	-	ID HUMAN SERVICES				RM APPROVED
						IO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		345254	B. WING		0	C 4/17/2025
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MONROE	REHABILITATION CENT	ER		212 SUNSET DRIVE EAST IONROE, NC 28112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	from 4/15/25 through information was obtain Therefore, the exit dan Event ID# 8MYN11. investigated NC0022 allegation resulted in	ned offsite on 4/17/25. te was changed to 4/17/25. The following intake was 9282. 1 of 1 complaint				
	Past-noncompliance	was identified at:				
		89 at a scope and severity /25 and was removed				
	Date of compliance w	vas 4/10/25.				
	The tag F689 constitu Care.	ited Substandard Quality of				
F 689 SS=J		ards/Supervision/Devices	F 689			
	supervision and assis accidents.	sident receives adequate tance devices to prevent is not met as evidenced				
	Medical Director, and	ns, record review, and staff, Legal Guardian interviews, isure Resident #1, who had		Past noncompliance: no plan of correction required.		
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	TITLE		(X6) DATE
	cally Signed					05/07/2025

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.

	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі	LE CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
							С
		345254	B. WING			04/17/202	
NAME OF PI	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
					1212 SUNSET DRIVE EAST		
MONROE	REHABILITATION CENT	ER			MONROE, NC 28112		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORT ORT		IAG		DEFICIENCY)	(I L	
F 689	Continued From page	e 1	F	689	9		
		was safely transported					
	back to the facility foll						
		25. Driver #1 failed to					
	secure Resident #1's	wheelchair to the van floor					
		#1 in the wheelchair per the					
		ctions during transport in the					
	-	ver #1 drove out of the					
		l right onto the main road, wheelchair she was in fell					
		g on the van floor. Driver #1					
		e of the road and observed					
		as bleeding and called 911.					
		sported by emergency					
		S) to the hospital for further					
	-	osed with a frontal scalp					
	laceration, left middle						
		(neck) fracture. The resident					
	· ·	rse outcome and injury when					
	transportation van pe	hair was not secured in the					
		cient practice occurred for 1					
		ed for accidents (Resident					
	#1).						
	,						
	The findings included						
	A review of the manual	facturer's instruction manual					
	for the transport van						
	securement and occu	-					
		y read in part: Attach the					
		connecting a hook and a					
		nto the floor anchorages					
		ace. Attach the tie-down					
		of the wheelchair frame					
		ng the tie downs are fixed at					
		rees. Ensure all tie-downs					
		rly tensioned (tightened).					
		f the lap belt across the Il the shoulder belt across					
	occupants pervis. Pu						

If continuation sheet Page 2 of 21

	MENT OF HEALTH AN					FORM	D: 05/20/2025 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	
			A. BUILDI	ING			С
		345254	B. WING			04/	17/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MONROE	REHABILITATION CENT	ER	1212 SUNSET DRIVE EAST				
			MONROE, NC 28112				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page the occupant's chest a connector. Adjust the so it rests on the occu Driver #1's training re completed van transp by the Administrator, i evaluation dated 1/14 Administrator, indicate for securing a wheelc transport van per the and all competencies Resident #1 was adm 6/01/23 with diagnose fracture and dementia The significant chang dated 2/14/25 reveale cognitively impaired, I impairment to one sid wheelchair for mobility maximal assistance w	e 2 and attach it to the lap belt height of the shoulder belt upant's shoulder. cords revealed she ortation training, provided on 10/16/24. A competency /25, completed by the ed Driver #1 was reviewed hair into the facility's manufacturer's instructions were checked as met. itted to the facility on es including right femur a. e Minimum Data Set (MDS) ed Resident #1 was severely had lower extremity	TAG		DEFICIENCY)	ΛΤΕ	DATE
	#1 was non-ambulato maximal assistance w wheelchair and the as mobility. Driver #1's statement transported Resident appointment in the fac appointment she load the van, secured the v belt. Driver #1 drove	•					

Facility ID: 953214

If continuation sheet Page 3 of 21

		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391		
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _			PLETED		
		345254	B. WING	B. WING			C / 17/2025		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	04/17/2025			
					1212 SUNSET DRIVE EAST	ODE			
MONROE	REHABILITATION CENT	ER		r	MONROE, NC 28112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ECTIVE ACTION SHOULD BE CC			
F 689	loud crash. She look observed Resident #' Driver #1 immediately of the road, stopped to on Resident #1. Resi side with her head fac laceration to her foreh Driver #1 noted the with the shoulder and lap the front left tie down the wheelchair. Driver blanket to apply press forehead. Resident # the Emergency Depa evaluation. Driver #1 wheelchair tipped over thought Resident #1 to wheelchair or had rele- belt. A phone interview wa on 4/15/25 at 12:07 P started working at the was trained to transport van. Driver #1 indica reading material, instru- demonstrations from secure a wheelchair i manufacturer's instruc- completed 3 to 4 retu- included the Administ while she secured the then she drove the va- miles and returned to received training for a the Administrator corr she started transporti Driver #1 revealed on	ed in the review mirror and I lying on the van floor. I pulled over on the left side he van and went to check dent #1 was lying on her left sing upward and she had a head that was bleeding. heelchair was tipped over, belt were disconnected, and strap was unhooked from r #1 called 911 and used a sure to Resident #1's 1 was transported by EMS to rtment (ED) for further was unsure how the er and reported to EMS she ried to stand up from the eased the shoulder and lap s conducted with Driver #1 M. She revealed she facility in October 2024 and ort residents in the facility ted the training included functional videos, and the Administrator on how to in the van using the ctions. She stated she also rn demonstrations which rator sitting in a wheelchair, e wheelchair in the van and un on the main road for a few the facility. She stated she approximately a month and opleted a skills check before ing residents on her own. 4/08/25 she transported	F	689					
	received training for a the Administrator com she started transporti Driver #1 revealed on	pproximately a month and pleted a skills check before ng residents on her own.							

Facility ID: 953214

If continuation sheet Page 4 of 21

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/20/2029 FORM APPROVED OMB NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254		B. WING _		C 04/17/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	
				1212 SUNSET DRIVE EAST	
MONROE	REHABILITATION CENT	ER		MONROE, NC 28112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE CIENCY)
F 689	Driver #1 revealed wi finished, she loaded if van, secured the whe and lap belt, and drow toward the main road the van before turning looked in the review if Resident #1 was repo- wheelchair but was si- lap belt were still con- turned right onto the something crash and Driver #1 revealed sh mirror and observed if over and Resident #1 She stated she imme- left side of the road a #1 indicated she wen observed Resident # her head facing upwa- laceration to her forel stated she also obser fallen over, the seat a disconnected, and the longer hooked on the indicated she called S pressure to Resident her until EMS arrived for EMS to arrive she Administrator and rep #1 revealed Resident and was not exhibitin distress. Driver #1 in they asked her to mo could provide treatme- stated the Administra was loaded into the a	ent during the appointment. hen the appointment was Resident #1 back into the velchair, applied the shoulder ve out of the parking lot . She indicated she stopped gright onto the main road, mirror and observed ositioning herself in the eated and the shoulder and nected. Driver #1 stated she main road and heard thought her clipboard fell. he looked in the rear-view the wheelchair had fallen was lying on the van floor. diately pulled over on the nd stopped the van. Driver t to the back of the van and 1 lying on her left side with ard, and the resident had a head that was bleeding. She rved that the wheelchair had and lap belt were e front left tie down was no wheelchair. Driver #1 211, used a blanket to apply #1's forehead and sat with . She indicated while waiting also contacted the ported the incident. Driver t #1 was not crying or yelling g any signs of pain or dicated when EMS arrived, ve the wheelchair so they ent to Resident #1. She tor arrived as Resident #1	F	389	

Facility ID: 953214

If continuation sheet Page 5 of 21

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED			
		345254	B. WING				C 17/2025			
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>				
				1	1212 SUNSET DRIVE EAST					
MONROE	REHABILITATION CENT	ER		Ν	MONROE, NC 28112					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE			
F 689	her to drive the van b she returned, she wro occurred. She stated reenactment of how s and Resident #1 in th and Director of Nursir returned to the facility the reenactment whe shoulder and lap belt she did not recall the clicking twice when sl #1 and that must have causing the wheelcha revealed she did not of shoulder and lap belt properly secured bect back to the facility for an appointment. She checked to ensure the #1 were secured prop revealed she was sus an investigation and h An observation was of PM of Driver #1 demo the wheelchair and R on 4/08/25 with the R sitting in the wheelcha front tie downs and the frame underneath the Driver #1 crossed the Regional Clinical Dire both sides of the lap k shoulder belt over hell stepped away from th the demonstration. D during the demonstration.	e Administrator instructed ack to the facility, and when ote a statement about what she also performed a she secured the wheelchair e van with the Administrator ng observing after they d. Driver #1 revealed during n she connected the it clicked twice. She stated shoulder and lap belt ne was securing Resident e been why it disconnected air to fall over. Driver #1 check the wheelchair or the	F	689						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED		
		345254	B. WING			0 .	C 4/17/2025		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•			
MONROE	REHABILITATION CENT	ER			1212 SUNSET DRIVE EAST MONROE, NC 28112				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	TION SHOULD BE COMP THE APPROPRIATE D			
F 689	to ensure it was secu A review of the facility 4/08/25 written by the indicated Resident #1 medical appointment in the van. Driver #1 laceration to her foref Driver #1 called 911 a transported by emerge (EMS) to the emerger further evaluation. Th Legal Guardian were The EMS records dat they arrived on scene the transport van. Driv transporting Resident review mirror and obs standing up from the her head. Resident # laceration to her foref and bruising to her lei removed from the bac secured in the ambula ED for further evaluat Attempts made to inte unsuccessful. A review of the ED re revealed Resident #1 from a wheelchair in t #1 had lacerations to forehead, and left har (CT) scan of the head	or checking the wheelchair red properly. incident report dated Director of Nursing was returning from a and fell from her wheelchair reported Resident #1 had a head and was bleeding. and Resident #1 was ency medical services ney department (ED) for e Medical Director and notified of the incident. ed 4/08/25 revealed when e Resident #1 was located in ver #1 reported she was #1 in the van, looked in the served that Resident #1 was wheelchair and fell hitting 1 was assessed to have a head and left index finger ft cheek. Resident #1 was ck of the transport van, ance, and transported to the ion. erview EMS staff were	F	68	9				

Facility ID: 953214

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		345254	B. WING				C /17/2025		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
				1	1212 SUNSET DRIVE EAST				
MONROE	REHABILITATION CENT	ER		l I	MONROE, NC 28112				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
F 689	(brain bleed), the CT cervical 7 (neck) fract revealed a comminute pieces) mildly displac finger. Resident #1 h applied to the skin tea splint was placed due laceration to Resident with dissolvable sutur laceration/hematoma cleaned thoroughly but treatment. Resident # and discharged back A nurse's Note dated by Nurse #1 indicated facility at approximate to a fall in the facility bruising to the left sid her forehead with stitt fracture, and left inde #1's pain medication was administered. An interview with Nurse AM indicated she was Resident #1 on 4/08/2 Nurse #1 revealed Re 8:30 AM with Driver # appointment. She sta on the facility van dur facility and was transp evaluation. Nurse #1 returned to the facility accompanied by her I observed with bruising and a laceration to her	scan of the spine revealed a ure, and the left-hand x-ray ed (broken into multiple ed fracture of the index ad a non-adhesive dressing ar on her left finger and a to the fracture. The t #1's forehead was repaired es and to the back of her head was ut required no further #1 was in stable condition to the facility. 4/08/25 at 2:33 PM written t Resident #1 returned to the ely 2:00 PM from the ED due van. Resident #1 had e of her face, a laceration to ches, a diagnosis of a neck x finger fracture. Resident was ordered as needed and se #1 on 4/16/25 at 11:58 s the nurse assigned to 25 from 7:00 AM to 7:00PM. esident #1 left the facility at t1 for an orthopedic ated Resident #1 had a fall ing transport back to the ported to the ED for further indicated Resident #1 a round 2:00 PM Legal Guardian and was g to the left side of her face, er forehead with stitches. port indicated Resident #1	F	689					

Facility ID: 953214

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STATEMENT OF DERICENCIES AND PLAN OF CORRECTION (X) INPOVERENSUPLERCUAR DENTIFICATION NUMBER: (X) INVERTIGATION NUMBER: (X)		-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/20/2025 MAPPROVED D. 0938-0391
345254 B. WING 04/17/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2/P CODE 321.20 MSCT DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, 2/P CODE 0 <td< td=""><td>STATEMENT C</td><td>OF DEFICIENCIES</td><td>(X1) PROVIDER/SUPPLIER/CLIA</td><td>i í</td><td></td><td></td><td></td><td>(X3) DATE COMF</td><td>SURVEY PLETED</td></td<>	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	i í				(X3) DATE COMF	SURVEY PLETED
MONROE REHABILITATION CENTER 122 20/USET DRIVE EAST MORROE, NC 2012 04/10 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (REAL ADRESS DE PRILL RESULATORY OR LS: DENTIFINING MFORMATION) D PREFIX TAG D PREFIX TAG D PREFIX CROSS-REFERENCE TO THE APROPRIATE DEFICIENCY (EACH OPRICE/TOT ACTION SHOULD BE CORRECTION TO ANOLD BE DEFICIENCY) 0000 (EACH OPRICE/TOT ACTION SHOULD BE CROSS-REFERENCE TO THE APROPRIATE DEFICIENCY) 0000 (EACH OPRICE/TO ACTION SHOULD APROPRIATE DEFICIENCY) 1000			345254	B. WING			_		
MONROE REHABILITATION CENTER MONROE, NC 28112 (M) D PHEFX TXG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DERICEX MUST BE RECEDED BY FULL REDULTIONY OR LSC DENTIFYING INFORMATION) PL PAGE PROVIDENTIFY ACTION SHOULD BE CARD STREETED AND OF CORRECTION (EACH DERICEX MUST BE RECEDED BY FULL REDULTIONY OR LSC DENTIFYING INFORMATION) PL PAGE PROVIDENTIFY ACTION SHOULD BE CARD STREETED AND OF CORRECTION DEFICIENCY Continued PROVIDENTIFY ACTION SHOULD BE CARD STREETED AND OF CORRECTION DEFICIENCY Continued PROVIDENT SHOULD BE CARD STREETED AND OF CORRECTION DEFICIENCY Continued PROVIDENT PROVIDENT SHOULD BE CARD STREETED AND OF CORRECTION DEFICIENCY Continued PROVIDENT DEFICIENCY Continued PROVIDENT SHOULD BE CARD STREETED AND OF CORRECTION DEFICIENCY Continued PROVIDENT DEFICIENCY Continued PROVIDENT SHOULD BE CARD STREETED AND OF CORRECTION DEFICIENCY Continue PROVIDENT SHOULD BE CARD STREETED AND OF CORRECTION DEFICIENCY Continue PROVIDENT SHOULD BE PROVIDENT SHOULD BE PROVIDENT SHOULD BE PROVIDENT SHOULD BE DEFICIENCY Conthor PROVIDENT SHOULD BE PROVIDENT SHOULD BE PROVIDENT	NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
WILD PREFX To S SUMARY STEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) DD PREFX TAG PROVIDER'S FLAN OF CORRECTION (EACH ORDERCIVE ACTION SHOULD BE CROSS-REFERENCE OT DIF APPROPRIATE DEFICIENCY) OPENTIFYING INFORMATION F 689 Continued From page 8 fracture and left index finger fracture, Nurse #1 revealed Resident #1 was at her baseline, was exhibiting no signs of distress and ted herself dinner. Nurse #1 stated she initiated neurological checks and monitored Resident #1 closely till the end of her shift. Nurse #1 indicated Resident #1 required extensions with shading and transfers and was unable to attempt standing on her own. Nurse #1 revealed Resident #1 had remained at her baseline, since the incident and three had been no changes to her level of cognitive or physical function. During a phone interview with the Legal Guardian on 4/17/25 at 7.56 AM she revealed on 4/08/25 she was notified by the Administrator Resident #1 fell on the facility wan and was transported to the ED for further evaluation. The Legal Guardian stated she arrived at the ED and Resident #1 had a laceration to her forehead, bruising to the left side of her face and after a CT scan and x-ray was alignosed with a neck fracture and left Index finger fracture. She indicated Resident #1 had a laceration to her forehead, bruising to the left side of her face and after a CT scan and x-ray was alignosed with a neck fracture and left Index finger fracture. She indicated Resident #1 had had no residual effects from her injuries. The Legal Guardian revealed since the fall Resident #1 had resident #1 had history of trying to stand up without staff assistance, but in the past few months she was requiring more aassistance with standing an harsførs and was not strong enough to attempt standing on her own. The Legal Guardian revealed she	MONDOE		ED			1212 SUNSET DRIVE EAS	r		
Precipix TXG (EACH DEFICIENCY MORE THE PRECEDED BY FULL REDULTORY OR LSC DENTIFYING INFORMATION) PRETX TXG (EACH DEFICENCY ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICENCY) OWNET DEFICENCY) F 689 Continued From page 8 fracture and left index finger fracture. Nurse #1 revealed Resident #1 was at the baseline, was exhibiting no signs of distress and fed herself dinner. Nurse #1 stated she initiated neurological checks and monitored Resident #1 closely till the end of her shift. Nurse #1 indicated Resident #1 required extensive assistance with standing and transfers and was unable to attempt standing on her own. Nurse #1 revealed Resident #1 had remained at her baseline since the incident and three had been no changes to her level of cognitive or physical function. During a phone interview with the Legal Guardian on 417/25 at 7:56 AM she revealed on 4/08/25 she was notified by the Administrator Resident #1 had a laceration to her forehead, bruising to the left side of her face and after a CT scan and x-ray was diagnosed with a neck fracture and left index finger fracture. She indicated Resident #1 had a laceration to her forehead, bruising to the left side of her face and after a CT scan and x-ray was clagnosed with a neck fracture and left index finger fracture. She indicated Resident #1 had a laceration to her forehead, bruising to the left side of her face and after a CT scan and x-ray was clagnosed with a neck fracture and left index finger fracture. She indicated Resident #1 had had no residual effects from her injuries. The Legal Guardian revealed since the fall Resident #1 had a history of trying to standing without staff assistance, but in the past few months she was requiring more aassistance with standing and transfers and was not strong enough to attempt standing on her own. The Legal Guardian revealed she was very concermed the facility	WONTOL					MONROE, NC 28112			
fracture and left index finger fracture. Nurse #1 revealed Resident #1 was at her baseline, was exhibiting no signs of distress and fed herself dinner. Nurse #1 stated she initiated neurological checks and monitored Resident #1 locicated Resident #1 required extensive assistance with standing and transfers and was unable to attempt standing on her own. Nurse #1 revealed Resident #1 had remained at her baseline since the incident and there had been no changes to her level of cognitive or physical function. During a phone interview with the Legal Guardian on 4/17/25 at 7:56 AM she revealed on 4/08/25 she was notified by the Administrator Resident #1 fell on the facility van and was transported to the ED for further evaluation. The Legal Guardian stated she arrived at the ED and Resident #1 had a laceration to her forehead, bruising to the left side of her face and after a CT scan and x-ray was adiagnosed with a neck fracture and left index finger fracture. She indicated Resident #1 had had ne residual effects from her injuries. The Legal Guardian stated Resident #1 had a history of trying to stand up without staff assistance, but in the past few wonths she was requiring more	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA		(X5) COMPLETION DATE
An interview was conducted with the Director of	F 689	fracture and left index revealed Resident #1 exhibiting no signs of dinner. Nurse #1 stat checks and monitored end of her shift. Nurs required extensive as transfers and was una her own. Nurse #1 re remained at her base there had been no ch cognitive or physical f During a phone interv on 4/17/25 at 7:56 AM she was notified by th fell on the facility van ED for further evaluat stated she arrived at t a laceration to her for side of her face and a was diagnosed with a finger fracture. She in exhibiting no signs of baseline. The Legal 0 fall Resident #1 has re had no residual effect Legal Guardian stated of trying to stand up w in the past few month assistance with stand not strong enough to own. The Legal Guar concerned the facility was safe while being van and the Administr concerns.	a finger fracture. Nurse #1 was at her baseline, was distress and fed herself ed she initiated neurological d Resident #1 closely till the e #1 indicated Resident #1 sistance with standing and able to attempt standing on evealed Resident #1 had line since the incident and anges to her level of function. iew with the Legal Guardian A she revealed on 4/08/25 ie Administrator Resident #1 and was transported to the ion. The Legal Guardian the ED and Resident #1 had ehead, bruising to the left after a CT scan and x-ray neck fracture and left index ndicated Resident #1 was distress and was at her Guardian revealed since the emained at her baseline and is from her injuries. The d Resident #1 had a history without staff assistance, but s she was requiring more ing and transfers and was attempt standing on her dian revealed she was very did not ensure Resident #1 transported in the facility's rator was aware of her	F	689				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		345254	B. WING				C 17/2025		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
MONROE	REHABILITATION CENT	ER			212 SUNSET DRIVE EAST MONROE, NC 28112				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(X5) COMPLETION DATE				
F 689	Nursing (DON) on 4/1 stated the morning of by the Administrator F wheelchair while bein van and was transpor further evaluation. Sh laceration to her foreh and was diagnosed w and left index finger fr Resident #1 returned approximately 2:30 P at her baseline. She in checks were initiated, her closely. She state remained at her base condition and no resid injuries. The DON re on 4/08/25 she obser reenactment. She ind reenactment Driver # Resident #1 and the w not check the tie dow belt to ensure they we DON revealed Driver think the shoulder and connected which caus over. She indicated D 4/08/25 and had not r stated the facility was transportation compar appointments. A phone interview witt 4/16/25 at 3:47 PM re 4/08/25 Resident #1 fi in the facility van due secured properly. Sh	6/25 at 12:53 PM. She 4/08/25 she was informed Resident #1 fell over in her g transported in the facility ted by EMS to the ED for ne stated Resident #1 had a nead which required sutures with a cervical 7 neck fracture racture. The DON revealed to the facility on 4/08/25 at M and was assessed to be ndicated neurological and staff were monitoring ed Resident #1 had line with no changes in her dual effects from her vealed following the incident ved Driver #1 perform a icated during the 1 reported after securing wheelchair in the van she did ns or the shoulder and lap ere secured properly. The #1 also reported she did not d lap belt were fully sed the wheelchair to tip river #1 was suspended on eturned to work. The DON now using a contracted my for all resident	F	689					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/20/2025 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345254	B. WING				C / 17/2025
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				12	12 SUNSET DRIVE EAST		
MONROE	REHABILITATION CENT	ER		м	ONROE, NC 28112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	forehead, was diagno fracture, and a fractur The Medical Director returned to the facility and has had no resid and no changes in he physical function. Th that residents should transport van to ensu During an interview w 4/16/25 at 12:31 PM started working at the He stated Driver #1 m safely transport resid indicated the training instructional videos, a wheelchair in the van guidelines. The Adm trained Driver #1 on h in the van and she co demonstrations. The observed Driver #1 se van per the manufact return demonstrations the skills checklist we 4/08/25, at approxima called and informed h van, and she called 9 revealed he went to v and Resident #1 was ambulance to be tran evaluation. The Adm drove the van back to statement, and comp incident. He indicate reenactment Driver # and lap belt and com	besed with a cervical 7 neck re to her left index finger. revealed Resident #1 (on 4/08/25 at her baseline ual effects from her injuries er level of cognitive or e Medical Director stated be secured properly in the re they were safe. with the Administrator on he indicated Driver #1 e facility in October 2024. eceived training on how to ents in the facility van. He included reading materials, and how to secure a per the manufacturer's inistrator indicated he now to secure a wheelchair ompleted 3 to 4 return Administrator revealed he ecure the wheelchair in the urer's instructions during all s and all requirements on ere met. He stated on ately 9:55, AM Driver #1 im Resident #1 fell in the 011. The Administrator where Driver #1 was located, being loaded into the sported to the ED for further inistrator revealed Driver #1 o the facility, wrote a leted a reenactment of the	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345254	B. WING			C 04/17/202	
NAME OF PROVIDER OR SUPPLIER MONROE REHABILITATION CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SUNSET DRIVE EAST MONROE, NC 28112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	I IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	when she was securi The Administrator sta the shoulder and lap and that was the caus wheelchair to fall ove revealed Driver #1 als check the tie downs of to ensure Resident # properly secured. He suspended pending a returned to work. The Driver #1 should have the facility van per the to ensure Resident # stated the facility star transportation compa appointments and wo contracted company f The facility was notifie on 4/15/25 at 5:55 PM The facility provided t action plan: Address how correcti accomplished for thos been affected by the 4/08/25 at approxima who had severe cogn loaded onto the facilit Driver to be transport following an orthoped Driver stated she sec The resident was trar which was being drive Resident #1 was place	ng Resident #1 in the van. ted that Driver #1 thought belt were not fully connected se of Resident #1 and r. The Administrator so reported she did not or the shoulder and lap belt 1 and the wheelchair were e stated Driver #1 was in investigation and had not e Administrator revealed e secured the wheelchair in e manufacturer's instructions 1 was transported safely. He ted using a contracted my on 4/09/25 for all resident for the foreseeable future. ed of Immediate Jeopardy <i>A</i> . the following corrective we action will be se residents found to have deficient practice. tely 9:50 AM, Resident #1, itive impairment, was y van by the facility Van	F	689	9		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING				C 17/2025	
NAME OF P	ROVIDER OR SUPPLIER		ł	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
MONROE	MONROE REHABILITATION CENTER				1212 SUNSET DRIVE EAST MONROE, NC 28112		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	other residents or sta orthopedic office is 1. facility. The Van Driver stated on East Roosevelt Bh approximately 1.5 mil a right turn on East R Driver stated she hea and saw resident #1 a over on its left side or over, the Van Driver s park and immediately Services (EMS). She driver's seat, to the re- towards Resident #1. on the aisle floor of th with the wheelchair or Driver stated she saw front of the resident's she had on the driver which was bleeding. S the seatbelt on the re- not in the wheelchair. Driver stated she mov way to allow EMS sta access the resident. At approximately 9:55 Driver, notified the Ad had fallen out of her v transported back to th appointment. Emerge were present, and res evaluated. Immediate resident's state appoi by the Administrator a	ff members in the van. The 5 miles away from the 4 at approximately 9:55 AM 1 off on the side of the road vd driving west bound, es from facility. After making oosevelt Blvd, the Van rd a "boom" sounding noise and her wheelchair turned in the van floor. After pulling stated she put the van in r called Emergency Medical then stepped past the ear of the van, and walked She observed Resident #1 the van, lying on her left side in its left side. The Van v blood coming from the head and used a blanket 's seat to apply to the area She stated she did not see sident and the resident was Once EMS arrived, the Van ved the wheelchair out of the ff to enter the van and 5 AM 4/08/25, the Van Iministrator that Resident #1 vheelchair while being the facility from an orthopedic ency Medical Services (EMS)	F	689			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	05/20/2025 APPROVED 0.0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` ´	PLE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED		
	345254		B. WING			(04/	C 17/2025	
NAME OF P	ROVIDER OR SUPPLIER		_ _	STREET ADDRESS, CITY, S	STATE, ZIP CODE	•		
				1212 SUNSET DRIVE EAS	ST			
MONROE	REHABILITATION CENT	ER		MONROE, NC 28112				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page	: 13	F 68	89				
	was parked. The van center by the Van Driv van. Upon return to the fac Director (RCD), the D Administrator, watched detailed reenactment secured Resident #1 Clinical Director sat in side of the van in the Resident #1 had been Van Driver to secure to Van Driver to secure to Van Driver had secure leaving the orthopedic proceeded by latching first to the back of the wheelchair latching de floor via the track in the not tighten them after Driver took the right ret to the van floor and attached bottom bar on the bot Van Driver communic either of the two rear mounts to the van floor	at the site where the van was driven back to the ver with no one else in the sility, the Regional Clinical irector of Nursing, and the d the Van Driver complete a of how the Van Driver had in the van. The Regional the wheelchair on the right same position where in the van and asked the he resident exactly how the ed Resident#1 before coffice. The Van Driver the back two chair hooks wheelchair frame. The evices were secured to the ne floor. The Van Driver did they were latched. The Van ear tie down strap mounted tached its right hook to the of the wheelchair. Then she own strap mounted to the d the left hook rear to the left tom of the wheelchair. The ated she did not tighten						
	attached it to the lap to restraint was mounted van. The shoulder rest over the right shoulder	belt buckle. The shoulder d to the right back wall of the straint belt went immediately r to the lap belt buckle. As lder restraint she stated,						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345254		B. WING			C 04/17/2025			
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
MONROE	REHABILITATION CENT	ER			1212 SUNSET DRIVE EAST MONROE, NC 28112			
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	"Oh there were two of been where it happer asked the Van Driver stated the buckle click the latch. The Van D remember hearing tw Resident #1 in. The I disengaged and reen mechanism several ti hear/feel the two clicks during the attempts. by latching the front th front of the wheelchai latching devices were track in the floor. The them after they were the right front tie down floor and attached its bottom bar on the front she took the left front the van floor and atta to the left bottom bar wheelchair. The Van did not tighten any of of Nursing then unbug and pulled the chair to see if the chair could was able to sway but even with a large and the front floor locks w Resident #1 was obso Driver stated the left f front was. The Van D floor hooks were attact the chair had tipped of At approximately 1:30	icks there, that must've hed." The Administrator to explain. The Van Driver ked "twice" to fully engage river explained she did not o clicks when she buckled Director of Nursing gaged the seatbelt locking mes to see if they could its referenced by the Van were neither heard nor felt The Van Driver proceeded wo chair hooks first to the r frame. The wheelchair e secured to the floor via the van driver did not tighten latched. The Van Driver took n strap mounted to the van right hook to the right nt of the wheelchair. Then tie down strap mounted to ched it to the left front hook on the bottom of the Driver communicated she the four straps. The Director ckled the over the lap belt owards the left in effort to flip/fall on its side. The chair not able to be tilted /flipped ount of force. When asked if ere intact at the time erved on the floor, the Van front was not, but the right river also stated both back ched to the wheelchair after	F	689				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345254			B. WING				C 17/2025	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MONROE	REHABILITATION CENT	ER			212 SUNSET DRIVE EAST IONROE, NC 28112			
(X4) ID PREFIX TAG				х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Another reenactment resident and the whee Administrator's office wheelchair, and the A resident. The Regiona Director of Nursing we Van Driver was able t side to mimic how the van. The Van Driver Administrator's head i which the Van Driver head. During the inter when she re-accounter locks and then the ba back on the handles of for movement of the of she usually did check wheelchair was secur asked the Van Driver seatbelt to ensure it w tearfully, no but she w The Van Driver was s completion of the writ results of the investig. At approximately 3:00 #1 returned with diagus scalp laceration, left r transverse cervical 7 physician was notified from the emergency r orders were obtained increased pain. Address how the facil residents having the p the same deficient pra	incident was obtained. of the position of the elchair was performed in the using a desk chair, as the administrator, as the al Clinical Director and ere also in attendance. The o position the chair on its left e resident was found in the also positioned the in the same manner to observed Resident #1's rview, the Van Driver stated ed locking the front two floor ck two, that she didn't pull of the wheelchair to check chair. She went on to say as her own confirmation the re. The Administrator then if she did a check of the vas engaged and she replied would from that point on. uspended 4/08/25 at the ten statement pending the ation by the Administrator.	F	689				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG _		C		
		345254	B. WING			04/	17/2025	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
MONROE	REHABILITATION CENT	ER			1212 SUNSET DRIVE EAST MONROE, NC 28112			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 689	and/or Director of Nur Driver received the ne the van safely. The dr necessary training an facility van to include emergency. The Van return demonstration Vice President of Ope Driver was trained on instructions on 10/16/ The Director of Nursir incidents and acciden 2/08/25 to 4/08/25 to falls/incidents had occ transport. No occurrent On 4/08/25, an audit of by the Director of Nur to ensure that the res with contracted wheel and that residents, an parties (RP) were not appointments. Startin requiring van transpon during the center's mo the Director of Nursin nurse designee to ver resident/RP notification On 4/09/25 an audit of previous seven days residents that were tra- incident or accident of	 w the facility Administrator rsing, to ensure the Van ecessary education to drive river was noted to have the d qualifications to drive the what to do in case of an Driver also provided a to the Administrator and erations. The facility Van the manufacturer's 24. and reviewed the facility ts for the period of time of ensure no other curred related to van nces were noted. of all appointments via van or 4/09/25 was completed sing and the Administrator idents were rescheduled Ichair transport company rd/or their responsible ified of scheduled g 4/09/25, all appointments rtation were reviewed orning clinical meeting by g, administrator and or rify transfer vehicle and on. was completed for the to identify any interviewable ansferred to ensure no ccurred during their van e no interviewable residents udit. This audit was	F	689				

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	MEDICAID SERVICES					APPROVED . 0938-0391	
DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		ISTRUCTION	(X3) DATE	SURVEY	
		A. BUILDII	NG		C		
	345254	B. WING _				17/2025	
NAME OF PROVIDER OR SUPPLIER							
HABILITATION CENTE	ER						
D SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	ĸ			(X5) COMPLETION DATE	
continued From page	17	F	89				
on 4/08/25 prior to respectively analysistance was necession 4/08/25 prior to respectively analysistance with the end of	scheduling van transport, chair transport company and certification, which r's instruction for transport and validated to be in place or. The swill be put into place or de to ensure that the not recur. The section of the wheelchair center for inspection. There and as a result of inspection. There and as a						
	DEFICIENCIES DRRECTION ADDER OR SUPPLIER HABILITATION CENTI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From page on 4/08/25 prior to re- te contracted wheeld ansport staff training cluded manufacture afety, were reviewed y facility Administrator ddress what measur ystemic changes ma- eficient practice will part on 4/08/25, the van was ansport van service ere no problems four neediately after the ansport appointment equired residents to ban were scheduled the heelchair transport of the chair transport of the chair transport of tarting 4/09/25, all appointment issistance was necess in 4/09/25, the Admini- te Vice President of iscking mechanisms/r heelchair and for the ansporting residents anufacturer's instruct as provided to the A	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DRRECTION 345254 AUDER OR SUPPLIER 345254 HABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Information of the second by	beFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT JORRECTION IX1) PROVIDER/SUPPLIER/CLIA (X2) MULT ABUILDI 345254 B. WING	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON JURE OR SUPPLIER 345254 B. WING HABILITATION CENTER STREET SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Ontinued From page 17 F 689 In 4/08/25 prior to rescheduling van transport, ea contracted wheelchair transport company ansport staff training and certification, which cluded manufacturer's instruction for transport afety, were reviewed and validated to be in place or (stemic changes made to ensure that the efficient practice will not recur. F 689 In 4/08/25, the van was sent to the wheelchair ansport van service center for inspection. There ere no problems found as a result of inspection. Inmediately after the incident on 4/08/25 all ansport appointments which would have equired residents to be transported via the facility an were scheduled through a contracted heelchair transport company. ffective 4/08/25 the facility contracted all esident van transports with contracted heelchair transport company. It center's iorning clinical meeting by the Director of uorning clinical meeting by the Direct of uorni	BERCERCICS (X1) PROVIDERSUPPLERCUA DENTFICATION NUMBER: (X2) MULTURE CONSTRUCTION A BUILDING JAS254 B: WING JDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SUNSET DRIVE EAST MONROE, NC 28112 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRECONT MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH DEPRECONT MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) PRETX TAG PRETX (EACH CORRECTIVE ACTION SHOULD BY CROSS-REFERENCED TO THE APPROPRIM DEFICIENCY OR LSC IDENTIFIEND (INFORMATION) ontinued From page 17 F 689 PROVIDER'S PLAN OF CORRECTION (EACH DEPRECINT AUTOR DEPRECIDED BY FULL REGULATORY OR LSC IDENTIFIEND (INFORMATION) F 689 ontinued From page 17 F 689 PRETX TAG CROSS-REFERENCED TO THE APPROPRIM DEFICIENCY) ontinued From page 17 F 689 ID REGULATORY OR LSC IDENTIFIEND (INFORMATION) F 689 ontinued From page 17 F 689 ID REGULATORY OR LSC IDENTIFIES (INFORMATION) ID REGULATORY (INFORMATION) ontinued From page 17 F 689 ID REGULATORY (INFORMATION) F 689 ontinued From page 17 F 689 ID REGULATORY (INFORMATION) ID REGULATORY (INFORMATION) ontinued From page 17 ID REGULATORY (INFORMATION) F 689 ID REGULATORY (INFORMATION) ID REGULATORY (INFORMATION) <td>DEFICIENCIES (X1) PROVIDERSUPLIERCUA (X2) MULTIPLE CONSTRUCTION (X3) DOTE A BUILDING 345254 B. WMG (X3) ONE ABBLITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SUNSET DRIVE EAST MABLITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE ADDRESS GOULATORY OR LSC DENTER/ING INFORMATION) Tage 1232 SUNSET DRIVE ADDRESS STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE ADDRESS 12342 MONROE, NC 28112 STREET ADDRESS 12342 12444 STREET ADDRESS, SUNSET DRIVE ADDRESS 1245 <td< td=""></td<></td>	DEFICIENCIES (X1) PROVIDERSUPLIERCUA (X2) MULTIPLE CONSTRUCTION (X3) DOTE A BUILDING 345254 B. WMG (X3) ONE ABBLITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SUNSET DRIVE EAST MABLITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE EAST MONROE, NC 28112 STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE ADDRESS GOULATORY OR LSC DENTER/ING INFORMATION) Tage 1232 SUNSET DRIVE ADDRESS STREET ADDRESS, CITY, STATE, ZIP CODE 1222 SUNSET DRIVE ADDRESS 12342 MONROE, NC 28112 STREET ADDRESS 12342 12444 STREET ADDRESS, SUNSET DRIVE ADDRESS 1245 <td< td=""></td<>	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X			(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG .		C		
		345254	B. WING			04/17/2025		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
MONROE	REHABILITATION CENT	ER			1212 SUNSET DRIVE EAST MONROE, NC 28112			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	IX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 689	 inspection regarding of for the van wheelchai On 4/09/25, the Admit to the Maintenance D Nursing regarding var the locking mechanism the wheelchair and for transporting residents instructions. The facility will contine wheelchair transport of transporting residents instructions. Indicate how the facility performance to make sustained. An ADHOC quality as held on 4/09/25 to rew the root cause. During Assurance (QA) meet team it was determine provide safe van transportation van per instructions. An audit will be compreceiving transport set twice a week for twelve contracted wheelchait compliant with the safe being secured and whisecured by the manual Once a new van driver 	he completion of the van manufacturer's instruction r securement system. nistrator provided education irector and Director of n safety related to checking ms/restraints on the van for r the seatbelt prior to a per manufacturer's ue to use the contracted company verses the facility a in the van. ity plans to monitor its sure that solutions are surance (QA) meeting was view the incident and identify g the ADHOC Quality ting with the Interdisciplinary ed the facility failed to sportation for Resident #1 heelchair in the r the manufacturer's leted of two residents rivices by the Administrator ve weeks to ensure the r transport company is fety guidelines of residents neelchairs being properly facturer's guidelines. er is identified, they will go	F	689				
		er is identified, they will go notor vehicle and driver						

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	-	ID HUMAN SERVICES				FORM	/ APPROVED	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED		
		345254 B. WING				C		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	04/	17/2025	
					1212 SUNSET DRIVE EAST			
MONROE	REHABILITATION CENT	ER			MONROE, NC 28112			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	safety program includ driver and vehicle ma keeping, routine vehic motor vehicle record of validation, securing w (video), safety respond drivers and vehicle in demonstration will als conducted by the Adm President of Operatio provide education and Effective 4/08/25, the of Nursing will be ultir implementation of this removal for this allege the education and trai The Quality Assurance will review the results monthly QA meeting f committee will determ needed. Alleged date of IJ rem The facility's alleged of 4/10/25. The facility's impleme Jeopardy removal and validated on 4/16/25. nursing staff revealed resident appointments provided by a contrace A phone interview cor center employee indic inspection of the facilit	ing components of a safe intenance program, record cle inspection/maintenance, questionnaire, driver skills theelchair training program asibilities for authorized spection validation. A return to be included and ministrator and Vice ns. The Administrator will d training. Administrator and Director mately responsible to ensure is immediate jeopardy ed noncompliance and that ining are provided. The Improvement committee of the weekly audits during for three months. The nine if further actions are hoval: 4/10/25. date of compliance is entation of the Immediate d corrective action plan was Interviews conducted with I transportation for all is from 4/09/25 were eted transportation company. nducted with the van service cated he completed a safety ity's van and wheelchair n 4/08/25 and all equipment	F	685				

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/20/2025 APPROVED D. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345254	B. WING			-		C 17/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MONROE	REHABILITATION CENT	ER			212 SUNSET DRIVE EAST MONROE, NC 28112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 689	wheelchair in the van instructions. An obser Administrator securing facility's van, the whe manufacturer's instruc- were identified. A revi incident/accident repo- that was completed o resident van incidents conducted with the M DON revealed they re Administrator on how the facility's van per th instructions and both demonstration. Drive completed for the DO and all areas of comp met. An interview con Administrator reveale transportation compai verified that all the co completed a driver sa checks were completed met. The alleged imm	histrator on how to secure a per the manufacturer's vation was conducted of the g a wheelchair in the elchair was secured per the ctions and no concerns ew of the audit of orts from 2/08/25 to 4/08/25 n 4/09/25 revealed no other a had occurred. Interviews aintenance Director and eceived training from the to secure a wheelchair in the manufacturer's completed return r basic skills checklists were N and Maintenance Director etency were checked as inducted with the d on 4/08/25 the my provided records, and he mpany's van drivers had fety program, and skills ed with all competencies uediate jeopardy removal lleged compliance date of	F	689				

Facility ID: 953214

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