STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 and complaint investigation survey was conducted on 8/7/23 through 8/10/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #0EHU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/7/23 through 8/10/23. Event ID# 0EHU11. The following intakes were investigated NC00203244, NC00204660, NC00205770 and NC00206772. 4 of the 4 complaint allegations did not result in deficiency.	F 000		
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 observation, record review and interviews with resident and staff, the facility failed to ensure a dependent resident could access the light switch located behind the bed for 1 of 1 resident reviewed for accommodation of needs. (Resident #48) Resident #48 was admitted to the facility on 08/29/21. Review of Resident #48's medical records revealed she had moved to her current bedroom	F 558	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F 558 1. Resident #48 light switch cord was	9/7/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 08/29/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	**1735 TODDVILLE ROAD CHARLOTTE, NC 28214**

(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 1 (Room 109A) on 06/27/23. The quarterly Minimum Data Set (MDS) dated 07/05/23 assessed Resident #48 with intact cognition. The MDS indicated walking between locations inside or outside the room did not occur for Resident #48 during the assessment periods. During an observation conducted on 08/07/23 at 1:25 PM, the switch for the light fixture behind Resident #48's bed was attached with a broken cord approximately 3 inches in length. The switch located on the wall was approximately 5 feet from the floor and around 4 feet from Resident #48's bed. Resident #48 was unable to reach the cord connected to the light switch from the bed if needed. An interview was conducted with Resident #48 on 08/07/23 at 1:31 PM. She stated she did not know how long the cord attached to the light switch behind the bed had been broken. She added she was bed bound and non-ambulatory. She did not have any control of the lights behind her bed as she could not reach the switch on the wall from her bed. She had to rely on nursing staff to control the light each time and it was very inconvenient to her. She added it would be great if she could have full control of the light switch behind her bed. During a subsequent observation conducted on 08/08/23 at 10:00 AM, the cord attached to the light switch behind Resident #48's bed remained in disrepair. During a joint observation conducted with Nurse #1 and Nurse Aide (NA) #1 on 08/08/23 at 2:11 PM, the access cord to the light switch for the	F 558	replaced on 08/08/2023. 2. An audit of light switch cords over patient beds was conducted by maintenance director on 08/24/2023. All necessary repairs were made by 09/07/2023. 3. Current staff were educated on importance of light switch cords being present to lights above patient beds. Current staff were educated on facility process of reporting concerns with call light switch cords into the facility work order system (REQQER) when repairs were needed and where obtain new equipment when necessary. Administrator and Director of Nursing provided education to facility staff on 09/07/2023. Any facility staff who is not educated will not be allowed to work until education is received. New facility staff will be educated by Administrator, Maintenance Director or designee will receive education during the orientation process 4. Maintenance Director or designee will conduct an audit on current patient rooms for presence of overbed light switch cords twice weekly x 4 weeks, once a week x 3 weeks, and once monthly x 1 month. Facility work order system (REQQR) will be reviewed by maintenance director of designee weekly to ensure necessary repairs are made. 5. Maintenance Director or designee will report results of the audits to the Quality Assurance Meeting x 1 month for further resolution if needed. 6. Date of compliance: 9/7/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	**1735 TODDVILLE ROAD CHARLOTTE, NC 28214**

(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 2	F 558		

light behind the bed remained inaccessible from Resident #48's bed.

A joint interview was conducted with Nurse #1 and NA #1 on 08/08/23 at 2:14 PM. Both nursing staff confirmed Resident #48 was bed bound and acknowledged that the switches on the wall were unreachable for Resident #48 from the bed. They had provided care for Resident #48 frequently in the past 2 weeks but did not notice the access cord for the light switch behind the bed was broken.

An interview was conducted with the Maintenance Director on 08/08/23 at 2:58 PM. He acknowledged that the cord to control the switch for the light behind Resident #48's bed was in disrepair, and it needed to be fixed immediately. He stated he did a walk through of the facility daily to identify repair needs but he rarely walked into resident's rooms unless there were repair issues. He depended heavily on staff to report repair or maintenance needs via work order system in the computer. He reported he checked the work order system at least twice daily to ensure all the repair needs were addressed in timely manner. He was not aware the access cord for the light switch behind the bed was broken as he had never received any report from the staff.

An interview was conducted with the Director of Nursing (DON) on 08/09/23 at 9:21 AM. She expected nursing staff to pay more attention to residents' home and reported repair needs to Maintenance Director in timely manner. It was her expectation for all the residents to have accessibility and full control of the light fixtures to accommodate their needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 3 An interview was conducted on 08/10/23 at 11:06 AM with the Administrator. She stated the cord to control the light switch for the light fixture behind Resident #48's bed should be in good repair. It was her expectation for all the residents to have full access and control of their light fixture all the time.	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable	F 583		9/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 583	Continued From page 4 federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, and resident interview the facility failed to provide privacy for a resident when the resident was transferred in a common area with their brief exposed. This occurred for one of one resident reviewed for personal privacy. (Resident #50) The findings included: Resident #50 was admitted to the facility on 9/9/20. A quarterly Minimum Data Set for Resident #50 dated 5/9/23 revealed she was cognitively intact. On 8/7/23 at 10:31 AM upon exiting a resident's room, Resident # 50 was observed being brought out of her room in a mechanical lift by Nurse Aide (NA) #2 and NA #3. NA #2 was positioned to the side of the resident guiding the resident in the sling. NA #3 was positioned behind the mechanical lift pushing it out of the room. Resident #50 was in the sling with her legs slightly upward, Resident #50's incontinence brief was exposed. A shower bed was positioned against the wall outside of Resident #50's room, Resident #50 was transferred to the shower bed. After the transfer was complete, NA #3 went into Resident #50's room, retrieved a sheet and covered the resident. During this transfer there were staff members on the hall and multiple	F 583	F583 1. NA # 2 and NA #3 was educated regarding covering a resident with a sheet or ensuring the resident has clothes on including a shirt and pants during transfer to avoid potential exposures. 2. Current residents have the potential to be affected by this practice. 3. Current Nursing staff will be educated on dignity. Education will include using a sheet to avoid potential exposure during transfers when the patient is not dressed appropriately. Education will be conducted by Director of Nursing or designee. Education will be completed 09/07/2023. Any member of nursing staff who is not educated will not be allowed to work until education received. Any new member of nursing staff will be educated by Director of Nursing or designee During the orientation process. 4. Director of Nursing or designee will audit for exposures during transfers. Audits will be 5 transfers weekly x 4 weeks then 3 transfers weekly x 4 weeks, then 1 transfer weekly x 4 week. 5. Results of audit will be reported by Director of Nursing to the Quality assurance Meeting x 1 month for further resolution as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 583	Continued From page 5 residents' room doors were open. During an interview on 8/7/23 at 12:02 PM NA #2 revealed she assisted NA #3 transfer Resident #50 to the shower bed. She stated they could not complete the transfer inside the resident's room because there was not enough room for the lift and shower bed. NA #2 revealed they usually covered Resident #50 with a sheet before bringing her into the hall. She further revealed she was guiding the resident out of the room while NA #2 was pushing the mechanical lift. When she noticed the resident was uncovered, they were already in the hall, so they just completed the transfer. She stated they should have covered the resident before exiting the room. An interview conducted with NA #3 on 8/7/23 at 12:13 PM revealed she was assigned to care for Resident #50 on that day. She further revealed when she and NA #2 were transferring Resident #50 to the shower bed she was rushing and forgot to cover the resident with a sheet before exiting the room. She stated she usually ensured residents that needed to be transferred in the hallway were covered. During an interview with Resident #50 on 8/7/23 at 2:10 PM she indicated she did not recall being uncovered during the transfer to the shower bed. She stated the staff usually covered her before they left the room. She preferred to be covered during transfers. During an interview on 8/7/23 at 2:27 PM the Director of Nursing revealed in some instances staff had to complete transfers in the hall. If a resident needed to be transferred in the hall staff	F 583	6. Date of compliance: 9/7/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 583	Continued From page 6 should ensure that the resident was covered. She further stated staff should have covered Resident #50 prior to exiting the room.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		9/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 584	Continued From page 7 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility failed to maintain a wheelchair in good repair for 1 of 2 residents reviewed for mobility device (Resident #18). The findings included: Resident #18 was admitted to the facility on 05/13/21. Review of weekly skin assessment from 06/02/23 through 08/03/23 revealed Resident #18's skin was intact without any issues. Review of the quarterly Minimum Data Set (MDS) dated 07/24/23 assessed Resident #18 with severe impairment in cognition and her primary mobility device was wheelchair. During an observation conducted on 08/07/23 at 10:24 AM, Resident #18 was seen sitting in her wheelchair next to her bed in her room. The left armrest of Resident #18's wheelchair was in disrepair with multiple torn spots, ripped edges, and cracked lines. In addition, some the bolts and nuts to hold the right armrest to the wheelchair were missing. Leaving the right armrest partially attached to the wheelchair and at risk of falling off. Resident #18 was wearing short sleeves	F 584	F584 1. Resident # 18 wheelchair arms were replaced on 08/07/2023. 2. An audit of current resident wheelchairs was conducted by 08/31/2023 by maintenance department with necessary repairs made by 09/07/2023. 3. Current staff were educated on importance of wheelchair arms being free of torn spots or ripped areas. Current staff were educated on facility process of reporting concerns with wheelchair arms in the facility work order system (REQQER) when repairs were needed and where obtain new equipment when necessary. Administrator and Director of Nursing provided education to facility staff on 09/07/2023. Any facility staff who is not educated will not be allowed to work until education is received. New facility staff will be educated by Administrator, Maintenance Director or designee will receive education during the orientation process. 4 Maintenance department or designee will conduct an audit of current patient□s wheelchair arms to ensure they are in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ____ B. WING ____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 584	Continued From page 8 sitting in the wheelchair and both of her arms were in contact with the broken armrests during the observation. An interview was conducted with Resident #18 on 08/07/23 at 10:27 AM. She said "I don't know" repeatedly when the surveyor attempted to interview her. During a joint observation conducted on 08/08/23 at 2:06 PM with Nurse #1 and Nurse Aide (NA) #1, Resident #18 was wearing short sleeves sitting in the wheelchair with her both arms in contact with the broken armrests. Nurse #1 assessed Resident #18's left arm and deteermined her skin was intact without any redness or rashes. A joint interview was conducted on 08/08/23 at 2:09 PM with Nurse #1 and NA #1. Both nursing staff acknowledged that the bilateral armrests for Resident #18's wheelchair were broken and needed to be fixed immediately. They provided care for Resident #18 frequently in the past couple weeks but had not noticed the armrests were in disrepair. The nurse stated she was going to file a work order to the maintenance department immediately. During a joint observation conducted on 08/08/23 at 2:41 PM with the Maintenance Director, Resident #18 was seen sitting in the wheelchair wearing short sleeves and the skin of her bilateral arms were in contact with the broken armrests. An interview was conducted on 08/08/23 at 02:43 PM with the Maintenance Director. He acknowledged that the armrests for Resident #18's wheelchair were in disrepair, and needed to	F 584	good repair twice weekly x 4 weeks, then once weekly x 4 weeks, then once a month x 1 month. Facility work order system (REQQR) will be reviewed by maintenance director of designee weekly to ensure necessary repairs are made. 5 Maintenance Director or designee will report results of the audits to the Quality Assurance Meeting x 1 month for further resolution if needed. 6. Date of compliance: 9/7/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 584	Continued From page 9 be fixed immediately. He stated he walked through the facility daily to identify repair needs but he rarely went into resident's rooms unless there were repair issues. He depended heavily on staff to report repair needs via work order system in the computer and he would check the work order system at least twice daily to ensure all the repair needs were addressed in timely manner. He was not aware of Resident #18's broken armrests as he had not received any report from the staff. An interview was conducted on 08/09/23 at 9:23 AM with the Director of Nursing. She expected the staff to be more attentive to resident's mobility devices and reported repair needs to maintenance department in timely manner. It was her expectation for all the mobility devices to be in good repair all the time. An interview was conducted with the Administrator on 08/10/23 at 11:06 AM. She expected the staff to report repair needs to maintenance department in timely manner. It was her expectation for all the mobility devices included wheelchair to be in good repair all the time.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		9/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 657	Continued From page 10 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews the facility failed to review and revise the care plan for 1 of 2 residents reviewed for comprehensive resident centered care plans (Resident #239). The findings included: Resident #239 was admitted to the facility on 7/20/23 with diagnoses inclusive of stroke and dementia. An admission Minimum Date Set (MDS) assessment dated 7/20/23 indicated Resident #239 had an indwelling urinary catheter. A Care Plan dated 7/20/23 indicated the presence of an indwelling catheter.	F 657	F657 1. Resident #239 comprehensive care plan□s has been revised to reflect their current status by Minimum Data Set assessment coordinator on 08/08/2023. 2. Current resident care plans audited for accuracy by Regional Director of Reimbursement on 08/21/2023.Careplan□s will be audited for accuracy in relation to care plans that have triggered for Falls, and falls interventions/ ADL changes (decline or improvement) and Nutrition needs/ devices/wt loss/supplements. 3. Minimum Data Set nurse and Care plan team was educated by Region of Director of Clinical Services or designee regarding the need for updating and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 657

Continued From page 11

A review of a physician's order dated 7/31/23 revealed the indwelling foley catheter was discontinued for Resident #239.

A review of a nursing progress note dated 7/31/23 indicated Resident #239's indwelling catheter was removed at 11:00 AM.

A review of physician orders dated 7/31/23 through 8/7/23 revealed no order for a condom catheter for Resident #239.

A review of nursing progress notes dated 8/1/23, 8/5/23, 8/8/23 revealed Resident #239 had a condom catheter.

During a phone interview on 8/8/23 at 2:06 PM a family member indicated Resident #239 was incontinent at night and preferred to wear a condom catheter instead of a diaper. She further indicated she purchased the supplies, left them in his room, and visited daily to change the condom catheter. When she was unable to visit on 8/6/23, she informed staff, who told her they needed a doctor's order and would ask the nurse practitioner. When she called back on 8/7/23, the order had not been written and she continued to change the condom catheter herself.

During an interview on 8/10/23 at 9:45 AM the MDS nurse indicated she did not review and update Resident #239's care plan to reflect the presence of a condom catheter because she did not see an order for one and did not realize the indwelling catheter had been discontinued.

During an interview on 8/10/23 at 4:32 PM the Director of Nursing (DON) revealed the indwelling catheter was discontinued on 7/31/23 and an

F 657

completion of the comprehensive care plan to reflect the resident□s status, falls and falls interventions, physical and nutritional needs including adaptive equipment. Education completed on 08/21/2023.
4. Regional Director of Clinical Reimbursement or Designee will audit Catheter Care plans weekly for 4 weeks, 5 MDS biweekly for 4 weeks, and then monthly for one month.
5. Results of audit will be reported by Minimum Data Set nurse to Quality Assurance Committee Meeting x1 month for further resolution if needed
6. Date of compliance: 9/7/2023

(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 657	Continued From page 12 order for a condom catheter for Resident #239 should have been entered, followed by a care plan update to reflect the change from an indwelling catheter to condom catheter.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide nail care for 1 of 2 residents (Resident #77) reviewed for activities of daily living (ADLs). The findings included: Resident #77 was admitted to the facility on 7/17/23 with diagnoses inclusive of dysphagia, stroke, epilepsy, and acute respiratory failure. An admission Minimum Data Set assessment dated 7/22/23 revealed Resident #77 had moderate cognitive impairment and required limited assistance with bed mobility, dressing, and personal hygiene; extensive assistance with toileting and transfers; supervision with eating and physical help with bathing. The MDS further revealed Resident #77 did not reject care such as ADL assistance. A review of August 2023 progress notes did not reveal Resident #77 refused care. A review of shower sheets dated 7/29/23 and	F 677	F677 1. Resident #77 nails were trimmed, filed and clean on 08/10/2023. 2. Current residents are at risk within the facility. An audit of current resident□s nail care completed for each resident. Any resident found to have inappropriate nail care was treated by the assigned nursing assistant. Audit completed by 08/31/2023. 3. Current nursing assistants were educated on Activities of Daily living including nail care. Education completed by Director of Nursing or designee by 09/07/2023. Any nursing assistant who is not educated will not be allowed to work until education is received. Any new nursing assistant will be educated by Staff Development or Director Nursing during the orientation process. 4. Director of Nursing or designee will audit 5 dependent residents for nail care 5x weekly x 4 weeks then 3x weekly x 4	9/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 677

Continued From page 13

8/5/23 indicated Resident #77 did not need toes nails or fingernails cut.

An observation and interview with Resident #77 on 8/7/23 at 9:01 AM revealed untrimmed and jagged fingernails extending beyond the tips of his fingers on both hands and three fingernails on right hand had brown matter under the nailbeds. The Resident stated no one asked him if he wanted his nails trimmed or cleaned and he wanted them done.

A second observation on 8/9/23 at 11:45 AM revealed Resident #77 had untrimmed fingernails extending beyond the tips of his fingers on both hands and three fingernails on right hand had brown matter under the nailbeds.

During a phone interview on 8/9/23 at 1:10 pm Nurse Aide #5 revealed she normally provided nail care on assigned shower days and as needed. She further revealed she provided Resident #77 with a bed bath instead of a shower on 8/8/23 (2nd shift, since his shower days were Tues/Th/Sat), recognized that his fingernails needed care but forgot to complete nail care during her shift. She also stated she documented the Resident's ADLs in the medical record and did not regularly complete shower sheets.

During an interview on 8/9/23 at 12:29 PM Nurse Aide #4 indicated she was assigned to Resident #77 on first shift (8/9/23) and did not recognize his nails needed to be trimmed or cleaned until the Surveyor observed them, then made her aware. She further indicated she would complete nail care before her shift ended.

During an observation and interview on 8/9/23 at

F 677

weeks, then weekly x 4 weeks.
5. Results of the audits will be reported by Director of Nursing and reviewed at Quality Assurance Meeting X 1 for further resolution if needed.
6. Date of compliance: 9/7/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 14 12:37 PM, Nurse #5 accompanied by the Surveyor, observed Resident #77's nails. Nurse #5 revealed the Resident's nails were overgrown and had brown matter under the nailbeds. She further revealed she would make sure a Nurse Aide provided nail care before the end of the shift. During an interview on 8/10/23 at 3:55 PM, Unit Manager #2 indicated she was made aware and observed Resident #77's nails on 8/9/23 before she was later made aware that the Activities assistant performed nail care after the Surveyor made another observation. She expected nail care to be performed as needed and on shower days. During an interview on 8/10/23 at 4:32 PM the Director of Nursing (DON) indicated she expected nail care to be performed on shower days and as needed.	F 677		
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. §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.	F 761		9/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 15 §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 secure a controlled substance in a permanently affixed compartment of the refrigerator in one of two facility medication rooms. (200 hall medication room) The findings included: On 8/8/23 at 3:13 PM an observation and interview were conducted with Nurse #3. The refrigerator in the 200-hall medication room was not locked and had a clear permanently affixed lock box that was locked and empty. In an unlocked drawer below the lock box was a medication, Lorazepam/Intensol (a controlled substance) oral concentrate 2 milligrams/milliliter. Nurse #3 stated the medication should have been in the lock box, and she was unsure of why the medication was not secured. She further stated she did not have a key to the lock box, but she would ask the Unit Manager (UM) #2 for the key. During an interview on 8/8/23 at 3:30 PM the UM #2 revealed the Lorazepam was a controlled substance and should have been in the locked box. She stated she did not know where the key to the lock box was, and she would follow up with	F 761	F761 1. The locked box in the refrigerator medication room was replaced on 08/10/2023. No residents were affected by this alleged practice. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Director of Nursing completed of audit of medication room refrigerators to ensure locked boxes are in place and narcotics requiring refrigeration are kept in locked box in refrigerator. Audit completed on 08/31/2023. Current licensed nurses educated by Director of Nursing on appropriate storage of medication specifically narcotic storage. Education completed by 09/07/2023. Any licensed nurses who is not educated will not be allowed to work until education received. Any new licensed nurse will be educated by Staff Development or Director of Nursing during orientation process. 4. Director of Nursing or designee will audit medication room refrigerators for lock boxes and proper storage of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	**1735 TODDVILLE ROAD** **CHARLOTTE, NC 28214**

(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 16 the Director of Nursing (DON). During an interview with the DON on 8/8/23 at 4:31 PM she revealed the key to the lock box had been lost for about a week, and a new lock box had been ordered from the pharmacy. She stated staff were supposed to store their controlled medications in the lock box on the 100-hall until the new lock box was installed in the 200-hall refrigerator.	F 761	refrigerated narcotics 3 times weekly x 4 weeks, weekly x 4 weeks, monthly x 1 month. 5. Results of the audits will be reported by Director of Nursing and reviewed at Quality Assurance Meeting X 1 for further resolution if needed. 6. Date of compliance: 9/7/2023	
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. §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 and staff interviews the facility failed to maintain ceiling vents in the kitchen free from accumulation of fuzzy grayish matter and failed to clean 2 of 3 ice machines	F 812	F812 1. The ice machines located in the 200 hall nourishment room and the kitchen were cleaned on 8/08/2023. The fuzzy	9/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ____ B. WING ____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 17 (the kitchen ice machine and 200 Hall nourishment room ice machine). These practices had the potential to affect food and beverages served to residents. Finding included: 1. During the initial tour of the kitchen on 08/07/2023 at 8:25 AM an observation of 2 ceiling vents located beside the dairy refrigerator revealed an accumulation of thick, fuzzy, grayish matter. No air was blowing from the ceiling vents. The tray line was located to the left of the ceiling vents. On 08/08/2023 at 1:15 PM an interview was conducted with the Dietary Manager (DM). He stated the ceiling vents should be free of any debris and needed to be cleaned. He also stated that he did not know when the last time the ceiling vents were cleaned. He further stated the maintenance department was responsible for cleaning the ceiling vents. 2. On 08/08/2023 at 2:15 PM an observation of the kitchen ice machine was conducted with the DM. The observation revealed a black substance located on the white plastic seal under the ice machine lids. The black substance was not in contact with the ice in the ice machine. On 08/08/2023 at 2:25 PM an observation of the 200 Hall nourishment room ice machine was conducted with the DM. The observation revealed a black substance located on the white plastic seal under the ice machine lids. The black substance was not in contact with the ice in the ice machine. An interview was conducted with the DM on	F 812	grayish matter on the vent on the ceiling in the kitchen was cleaned 08/08/2023. 2. An audit of all ice machines and ceiling vents in the kitchen was conducted by the Maintenance Director. Audit completed by 8/31/2023. 3. Education was provided to the Maintenance Director and Maintenance Assistant on ceiling vent and ice machine sanitation by the Regional Maintenance Director. 4. The Maintenance Director or designee will audit ice machine and ceiling vent sanitation in the kitchen 3x weekly x 4 weeks, weekly x 4 weeks and monthly x 1 month. 5. Results of the audits will be reported by Director of Nursing and reviewed at Quality Assurance Meeting X 1 for further resolution if needed. 6. Date of compliance: 9/7/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 18 08/08/2023 at 2:25 PM. The DM stated the ice in both ice machines needed to be discarded and the ice machines thoroughly cleaned. He also stated the maintenance department was responsible for cleaning and maintaining the ice machines. During an interview with the Maintenance Supervisor on 08/09/2023 at 08:30 AM, he stated the ice machines are cleaned and sanitized by an outside contract company every 6 months. He stated the ice machines were last cleaned on 03/22/2023. During an interview with the Administrator on 08/10/2023 at 8:00 AM, she stated her expectations were for the ice machines and ceiling vents to be cleaned routinely.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		9/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 19	F 867		

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 20	F 867		

safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 21

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint survey and recertification conducted on 4/14/22. Four repeat deficiencies were originally cited on the 4/14/22 survey under the areas of Resident Rights (F558), Comprehensive Resident Centered Care Plan (F657), Pharmacy Services (F761), and Food and Nutrition Services (F812) and were subsequently recited on the current recertification and complaint survey of 8/10/23. These repeat deficiencies during the 2 federal surveys show a pattern of the facility's inability to sustain an effective QAA Program.

The findings included:

This citation is cross referenced to:

F558: Based on observation, record review and

F 867

F867
1. Resident #48 light switch cord was replaced on 08/08/2023. Resident #239 comprehensive care plan□s has been revised to reflect their current status by Minimum Data Set assessment coordinator on 08/08/2023. The locked box in the refrigerator medication room was replaced on 08/10/2023. No residents were affected by this alleged practice. The ice machines located in the 200 hall nourishment room and the kitchen were cleaned on 8/08/2023. The fuzzy grayish matter on the vent on the ceiling in the kitchen was cleaned 08/08/2023.
2. An audit of light switch cords over patient beds was conducted by maintenance director on 08/24/2023. All necessary repairs were made by 09/07/2023. Current resident care plans audited for accuracy by Regional Director of Reimbursement on 08/21/2023.Careplan□s will be audited for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 22

interviews with resident and staff, the facility failed to ensure a dependent resident could access the light switch located behind the bed for one of one resident reviewed for accommodation of needs. (Resident #48)

During the recertification and complaint survey completed on 4/14/22 the facility failed to provide the correct size briefs for one of four residents reviewed for accommodation of needs.

F657: Based on observations, record review, resident interview and staff interviews the facility failed to review and revise the care plan for one of two residents reviewed for comprehensive resident centered care plans. (Resident #239)

During the recertification and complaint survey completed on 4/14/22 the facility failed to invite a resident to participate in the development and revision of their care plan for one of eight residents reviewed for care plan meetings.

F761: Based on observations and staff interviews the facility failed to secure a controlled substance in a permanently affixed compartment of the refrigerator in one of two facility medication rooms. (200 hall medication room)

During the recertification and complaint survey completed on 4/14/22 the facility failed to remove expired medications from two of two medication carts, remove expired medications from one of two medication storage rooms, and date and refrigerate a probiotic after opening in one of two medication carts.

F812: Based on observations and staff interviews the facility failed to maintain ceiling

F 867

accuracy in relation to care plans that have triggered for Falls, and falls interventions/ ADL changes (decline or improvement) and Nutrition needs/ devices/wt loss/supplements. Director of Nursing completed of audit of medication room refrigerators to ensure locked boxes are in place and narcotics requiring refrigeration are kept in locked box in refrigerator. Audit completed on 08/31/2023. An audit of all ice machines and ceiling vents in the kitchen was conducted by the Maintenance Director. Audit completed by 8/31/2023.

3. Current staff were educated on importance of light switch cords being present to lights above patient beds. Current staff were educated on facility process of reporting concerns with call light switch cords into the facility work order system (REQQER) when repairs were needed and where obtain new equipment when necessary. Administrator and Director of Nursing provided education to facility staff on 09/07/2023. Any facility staff who is not educated will not be allowed to work until education is received. New facility staff will be educated by Administrator, Maintenance Director or designee will receive education during the orientation process.
Minimum Data Set nurse and Care plan team was educated by Region of Director of Clinical Services or designee regarding the need for updating and completion of the comprehensive care plan to reflect the resident□s status, falls and falls interventions, physical and nutritional needs including adaptive equipment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 23 vents in the kitchen free from accumulation of fuzzy grayish matter and failed to clean 2 of 3 ice machines (the kitchen ice machine and 200 Hall nourishment room ice machine). These practices had the potential to affect food and beverages served to residents. During the recertification and complaint survey completed on 4/14/22 the facility failed to discard food products on or before their expiration date and hold foods at a temperature of at least 135 degrees Fahrenheit on the steam table. During an interview on 8/10/23 at 3:48 PM the Administrator revealed their QAA committee met monthly. During the meetings the committee reviewed their current process improvements, and discussed items that may need a process improvement. The administrator stated the repeat citations were in the same category but in a different area. She revealed from the previous survey the facility had citations related to expired foods, palatability, and preferences. The facility put a lot of focus on correcting those areas and gave less attention to the areas that were cited on the current survey. The Administrator indicated this was the case for all the repeat citations.	F 867	Education completed on 08/21/2023. Director of Nursing completed of audit of medication room refrigerators to ensure locked boxes are in place and narcotics requiring refrigeration are kept in locked box in refrigerator. Audit completed on 08/31/2023. Current licensed nurses educated by Director of Nursing on appropriate storage of medication specifically narcotic storage. Education completed by 09/07/2023. Any licensed nurses who is not educated will not be allowed to work until education received. Any new licensed nurse will be educated by Staff Development or Director of Nursing during orientation process. Education was provided to the Maintenance Director and Maintenance Assistant on ceiling vent and ice machine sanitation by the Regional Maintenance Director. 4. Maintenance Director or designee will conduct an audit on current patient rooms for presence of overbed light switch cords twice weekly x 4 weeks, once a week x 3 weeks, and once monthly x 1 month. Facility work order system (REQQR) will be reviewed by maintenance director of designee weekly to ensure necessary repairs are made. Regional Director of Clinical Reimbursement or Designee will audit Catheter Care plans weekly for 4 weeks, 5 MDS biweekly for 4 weeks, and then monthly for one month. Director of Nursing or designee will audit medication room refrigerators for lock boxes and proper storage of refrigerated narcotics 3 times weekly x 4 weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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 24	F 867	weekly x 4 weeks, monthly x 1 month. The Maintenance Director or designee will audit ice machine and ceiling vent sanitation in the kitchen 3x weekly x 4 weeks, weekly x 4 weeks and monthly x 1 month. 5. Results of the audits will be reported by the Administrator and reviewed at Quality Assurance Meeting X 3 for further resolution if needed. 6. Date of Completion 09/07/2023	