrist.	F 656	therapy staff on communicating recommendations for orthotics, braces, and splints to the Nursing team and not just documenting them; completed by April 4, 2019. The facility Director of Rehabilitation will be responsible for printing all therapy restorative recommendations for orthotics, braces, and splints and bringing them to the morning stand-up meeting for review by the nursing team. Nursing administration will assess the recommendation from therapy and place on the care plan for implementation by nursing staff. The Nurse Consultant provided education to Nursing Administration that care plans need to reflect current resident status and should be reviewed with each quarterly or annual assessment; completed by April 4, 2019. The Nurse Consultant or designee will audit therapy recommendations for programs for orthotics, braces, and splints on residents discharged from therapy and remaining in the facility. The audit will review any residents discharged since the last audit up to a random sample of 5 resident care plans. The audit will assess if any splinting, braces, or orthotic device programs were recommended and are updated/accurate on the current care plan, for 1 time per week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months to ensure the deficient practice does not recur. How the facility plans to monitor its performance to make sure that solutions are sustained. Any issues identified on	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 656	Continued From page 15 An interview was completed on 3/7/2019 at 3:00 PM with the MDS Nurse. The MDS Nurse revealed she only completed the Annual and Significant Change care plans. The MDS Nurse did not provide a reason as to why the resting hand splinting device was not developed in Resident #28's plan of care. An interview was completed on 3/7/2019 at 3:36 PM with the Administrator. The Administrator stated her expectation would be for the IDT (Interdisciplinary Care Plan) to follow the policy and procedures, which were in line with the regulations, in regards to care plan development.	F 656	the audits will be immediately corrected with coaching/discipline as needed to the nursing administration team. Results of the audits will be presented in the quarterly QAPI meeting and reviewed for any need for systemic changes or further education.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff	F 688	F688	4/5/19

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 688	Continued From page 16 interviews, and record review, the facility failed to apply a left resting hand splinting device recommended by occupational therapy to be worn daily for up to 8 hours for 1 of 3 residents (Resident #28) reviewed for range of motion. Findings included: Resident #28 was admitted to the facility on 3/4/2015, with the most recent readmission being 12/7/2018. Resident #28's diagnoses included muscle weakness, hemiplegia and hemiparesis affecting left dominant side, and chronic pain. Review of Resident #28's plan of care revised on 3/28/2018 revealed no care plan in place for left resting hand splinting device. Review of the Therapy Restorative Nursing Referral dated 4/17/2018, with the most recent review being 12/7/2018, revealed Resident #28 had a referral in place for splinting to the left hand/ wrist up to 8 hours per day. Splinting device was to be applied in the mornings per the Therapy Restorative Nursing Referral. Review of the Quarterly Minimum Data Set (MDS) dated 1/2/2019 revealed Resident #28 was cognitively intact. Resident #28 required extensive assistance with bed mobility and personal hygiene. Resident #28 was coded as having functional limitation in range of motion to upper and lower extremities on one side. Resident #28 was not coded as having any behavioral symptoms or receiving therapy services. On 3/5/2019 at 10:07 AM an observation of Resident #28's night stand revealed a blue	F 688	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #28 had his splint immediately applied as observed during survey. How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of residents with splinting, braces, or orthotic devices completed by April 4, 2019 with immediate education to nursing staff and corrections to the care plan as indicated. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Rehabilitation provided education to the therapy staff on communicating recommendations to the Nursing team and not just documenting them; completed by April 4, 2019. The facility Director of Rehabilitation will be responsible for printing all therapy restorative recommendations for orthotics, braces, and splints and bringing them to the morning stand-up meeting for review by the nursing team. Nursing administration will assess the recommendation from therapy and will determine which devices need implemented and place on the care plan for staff application. Nursing staff (nurses and aides) were provided in-service education on the facility restorative program, including splinting, braces, and	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 688	Continued From page 17 splinting device. Resident #28 was observed in bed with left hand/ arm resting by his side. Resident #28 stated he was unable to move his left hand/ arm due to having a stroke. Resident #28 verbalized he had a splint near the television. Resident #28 further stated he could not recall the last time he had his splinting device applied by staff. Follow up observations were completed on 3/5/2019 at 11:33 AM, 3/5/2019 at 4:55 PM, 3/6/2019 at 9:52 AM, and 3/6/2019 at 3:43 PM which revealed the blue splint remained on the night stand in Resident #28's room. On 3/7/2019 at 12:15 PM an interview and observation was completed with the Rehab Manager and Occupational Therapist in Resident #28's room. The observation revealed the splinting device was in place for Resident #28. Resident #28 stated nursing found the device on the night stand and applied the device sometime this morning. The Occupational Therapist assessed the splint application and stated Resident #28's fingers were pliable, and the splinting device was more for comfort, but still recommended. The Occupational Therapist explained Resident #28 would have been assessed to ensure the splinting device remained appropriate after his readmission. The Occupational Therapist verbalized she had not discontinued the splinting device for Resident #28's hand/wrist. An interview was completed on 3/7/2019 at 12:51 PM with nurse aide (NA) #1. NA #1 stated she was aware Resident #28 had a splinting device. NA #1 stated she applied the splinting device today and would need to check with therapy	F 688	orthotic devices, by the Nurse Consultant and Director of Nursing; completed by April 4, 2019. The Director of Nursing or designee will audit therapy recommendations for programs for orthotics, braces, and splints on residents discharged from therapy and remaining in the facility. The audit will review any residents discharged since the last audit up to a random sample of 5 residents. The audit will assess if any splinting, braces, or orthotic devices are being placed on the resident for 1 time per week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months to ensure deficient the practice does not recur. How the facility plans to monitor its performance to make sure that solutions are sustained. The findings of all audits will be shared with the QAPI committee for review of any further education or systemic changes needed. Staff found to be non-compliant with the application of splints, braces, or orthotic devices will receive progressive discipline.	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 688	Continued From page 18 regarding how long Resident #28 would need to wear splint. NA #1 stated that prior to today (3/7/2019), she could not recall the last time she applied Resident #28's splinting device. NA #1 stated that splinting device was lost (uncertain how long), and she was not certain if 3rd shift found the splinting device in Resident #28's room, and just placed splinting device on the night stand without communicating with anyone. An interview was completed on 3/7/2019 at 3:36 PM with the Director of Nursing. The DON stated her expectation would be for splinting devices to be applied by nursing staff per the recommendations of the therapy department.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		4/5/19

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 692	Continued From page 19 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide a frozen nutritional supplement as ordered for 1 of 3 residents (Resident #46) reviewed for nutrition. Findings included: Resident #46 was admitted to the facility on 4/24/2018. Resident #46 had diagnoses that included cerebrovascular disease, diabetes, dysphagia, and lack of coordination. Review of the electronic medical record revealed a dietary order dated 1/24/2019 which read in part: frozen nutritional supplement two times daily. Review of the Quarterly Minimum Data Set (MDS) dated 1/25/2019 revealed Resident #46 had cognitive impairments and required supervision with meals with weight loss indicated and not on prescribed weight loss regimen. Review of the Registered Dietician note dated 1/29/2019 read in part: Resident #46 at risk for weight fluctuations given diagnosis of dysphagia requiring mechanically altered diet, variable intake by mouth, anorexia and diabetes. Average meal intake was 50 to 100% per meal. Resident #46 received frozen nutritional supplement two times daily. Review of the care plan related to Nutritional Risk dated 5/7/2018 and revised on 3/6/2019 revealed that Resident #46 required a mechanically altered	F 692	F692 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #46 has shown no signs of weight loss and has gained weight; the supplement was discontinued for resident #46. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Dietary staff were educated by the Registered Dietician and Dietary Manager on ensuring tray accuracy regarding supplements; completed by April 4, 2019. Nursing staff were educated by the Director of Nursing on checking tray cards for supplements when providing trays to residents; completed by April 4, 2019. The dietary manager or supervisor will audit trays for supplements at least 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 1 time per week for 4 weeks to ensure deficient practice does not recur. How the facility plans to monitor its	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 692	Continued From page 20 and therapeutic diet related to dysphagia and diabetes. The goal identified for Resident #46 was to avoid significant weight changes. An intervention for Resident #46 included to provide and serve supplements as ordered. An observation on 3/5/2019 at 1:40 PM was completed which revealed Resident #46 eating lunch in his room. Resident #46 received Chicken Dijon (bite size pieces), turnip greens, parslied rice, fruit, unsweetened tea and water. Review of Resident #46's meal ticket revealed a frozen nutritional supplement should have been provided. No frozen nutritional supplement was observed on Resident #46's meal tray. An observation on 3/7/2019 at 1:21 PM was completed which revealed Resident #46 eating lunch in his room. Resident #46 received BBQ chicken (bite size pieces), mac and cheese, turnip greens, sweet potato pie, water and unsweetened tea. Review of Resident #46's meal ticket revealed a frozen nutritional supplement should have been provided. No frozen nutritional supplement was observed on Resident #46's meal tray. An interview was completed on 3/7/2019 at 3:11 PM with Nurse Aide (NA) #1. NA #1 stated she delivered Resident #46's meal trays. NA #1 stated Resident #46 required set up with his meals. NA #1 verbalized Resident #46 usually received a frozen nutritional supplement with his meals. NA #1 continued to verbalize if an item was left off the resident's meal tray, then staff would retrieve item from dietary. NA #1 did not verbalize if she checked Resident #46's meal ticket. NA #1 could not explain why Resident #46's frozen nutritional supplement was omitted	F 692	performance to make sure that solutions are sustained. The findings of all audits will be shared with the QAPI committee for review of any further education or systemic changes needed. Staff found to be imprecise in tray accuracy will receive progressive discipline.	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 692	Continued From page 21	F 692		

and not provided.

An interview was completed with Nurse #1 on 3/7/2019 at 3:18 PM. Nurse #1 stated she was not aware that Resident #46 did not receive his frozen nutritional supplement on his meal tray. Nurse #1 stated normal practice would be for the frozen nutritional supplements to come out from the kitchen on the meal trays. If items were missing, then the nurse aide would inform the nurse, and the nurse aide would go to the kitchen to retrieve the missing item. Nurse #1 could not explain why Resident #46's frozen nutritional supplement was omitted and not provided.

An interview was completed on 3/7/2019 at 3:49 PM with the Dietary Manager (DM). The DM stated the dietary department would be responsible for ensuring frozen nutritional supplements were delivered from the kitchen, to the unit, and nursing would deliver the meal tray to the resident. The DM was not aware Resident #46 did not receive his frozen nutritional supplement on his meal tray. The DM stated he expected his staff to pay attention to the resident's meal tickets and ensure the meal tray was accurate with all items listed prior to leaving the kitchen.

An interview was completed on 3/7/2019 at 3:59 PM with the Director of Nursing (DON). The DON stated she expected the NA's to review the meal ticket and ensure that all items were on the meal tray for the residents. If there were items missing, then the DON expected for the NA to go to the kitchen to retrieve the item.

An interview was completed on 3/7/2019 at 5:21 PM with the Registered Dietician Consultant. The

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 692	Continued From page 22 RD stated Resident #46 was ordered a frozen nutritional supplement BID (twice a day) and he should receive this item at lunch and dinner. The RD stated she expected frozen nutritional supplements to go from the dietary department, and nursing to provide a second check on the units. If an item was missed, she expected nursing to come to dietary to obtain the missing item, or in this case, obtain the frozen nutritional supplement for the resident.	F 692		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff and physician interviews, and record review, the facility failed to administer the correct dose of potassium chloride to 1 of 7 residents observed during a medication pass (Resident #44). The findings included: Resident #44 was admitted to the facility on 12/15/18 with diagnoses which included end stage renal disease with dialysis. Review of a nursing note dated 02/28/19 revealed documentation of receipt of Resident #44's potassium level of 2.5 millimoles per Liter (mmo.L). (Normal potassium levels range from 3.6 to 5.0 mmo.L according to the National Institute of Health, U.S. Department of Health and Human Services.) The physician received notification of the low potassium level.	F 760	F760 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The nurse providing the incorrect dose was immediately counseled, the patient□s dose for March 7, 2019 was corrected, and the physician was notified. A medication error report has been completed and there was no adverse effect to the resident. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice.	4/5/19

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 760	Continued From page 23 Review of physician's orders dated 02/28/19 revealed direction to administer potassium chloride 60 milliEquivalents (mEq.) daily to Resident #44. Review of Resident #44's electronic Medication Administration Record (eMAR) revealed documentation of potassium chloride 60 mEq. daily administration at 8:00 AM from 03/01/19 to 03/07/19. Five dates (03/01/19, 03/04/19, 03/05/19, 03/06/19 and 03/07/19) were documented as administered by Nurse #1. Observation on 03/07/19 at 8:56 AM revealed Nurse #1 prepared potassium chloride to administer to Resident #44. Review of Resident #44's potassium chloride medication card revealed each potassium chloride tablet contained 20 mEq. The pharmacy label indicated direction to administer 60 mEq. of potassium chloride daily. Observation on 03/07/19 at 9:01 AM revealed Nurse #1 broke the potassium chloride 20 mEq. in half and administered the medication to Resident #44 with water. Interview with Nurse #1 on 03/07/19 at 9:07 AM revealed she administered potassium chloride 20 mEq. to Resident #44. Nurse #1 explained she thought the one tablet contained 60 mEq. of potassium chloride. Nurse #1 reported she should have administered 3 potassium chloride 20 mEq. tablets to Resident #44. Continued interview with Nurse #1 reported she administered one potassium chloride 20 mEq.. tablet to Resident #44 on 03/01/19, 03/04/19,	F 760	The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The Nurse Consultant and the Director of Nursing provided education to licensed nursing staff on the five rights of medication administration, including verifying the correct dosage; completed on April 4, 2019. Nursing administration will conduct medication pass audits on licensed nursing staff monthly for 3 months and then quarterly to monitor for the dispensing of accurate dosage. How the facility plans to monitor its performance to make sure that solutions are sustained. The results of the mediation pass audits will be reported to the QAPI committee for analysis of any patterns, trends, or need for further systemic changes. Any staff found to be non-compliant with the dispensing of accurate drugs will receive progressive discipline.	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 760	Continued From page 24 03/05/19 and 03/05/19 in addition to the dose administered on 03/07/19. Observation of Resident #44's potassium chloride medication card with Nurse #1 on 03/07/19 at 10:17 AM revealed 19 potassium chloride 20 mEq. tablets available for administration. Nurse #1 reported she administered 2 additional potassium chloride tablets upon discovery of the incorrect administered dose and the card initially held 21 tablets. Further observation revealed two potassium chloride cards of 30 tablets each were in the back up medication storage. The medication cards indicated a fill date of 02/28/19 of ninety 20 mEq. tablets. (Sixty-nine potassium chloride 20 mEq. tablets should be available instead of the 81 tablets available if the correct dose of 3 tablets daily had been administered.) Interview with the Director of Nursing (DON) on 03/07/19 at 10:42 AM revealed she expected staff to administer medications as ordered. Telephone interview on 03/07/19 at 12:35 PM with Resident #44's physician revealed Resident #44 should receive medications as ordered.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		4/5/19

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 761	Continued From page 25 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard 6 bottles of an expired over the counter (OTC) medication (Aspirin) and 2 bottles of vitamin supplements (Vitamin B12 and Multi-Vitamin) from 1 of 3 medication storage rooms and remove loose pills and debris from 2 of 4 medication carts. The findings included: a. An observation of the 100 unit medication storage room occurred on 3/7/19 at 12:51 PM with Nurse #2. During the observation, the following OTC medications or vitamin supplements were observed: · 1 bottle of a Multi-Vitamin with Iron, 100 pills, with a manufacturer expiration date stamp of June 2018 · 1 bottle of Vitamin B 12, 100 pills, with a	F 761	F761 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The Nurse Consultant and Director of Nursing	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 761	Continued From page 26 manufacturer expiration date stamp of November 2018 · 6 bottles of Aspirin 325 mg, 100 pills per bottle, with a manufacturer expiration date stamp of January 2019 During the observation, Nurse #2 stated that management was responsible for monitoring the medication storage rooms for expired items. b. An observation of medication cart #2 (rooms 113 - 124) on the 100 unit occurred on 3/7/19 at 12:15 PM with Nurse #2. During the observation of the medication cart, 15 loose pills and debris was observed in the drawers of the medication cart. The loose pills were various sizes, shapes and colors. Nurse #2 stated during the observation that she monitored the medication cart for cleanliness and loose pills weekly and that she had last checked the cart on Saturday with some loose pills noted/discarded. She stated that monitoring the medication cart for cleanliness was the responsibility of all nurses. Nurse #2 further stated that the medications should be dispensed into a medication cup and that medications on the cart should be maintained to minimize overcrowding and the loss of pills. c. An observation of medication cart #1 (rooms 101 - 112) on the 100 unit occurred on 3/7/19 at 12:57 PM with Nurse # 3 During the observation of the medication cart, 6 loose pills and debris was observed in the drawers of the medication cart. The loose pills were various sizes, shapes and colors. Nurse #3 stated during the observation that she monitored the medication cart for cleanliness/loose pills at least weekly and that she last checked it on Monday with no loose	F 761	provided facility licensed nurses education on the labeling and storage of drugs; completed by April 4, 2019. Nursing administration will conduct medication pass audits on licensed nursing staff monthly for 3 months and then quarterly to monitor the medication carts for the labeling and storage of medications. Nursing administration will also conduct reviews of medications in the facility storage rooms for expired medication disposal, 1 time per week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months. The facility pharmacist will also review medication carts monthly and report any concerns with labeling and storage of drugs to the Administrator and the Director of Nursing. How the facility plans to monitor its performance to make sure that solutions are sustained. The results of the mediation pass audits and the pharmacy reviews will be reported to the QAPI committee for analysis of any patterns, trends, or need for further systemic changes. Any staff found to be non-compliant with the storage and labeling of drugs will receive progressive discipline.	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 761	Continued From page 27 pills/debris noted. She stated that monitoring the medication cart for cleanliness was the responsibility of all nurses. An interview on 3/7/19 at 1:18 PM with the unit coordinator revealed she expected nurses to inform her anytime expired/loose pills were found, and that nurses should check their medication carts/medication storage rooms at least twice weekly for cleanliness/expired items. The Director of Nursing (DON) was interviewed on 3/7/19 at 4:30 PM and stated that she would expect nurses to follow the facility's policy regarding medication storage. The DON stated she expected monitoring by all nurses of carts/storage rooms at least monthly for expired medications and cleanliness and that she expected nurses to take any loose pills to central supply to be discarded in a sharps container.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		4/5/19

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 812	Continued From page 28 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, Registered Dietician Consultant (RDC) interview, and staff interviews, the facility failed to cover, label, and date food items in 1 of 1 walk in refrigerators, monitor produce (bell peppers) and fruit (oranges) with signs of spoilage in 1 of 1 walk in refrigerators, and failed to store and monitor produce (onions) with signs of spoilage per manufacturer recommendations. Findings included: An initial tour of the kitchen was completed on 3/5/2019 at 8:56 AM with the Day Cook and Dietary Aide (DA) #1. The initial tour revealed the following problems: An observation of the walk-in refrigerator revealed an uncovered container of green beans, available for use, with no label and no date. An observation of the walk-in refrigerator revealed 1 box of bell peppers with signs of spoilage (white fuzzy matter and black spots) identified on 2 bell peppers. An observation of the walk-in refrigerator revealed 1 box of oranges with signs of spoilage (white/ blueish fuzzy matter) identified on 1 orange. 1 box of yellow onions stored underneath a	F 812	F812 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Unlabeled, undated, and food showing signs of spoilage were immediately discarded, as observed during survey. No residents were affected by the alleged deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Dining services staff (cooks and aides) were in-serviced by the Dietary Manager and the Registered Dietician on proper food storage practices, including how to cover, label, and date food and how to store and monitor produce; completed by April 4, 2019. The Registered Dietitian will monitor for sanitation to meet regulatory standards during her facility visits and include this on her monthly visit report to Administration. The Dietary Manager will audit food storage in the kitchen weekly	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 812	Continued From page 29 kitchen preparation area with manufacturers temperature ranges labeled on the box to store between 45 degrees Fahrenheit and 50 degrees Fahrenheit. An interview was completed on 3/5/2019 at 9:15 AM with the Day Cook. The Day Cook revealed that he monitored the walk-in refrigerator when he was on duty. The Day Cook stated he covered, dated, and labeled items that he prepared in the walk-in refrigerator properly. The Day Cook could not explain why items were not covered, labeled and dated properly in the walk-in refrigerator. The Day Cook did not indicate the last time he monitored the walk-in refrigerator to ensure items were covered, labeled and dated properly. An interview was completed on 3/5/2019 at 9:17 AM with the Dietary Aide (DA) #1. The DA #1 stated she assisted with cooking in the kitchen. The DA #1 explained when she cooked, she covered, labeled and dated items that she prepared in the walk-in refrigerator. The DA #1 further stated when she did not cook, she did not monitor items in the walk-in refrigerator to ensure they were covered, labeled, and dated properly. An interview was completed on 3/5/2019 at 9:20 AM with the Day Cook and DA #1. The Day Cook and DA #1 revealed that potatoes and onions were always stored underneath the preparation table in the kitchen. The Day Cook and DA #1 were not aware of the manufacturer's recommendations regarding the storage of potatoes and onions. A follow up visit of the kitchen was completed at 9:30 AM with the RDC. The follow up visit revealed the following additional problems:	F 812	for 4 weeks, then monthly for 2 months, then quarterly for 1 quarter to ensure deficient practice does not recur. How the facility plans to monitor its performance to make sure that solutions are sustained. The results of the audits and the will be reported to the QAPI committee for analysis of any patterns, trends, or need for further systemic changes. Any staff found to be non-compliant will receive progressive discipline.	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 812	Continued From page 30	F 812		

An observation of the walk-in refrigerator revealed a covered container with a brown substance with no label or no date.

An observation of the walk-in refrigerator revealed four slices of cheese that were in a clear wrapping with no label or no date.

An ambient temperature via digital thermometer was obtained by the RDC on 3/5/2019 at 9:32 AM. The ambient temperature of the kitchen gave a reading of 72 degrees Fahrenheit.

Surface temperature obtained of the yellow onions revealed the following reading:

Yellow Onions- 65.5 degrees Fahrenheit.

No signs of spoilage and pest activity was observed at this time to the yellow onions.

A follow up interview was completed with the RDC on 3/5/2019 at 9:35 AM regarding the storage of onions. The RD stated onions were safe at room temperature because they have not been sliced or cut. The RD continued to state the temperatures referenced on the boxes of the onions were referencing temperatures for peak freshness.

An additional interview was completed with the RDC on 3/5/2019 at 9:35 AM. The RDC explained the green beans should have had a lid on them, labeled properly and dated. The RDC stated she would dispose of them, the 2 bell peppers with white fuzzy matter and black spots were obtained by the RDC, and she stated they

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 812	Continued From page 31 should be discarded. The 1 orange with white/ bluish fuzzy matter was obtained by the RDC, and she stated the orange should be discarded as well. Additionally, the RDC verbalized the brown substance was gravy and this should have a label and date on it. The RDC discarded the brown substance. The RDC further verbalized the 4 slices of cheese should be properly labeled and dated. The 4 slices of cheese were discarded by the RDC. The RDC stated her expectation was that all dietary staff have the responsibility to monitor food items for proper covering, labeling, dating and storage. An additional visit to the kitchen was completed on 3/7/2019 at 8:04 AM. The RDC was present. Several flying insects were observed in kitchen preparation area where and onions were stored under the preparation table. The observation revealed signs of spoilage (soft, mushy, brownish matter) to 3 yellow onions within the box of yellow onions. The RDC discarded the 3 onions yellow onions with signs of spoilage. An interview was completed with the Administrator on 3/7/2019 at 3:28 PM. The Administrator stated her expectation would be for the Dietary Manager to follow policy and procedure regarding storing, labeling, dating and covering food items to minimize any risks to residents.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		4/5/19

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 867	Continued From page 32 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee put into place in June, 2018. These were for deficiencies cited during the facility's recertification survey conducted on 05/25/18, F 688, F 761 and F 812. The deficiencies were in the areas of range of motion (ROM), medication storage and kitchen sanitation. The continued failure of the facility to sustain compliance, during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: F 688: Increase/Prevent Decrease in ROM/Mobility. Based on observations, resident and staff interviews, and record review, the facility failed to apply a left resting hand splinting device recommended by occupational therapy to be worn daily for up to 8 hours for 1 of 3 residents (Resident #28) reviewed for range of motion. The facility was recited for F 688 for failure to apply a splinting device. The F 755 was originally cited during a recertification survey on 05/25/18 for failure to apply an ankle/foot orthotic to maintain foot alignment. F 761: Label/Store Drugs & Biologicals. Based on observation and staff interviews, the facility failed	F 867	F867 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #28 had his splint immediately applied as observed during survey. F761 and F812 had no residents affected by the alleged deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Administrator educated the facility QAPI (Quality Assurance and Performance Improvement) committee members on how to develop and implement appropriate plans of action to correct identified quality deficiencies; completed March 29, 2019. The facility will implement Performance Improvement Plans based on the plan of correction for F-tags F688, F761, and F812 and share the findings with the QAPI committee each month for 4 months. The QAPI committee will continue to use audits and data to determine areas below expectation and implement Performance	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 867	Continued From page 33 to discard 6 bottles of expired over the counter (OTC) medication (Aspirin) and 2 bottles of vitamin supplements (Vitamin B12 and Multi-Vitamin) from 1 of 3 medication storage rooms and remove loose pills and debris from 2 of 4 medication carts. The facility was recited for F 761 for failure to remove expired medications, loose pills and debris. The F 761 was originally cited during a recertification survey on 05/25/18 for failure to remove expired controlled medication from a medication cart and an unsecured medication cart. F 812: Food Procurement, Store/Prepare/Serve - Sanitary. Based on observations, Registered Dietician Consultant (RDC) interview, and staff interviews, the facility failed to cover, label, and date food items in 1 of 1 walk in refrigerators, monitor produce (bell peppers) and fruit (oranges) with signs of spoilage in 1 of 1 walk in refrigerators, and failed to store and monitor produce (potatoes and onions) with signs of spoilage per manufacturer recommendations. The facility was recited for F 812 for failure to cover, label and date food items and monitor food items for signs of spoilage. The F 812 was originally cited during a recertification survey on 05/25/18 for failure to use beard guards, store ice cream in a freezer and discard spoiled vegetables. Interview with the Administrator on 03/08/19 at 2:30 PM revealed the facility's quality assurance committee monitored splint application, medication storage and kitchen sanitation. The Administrator reported audit tools which	F 867	Improvement Plans as indicated. How the facility plans to monitor its performance to make sure that solutions are sustained. Monthly QAPI committee minutes will be sent to the Corporate Quality Assurance Nurse for review and recommendations.	

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 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 867	Continued From page 34 monitored compliance with splint application and medication storage identified no concerns. The Administrator explained the facility's quality assurance committee identified concerns regarding kitchen sanitation and practices and had just begun steps to remedy identified problems.	F 867		