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 06/04/2021

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

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 06/01/21 through 06/04/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VJYC11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 06/01/21 to conduct a recertertification and complaint survey and exited on 06/03/21. Additional information was obtained on 06/04/21. Therefore, the exit date was changed to 06/04/21. One of the 4 complaint allegations was substantiated but did not result in a deficiency and 3 of the 4 complaint allegations were not substantiated. Event ID# VJYC11.	F 000		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with staff, pharmacy and physician the facility failed to ensure an intravenous (IV) medication was prepared utilizing sterile technique in 1 of 1 intravenous antibiotic medication administration observed (Resident #29). Findings included:	F 694	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Director of Nursing Services (DON) reeducated Nurse #1 to utilize sterile technique when administering Intravenous (IV) antibiotics to residents. Nurse #1 was re-educated by Director of Nursing to clean and use alcohol to disinfect installation port for Resident #29.	6/28/21

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

Electronically Signed | 06/25/2021

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F 694	Continued From page 1 Resident #29 was admitted to the facility on 09/03/21 with diagnoses that included osteomyelitis of the sacrum, dementia, heart failure, chronic pain and osteoarthritis. Review of the Medication Record indicated Ampicillin 1 Gram every 6 hours was ordered IV on 5/28/21 for osteomyelitis. An observation was completed with Nurse #1 on 06/03/21 at 12:02 PM as she was mixing an IV antibiotic for Resident #29. She removed the 100 milliliter (ml) normal saline solution (NSS) bag from the sterile packaging and placed it on top of the medication cart. The nurse diluted the antibiotic vial with 10 ml NSS after wiping the antibiotic vial top with alcohol. She wrote a medication label with the dose, date and time and turned the NSS bag over on top of the medication cart and applied the label. Nurse #1 turned the NSS bag over again and instilled the 5 ml dose in two increments of 2 ml and 3 ml, utilizing a 3 ml syringe into the port of the 100 ml bag and failed to disinfect the port with alcohol both times. An interview was conducted with Nurse #1 on 06/03/21 at 12:10 PM and she was asked why she had not disinfected the instillation port of the 100 ml NSS bag. She stated she did not know that she needed to do that. A phone interview was conducted on 06/04/21 at 11:36 AM with the Pharmacist that covered the facility regarding the process for the IV antibiotic mixture and instillation into the 100 ml NSS bag. He stated that once the NSS bag was removed from the package it was no longer sterile and the nurse should have cleaned the port prior to inserting the syringe into the NSS bag each time.	F 694	Address how the facility will identify other residents having the potential to be affected by the same deficient practice; No other residents are in facility with intravenous (IV) medication. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; 100% resident audit completed on 6/3/21 revealed no other residents with Intravenous medication orders. Director of Nursing initiated education regarding sterile technique with Intravenous medication administration on 6/3/21 for all facility nurses. This education will be added to new nurse orientation. Pharmacy Nurse Consultant conducted Intravenous training for nurses on 6/7/21. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and DON or Designee will conduct random observations of nurses administering Intravenous medication administration weekly for four weeks and monthly for three months thereafter. If no residents in the facility have Intravenous medication ordered, Director of Nursing or Designee will complete an Intravenous skills validation checklist weekly for four weeks and monthly for three months thereafter. Results of these audits will be reviewed in facility□s Quality Assurance and Performance Improvement meeting	

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F 694	Continued From page 2 He also noted that the nurse should have used the proper syringe size to ensure she would not have to reenter the NSS bag a second time. An interview was conducted with the Medical Director on 06/04/21 at 1:05 PM regarding the IV antibiotic medication instillation into the NSS bag without disinfecting the port. He stated the medication should have been mixed properly under sterile technique and the nurse should have ensured that no cross contamination occurred. The former DON was interviewed via phone on 06/04/21 at 12:15 PM and she stated she had been the Infection Prevention nurse until 2 weeks ago. She said that when IV antibiotics were mixed and instilled into the NSS bags, the nurse should wipe the port off prior to injecting the medications. An interview was conducted with the Administrator and the current DON (in the DON role since 5/24/21) on 06/04/21 at 1:13 PM regarding the technique used for the intravenous antibiotic medication when it was instilled into the 100 ml NSS bag. The DON noted that the port of the NSS bag should have been disinfected prior to insertion of the IV antibiotic medication and sterile technique followed.	F 694	monthly for three months until compliance is achieved. The Director of Nursing is responsible for ensuring solutions are sustained. Completion Date: 6/28/21	
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,	F 812		6/30/21

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F 812	Continued From page 3 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. §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, record review and staff interviews, the facility failed to label, and date opened food items stored for use in 1 of 1 walk in refrigerator and 1 of 2 nourishment rooms. Findings included: 1. An observation of the kitchen conducted with the Food Service Supervisor on 06/01/21 at 11:30 AM revealed the following items were not labeled or dated upon opening: a. An undated and unlabeled package of opened sliced turkey breast was observed in the walk-in refrigerator. b. An undated and unlabeled opened plastic bag of lettuce was observed in the walk-in refrigerator. c. An undated and unlabeled opened plastic bag of cheese cubes was observed in the walk-in refrigerator. 2. An observation of the kitchen on 06/03/21	F 812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: All unlabeled or undated food and beverage items in the nourishment rooms and kitchen walk-in refrigerator were immediately discarded upon identification on 6/1/21 and 6/3/21. All other facility refrigerators were checked to ensure no other unlabeled or undated food or beverage items existed. No unlabeled or undated food or beverages were identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All facility refrigerators were checked to ensure no other unlabeled or undated food or beverage items existed. Address what measures will be put into place or systemic changes made to	

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F 812	Continued From page 4 at 9:30 AM conducted with the Food Service Supervisor revealed the following items observed in the walk-in refrigerator were not labeled or dated upon opening: a. An undated and unlabeled opened plastic container of strawberries. b. An undated and unlabeled opened plastic bag of hard, boiled eggs. c. An undated and unlabeled opened plastic bag of grapes. 3. An observation of the nourishment room on 06/03/21 at 10:15 AM on the 200-hall revealed two undated and unlabeled opened plastic bottles of lemonade located in the refrigerator. Review of the facility policy titled "Outside food for patients" states items brought in by family must be labeled and dated with the patient's name, room number and use by date. An interview was conducted with the wound nurse on 06/03/21 at 10:17 AM. The wound nurse stated the lemonade must belong to a resident. The wound nurse further stated items brought into the facility for residents must be labeled with the resident's name and date. An interview conducted with the Food Service Supervisor on 06/03/21 at 03:40 PM revealed the staff member that opened the food item was responsible for putting the open date and use by date on the item. The Food Service Supervisor further stated only staff have access to the nourishment rooms, and she has a sign on the refrigerator in each nourishment room alerting staff to label and date all resident items.	F 812	ensure that the deficient practice will not recur; Dietary Manager, with assistance from the Consultant Dietician, began educating dietary staff on proper labeling, dating, and storing food and beverage items on 6/1/21. Education continued through 6/28/21 and included all dietary personnel. The consultant Dietician will complete a monthly kitchen sanitation audit to check for proper labeling and dating of items per facility policy. The Consultant Dietician and/or Administrator will also follow up with weekly audits of the walk-in fridge and freezer in the kitchen to ensure compliance with labeling and dating food and beverage items according to policy and regulation, and to ensure that the education provided to staff to reinforce the process of labeling and dating food and beverage items is effective. Education began on 6/1/21 for all dietary and nursing staff began on labeling and dating items in the nourishment rooms and will be completed on 6/30/21. Education included reviewing the policy on foods brought by Family/Visitors. The nursing staff is responsible for removing items from nourishment rooms before the "use by" date and no items are to be stored for longer than 7 days. Signage is posted on both nourishment room refrigerators informing staff "Please label and date items for 7 days" as an added reminder. The member of facility staff that places	

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F 812	Continued From page 5 An interview with the Administrator on 06/03/21 at 03:50 PM revealed it was her expectation that the food and beverage items be labeled and dated upon opening.	F 812	the food in the nourishment room is responsible for labeling and dating said item. Items needed for labeling and dating are present in nourishment rooms for ease of use. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Administrator or Designee will conduct random observations of nourishment rooms and kitchen refrigerators for unlabeled or undated food and beverage items three times per week for twelve weeks, once weekly times twelve weeks, and monthly times six months until compliance is achieved. Results of these audits will be reviewed in facility□'s Quality Assurance and Performance Improvement meeting monthly for twelve months until compliance is achieved. Department Managers will conduct twice daily audits of nourishment rooms to ensure no unlabeled or undated food is present, with immediate correction and re-education if needed. The results of these audits will be brought to morning meeting Monday through Friday and reviewed with the Interdisciplinary Team. Saturday and Sunday nourishment room audits will be completed by the Manager on Duty or Designee to ensure nourishment rooms are free from unlabeled or undated items, with immediate correction if needed. Results of these weekend audits will be reviewed by the Director of Nursing or designee on	

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F 812	Continued From page 6	F 812	each Monday morning. All Audit results will be reviewed and brought to monthly Quality Assurance and Performance Improvement meetings monthly for twelve months until compliance is achieved and sustained. The administrator is responsible for ensuring solutions are implemented and sustained. Date of Completion: 6/30/21	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		7/2/21

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F 880	Continued From page 7 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 8 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with staff, pharmacy and construction workers the facility failed to follow The Centers for Disease Control (CDC) guidelines for personal protective equipment (PPE) with Enhanced Droplet Precautions (EDP) in 3 of 6 staff/construction workers observed and failed to wear masks that covered the mouth and nose in 3 of 10 staff/construction workers observed during the COVID-19 pandemic. Findings included 1. An observation was done on 06/01/21 at 12:14 PM of Patient Care Assistant (PCA) #1 on the 100 hall. PCA #1's mask was below the nose for several minutes when she was talking at the desk. She would adjust the mask at times over her nose and it would slide down again. Construction Worker #1 was observed on 06/01/21 at 12:34 PM working on the 100 hall outside of occupied resident's rooms laying new tile with his mask below his nose. An observation was done of Construction Worker #2 in the dining room hallway on 06/03/21 at 11:00 AM with the mask consistently below his nose as he was putting down new tile in the area. Several staff and residents were passing him in the hallway. A phone interview was done with Construction Supervisor #1 on 06/04/21 at 12:30 PM regarding the masks not being worn/worn covering the nose	F 880	Corrective action has been accomplished for the alleged deficient practice not adhering to proper infection control procedures specifically for residents on the intake/isolation hall related to enhanced droplet -contact precautions. Staff education provided immediately by the Regional Clinical Manager/Infection Preventionist (IP) and Director of Nursing with the staff identified as violating policy/procedure for infection control (PCA #1) on 6/1/21. Education included when to perform hand hygiene before and after entering a resident room, proper disposal of used gloves, wearing a face mask properly and continuously wearing of PPE while on the isolation unit, proper use of gowns and cleaning and disinfecting of equipment between uses. Education reinforced that Enhanced Droplet Isolation Precautions are always followed, regardless of reason for entry to hallway or resident room. On 6/2/21, education was provided for Construction Worker #1 and Construction Worker #2 by the Regional Clinical Manager to included reviewing signage that indicates when gowns and gloves are appropriate, isolation precautions, distinguishing between a surgical and N95 mask, proper mask placement on face including covering the mouth and nose, and providing several locations to obtain	

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F 880	Continued From page 9 by the construction staff. He stated he had a surgical mask on 06/01/21 and went down the Enhanced Droplet Precautions (EDP) admission hall for supplies with Construction Worker #1. He stated Construction Worker #1 should have had a mask on and his staff should have worn masks covering their nose consistently. He noted education had been done for him and his staff about wearing appropriate Personal Protective Equipment (PPE) and for masks on all construction workers to cover the mouth and nose this week. An interview was conducted with PCA #1 on 06/01/21 at 12:17 PM regarding the mask protocol. She said the mask should be over her mouth and nose, but it kept falling below her nose when she was talking. An interview was completed on 06/04/21 at 10:39 AM with the Unit Manager regarding PPE for the admission hall and masks protocol. She stated if a resident was down the quarantine admission hallway, anyone entering the hall were to wear full PPE with the delivery of trays or construction workers entering for supplies per the EDP posted sign. When asked about staff with masks below their nose, she stated they were to be worn above the nose and staff had constant reminders to pull the masks up. An interview was done with the Corporate Nurse, former Director of Nursing (DON) in role through May 2021, and the current DON (in role for 1 week) on 06/03/21 at 3:25 PM. They were informed of the 2 construction workers-1 without a mask and 1 with a surgical mask in the EDP hall and the staff with the mask not covering the nose. The Corporate Nurse stated construction	F 880	PPE. Administrator spoke Construction Supervisor #1 and provided an in-service via phone on 6/1/21, as well as provided written materials outlining infection control procedures that must be adhered to while in the facility. This education will be provided to all construction workers that enter the facility. Other residents who are on isolation have the potential to be affected by the same alleged deficient practice; therefore, the Regional Clinical Manager/Infection Preventionist has conducted an audit of current residents and no other residents were found to be affected by the deficient practice. The corrective action - education- will help protect other residents in similar situations from being affected by the alleged deficient practice. Measures put into place to ensure that the alleged deficient practice does not recur include: Director of Nursing began observation/surveillance rounds of staff on 6/1/21 to ensure proper donning and doffing of PPE, hand hygiene, and cleaning equipment between resident use. Regional Nurse Managers began competency quizzes on 6/1/21 to ensure staff can verbalize the company policy as well as demonstrating the use of proper PPE utilization and adherence to policy and best practices while providing patient care and while on the isolation/intake unit.	

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F 880	Continued From page 10 workers were to follow the same protocol as staff and always wear their mask and goggles when on the EDP unit and all masks were to cover the mouth and nose. 2. An observation was done on 06/01/21 at 11:50 AM of Construction Worker #1 and Construction Supervisor #1 walking in the Enhanced Droplet Precaution (EDP) hall for new unvaccinated admissions without a gown, N95 mask or gloves. One resident was on the hallway at the time with the door open. An observation of PCA #1 was conducted on 06/01/21 at 12:44 PM taking a lunch tray into the admission hallway with a surgical mask on. The sign on the hallway door for EDP required a gown, gloves, face shield and N95 mask if entering the resident's room. A phone interview was done with Construction Supervisor #1 on 06/04/21 at 12:30 PM regarding the Personal Protective Equipment (PPE) worn by the construction staff. He stated he had a surgical mask on 06/01/21 and went down the EDP admission hall for supplies. He said he was not aware of the requirements as when they first surveyed the hall, there were no residents down that hall and there was no isolation on the hall. He noted education had been done for him and his staff about wearing appropriate PPE, reading the signs and for masks on all construction workers to cover the mouth and nose this week. Patient Care Assistant (PCA) #1 was interviewed on 06/01/21 at 12:45 PM regarding the Enhanced Droplet Precaution signage and the required PPE for that hallway. She stated that when they just took a tray into the resident's room, they did not	F 880	These observations included ensuring construction workers, who are not facility personnel, were following proper PPE procedures as instructed. Director of Nursing and Regional Clinical Manager began In-service/re-education for all staff related to the Centers for Disease Control (CDC), State Guidelines and Company policy and expectations related to Infection Prevention and Control. This in-service/re-education and continued education included: when to perform hand hygiene before and after entering a resident room, proper disposal of used gloves, wearing a face mask properly and continuously wearing of PPE while on the isolation unit, proper use of gowns and cleaning and disinfecting of equipment between uses. Education will be completed by the Director of Nursing or Regional Clinical Manager by 7/2/21 and new employees will receive this education during orientation. Increased surveillance rounds during Room Round audits 5 times per week to include a weekend day will be completed by Director of Nursing and Department Managers for 1 month; then at least weekly for 3 months thereafter to identify any variance from policy regarding adhering to the policy and procedure for Infection Prevention and Control and Transmission/Enhanced Precautions. Directed Plan of Correction (DPOC) steps are being implemented by the facility as recommended and will be completed by	

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(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 880	Continued From page 11 need to wear the other PPE. An interview was done with the Corporate Nurse, former Director of Nursing (DON) in role through May 2021, and the current DON (in role since 5/24/21) on 06/03/21 at 3:25 PM. They were informed of the 2 construction workers, one without a mask and one with a surgical mask in the EDP hall with no additional PPE. The Corporate Nurse and the current DON stated construction workers and all personnel were to wear N95 masks, gown and gloves on the EDP admission hall and have eye protection when going into resident's room on the admission hall. An interview was conducted with the Administrator on 06/01/21 at 11:56 AM regarding Construction Worker #1 without a mask and the Construction Supervisor #1 with a surgical mask both walking down the admission hallway. The admission hall had the door closed with an Enhanced Droplet Precautions (EDP) sign on the door. The Administrator stated the hallway led to the rooms of the unvaccinated or partially vaccinated new admissions that were in quarantine for 14 days. She stated they should have been in full PPE, but they had not been in resident's rooms. The Administrator said they should have been in full PPE per the EDP signage which included a gown, gloves and N95 mask, and if they had been in resident's room to have face protection. There was one new admission on the hallway at the time. A follow-up interview was conducted with the Administrator on 06/01/21 at 3:52 PM regarding the masks not being worn by the construction staff, staff's mask slipping below the nose, and the EDP PPE not being worn per the CDC	F 880	the Director of Nursing, Regional Clinical Manager and Administrator. Part of this DPOC includes education in the form of the following training/education: o http://youtu.be/t7OH8ORrg - Sparkling Surfaces o http://youtu.be/xmYMUly7qiE - Clean Hands o https://youtu.be/1ZbT1Njv6xA - Closely Monitor Residents o https://youtu.be/7srwrF9MGdw - Keep COVID-19 Out! o https://youtu.be/YYTATw9yav4 - Lessons Facility held a Quality Assurance/Performance Improvement meeting to conduct a Root Cause Analysis on 6/25/21 with the Medical Director, Director of Nursing, Regional Clinical Manager/Infection Preventionist, Regional Operations Manager, Administrator and select members of the QAPI committee. The Director of Nursing/Regional Nurse Consultant will review data obtained during rounds, analyze the data and report patterns/trends to the QAPI committee every month for 6 months. The QAPI committee and Governing Body will evaluate the effectiveness of the above plan, and will add additional interventions, based on identified outcomes, to ensure continued compliance. The Administrator is responsible for overseeing the implementation of this plan	

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 06/04/2021

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F 880	Continued From page 12 guidelines. She said staff and construction workers should wear surgical masks over their mouth and nose. The former DON was interviewed via phone on 06/04/21 at 12:15 PM and she stated she had been the Infection Prevention nurse until 2 weeks ago. She stated inservices had been completed previously, and that week for staff regarding masks covering the mouth and nose at all times, and the appropriate PPE with new admissions in EDP. She noted staff that entered the hallway were to wear the N95, gown, gloves and in addition, eye protection if going in the room. She said this included when meal trays were taken to a resident. An interview was conducted with the Administrator and the current DON on 06/04/21 at 1:13 PM regarding infection control findings. The Administrator and DON both stated the expectation for masks and Enhanced Droplet Precautions is that staff and construction workers followed the signage on the room doors and the hallway door and wore the appropriate masks and PPE, and all masks were to worn above the nose.	F 880	of correction. Completion date: 07/02/21	