| DEPART                   | MENT OF HEALTH AN   | ID HUMAN SERVICES   |                     |  | FORM APPROVED                 |
|--------------------------|---|---|---------------------|--|-------------------------------|
| CENTER                   | S FOR MEDICARE &  | MEDICAID SERVICES   |                     |  | OMB NO. 0938-0391             |
|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |  | (X3) DATE SURVEY<br>COMPLETED |
|                          |   | 345471  | B. WING             |  | C<br>03/29/2014               |
| NAME OF P                | ROVIDER OR SUPPLIER   | I   | S                   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |
| MECKLEN                  | NBURG HEALTH & REHA   | BILITATION CENTER   |                     | 415 SANDY PORTER ROAD<br>HARLOTTE, NC 28273  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI/<br>DEFICIENCY)  |                               |
| F 000                    | INITIAL COMMENTS  |   | F 000               |  |                               |
| F 323<br>SS=J            | Resident #5 exited th<br>property without staff<br>Immediate jeopardy v<br>3:39 PM when the fac<br>implemented an acce<br>compliance. The fac<br>compliance at a lowe<br>(an isolated deficience<br>potential for more tha<br>immediate jeopardy)<br>the monitoring of sys<br>effective and complet<br>483.25(h) FREE OF<br>HAZARDS/SUPERVI<br>The facility must ensu<br>environment remains<br>as is possible; and ea                                    | ptable credible allegation of<br>lity remains out of<br>r scope and severity of D<br>y, no actual harm with<br>n minimal harm that is not<br>for Resident #5 to ensure<br>tems put into place are<br>ion of employee education.<br>ACCIDENT<br>SION/DEVICES<br>ure that the resident<br>as free of accident hazards | F 323               |  | 4/21/14                       |
|                          | This REQUIREMENT is not met as evidenced<br>by:<br>Based on observations, a review of the medical<br>record and facility records and interviews with the<br>physician and staff, the facility failed to identify,<br>assess, and implement elopement interventions,<br>for a cognitively impaired resident who verbally<br>expressed a desire to leave the facility in 1 of 3<br>sampled residents reviewed for their risk of<br>elopement. (Resident #5) |   |                     | Mecklenburg Health Care Center<br>The statements included are not an<br>admission and do not constitute<br>agreement with the alleged deficiencies<br>herein. The plan of correction is<br>completed in the compliance of state a<br>federal regulations as outlined. To rem<br>in compliance with all federal and state<br>regulations the center has taken or will | nd<br>nain                    |
| LABORATORY               | DIRECTOR'S OR PROVIDER/   | SUPPLIER REPRESENTATIVE'S SIGNATUR  | RE                  | TITLE  | (X6) DATE                     |
| Electroni                | cally Signed  |   |                     |  | 04/16/2014                    |

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.

| STATUSENT OF DEFIDENCIES     (x) DESTIFICATION NUMBER     (x) MULTELE CONSTRUCTION     (x) CONFECTION       AND PLAN OF CORRECTION     345471     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION       NME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2IP CODE     03/29/2014       MECKLENBURG HEALTH & REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, 2IP CODE     03/29/2014       MECKLENBURG HEALTH & REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, 2IP CODE     03/29/2014       MECKLENBURG HEALTH & REHABILITATION CENTER     IT PREFIX     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION       PARE DR     SUMMARY STATEMENT OF DEFICIENCIES     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION       PARE DR     SUMMARY STATEMENT OF DEFICIENCIES     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION       PARE DR     SUMMARY STATEMENT OF DEFICIENCIES     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION       PARE DR     SUMME OF PROVIDER SPLAN OF CORRECTION     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION       MAIL DR     SUMME OF PROVIDER     SUMME OF MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION       MAIL DR     SUMME OF MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION     (x) MULTELE CONSTRUCTION <td< th=""><th></th><th></th><th>ID HUMAN SERVICES<br/>MEDICAID SERVICES</th><th></th><th></th><th></th><th>FOR</th><th>D: 09/29/2014<br/>M APPROVED<br/>D. 0938-0391</th></td<>  |             |   | ID HUMAN SERVICES<br>MEDICAID SERVICES  |         |     |   | FOR   | D: 09/29/2014<br>M APPROVED<br>D. 0938-0391 |
|---|-------------|---|---|---------|-----|---|---|---|
| 346471         INVING         03/39/2014           INVINE OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, 2P CODE         2415 SANDY PORTER ROAD<br>CHARLOTTE, NC 28273           IMPERX         ESUMMARY STATEMENT OF DEFICIENCIES<br>IFREETX         STREET ADDRESS, CITY, STATE, 2P CODE         2415 SANDY PORTER ROAD<br>CHARLOTTE, NC 28273           IMPERX         ESUMMARY STATEMENT OF DEFICIENCIES<br>IFREETX         Important Construction International Constitutes the Contention International Constitutes the Content Internation International Constitutes the Content International Constitutes the Content International Constitutes the Content Internation International Internation Internaternation Internatintereconternation Internaterecon  | STATEMENT ( | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   | · /     |     |   | (X3) DATE<br>COM  | E SURVEY<br>PLETED                          |
| MECKLENBURG HEALTH & REHABILITATION CENTER         215 SAMOY PORTER ROAD<br>CHARLOTTE, NC 2273           Image: Interpret |             |   | 345471  | B. WING |     |   |   | -   |
| MECKLEMBURG HEALTH & REHABILITATION CENTRE         CHARLOTTE, NC 22273           Image: Complexity of the content of the pericence of t    | NAME OF PI  | ROVIDER OR SUPPLIER   | •   |         | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |   |
| PREFIX<br>TAG         CEAH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC DENTIFYING INFORMATION)         PREFIX<br>TAG         CEASE REFERENCE ACTORECTIVE ACTION SHOULD BE<br>CROSS-REFERENCE ACTO THE APPROPRIATE<br>DEFICIENCY)         COMPLETION<br>DWE           F 323         Continued From page 1<br>Immediate jeopardy began on 03/19/14 when<br>Resident #5 exited the building and facility<br>property without staff supervision or knowledge.<br>Immediate jeopardy was removed on 03/29/14 at<br>3:39 PM when the facility provided and<br>implemented an acceptable credible allegation of<br>compliance. The facility remains out of<br>compliance at a lower scope and severity of D<br>(an isolated deficiency, no actual harm with<br>potential for more than minimal hart that is not<br>immediate jeopardy ior Resident #5 to ensure<br>the monitoring of systems put into place are<br>effective and completion of employee education.<br>The findings included:<br>The facility's policy. "Behavioral<br>Assessment/Behavior Sahall be evaluated and care<br>planned. Residents shall be observed by staff on<br>all shifts and report any untoward behavior<br>(unusual), that is observed by a lacensed nurse.<br>influencing behaviors after the initial admission to<br>the center, utilize the Wandering/Elopement Risk<br>Assessment/Behaviors after the initial admission to<br>the center, utilize the Wandering/Elopement Risk<br>Assessment/Behaviors admitted to the facility on         F323           Resident #5 was admitted to the facility on         F323         F323   | MECKLEN     | IBURG HEALTH & REHA   | BILITATION CENTER   |         |     |   |   |   |
| Immediate jeopardy began on 03/19/14 when         Resident #5 exited the building and facility         property without staff supervision or knowledge.         Immediate jeopardy was removed on 03/29/14 at         3:39 PM when the facility provided and         implemented an acceptable credible allegation of         compliance. The facility remains out of         compliance at a lower scope and severity of D         (an isolated deficiency, no actual harm with         potential for more than minimal harm that is not         immediate jeopardy) for Resident #5 to ensure         the monitoring of systems put into place are         effective and completion of employee education.         The facility's policy. "Behavioral         Assessment/Behavior shall be assessed and monitored. Factors         influencing behaviors as well as management         interventions shall be evaluated and care         planed. Resident shall be observed by staff on all shifts and report any untoward behavior         (unusual), that is observed to a licensed nurse.         a resident begins demonstrating unsafe aimless         wardering behaviors after the initial admission to         the centry. uilize the Wandering/Elopement Risk         Assessment/Behaviord was quarterly and update care plan accordingly."         Resident #5 was admitted to the facility on  | PREFIX      | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL  | PREF    |     | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR   | BE  | COMPLETION                                  |
| services after sustaining a fall with lumbar (back)<br>fracture at home. Diagnoses included lumbar<br>fracture, confused state and mild/moderate<br>dementia.applied on him upon return to the facility<br>and the Director of Nursing did every 30<br>minute checks from 0700 a.m. to 0600<br>p.m. on 03/20/2014. (3/20/14)A Wandering/Elopement Risk Assessment datedon 03/21/2014 resident #5 Wandering<br>and Elopement Risk Assessment was   | F 323       | Immediate jeopardy to<br>Resident #5 exited th<br>property without staff<br>Immediate jeopardy v<br>3:39 PM when the face<br>implemented an accel<br>compliance. The faci<br>compliance at a lowe<br>(an isolated deficience<br>potential for more that<br>immediate jeopardy) the<br>monitoring of syste<br>effective and complete<br>The findings included<br>The facility's policy, "I<br>Assessment/Behavior<br>09/01/11, recorded in<br>shall be assessed an<br>influencing behaviors<br>interventions shall be<br>planned. Residents s<br>all shifts and report at<br>(unusual), that is obse<br>a resident begins der<br>wandering behaviors<br>the center, utilize the<br>Assessment form and<br>quarterly and update<br>Resident #5 was adm<br>03/04/14 from the hos<br>services after sustain<br>fracture, confused stat<br>dementia. | began on 03/19/14 when<br>e building and facility<br>supervision or knowledge.<br>was removed on 03/29/14 at<br>cility provided and<br>eptable credible allegation of<br>ility remains out of<br>r scope and severity of D<br>cy, no actual harm with<br>in minimal harm that is not<br>for Resident #5 to ensure<br>tems put into place are<br>tion of employee education.<br>Behavioral<br>r Monitoring", effective<br>part, "Problematic behavior<br>d monitored. Factors<br>as well as management<br>evaluated and care<br>hall be observed by staff on<br>ny untoward behavior<br>erved to a licensed nurse. If<br>monstrating unsafe aimless<br>after the initial admission to<br>Wandering/Elopement Risk<br>d re-evaluate at least<br>care plan accordingly."<br>hitted to the facility on<br>spital for rehabilitation<br>ing a fall with lumbar (back)<br>gnoses included lumbar<br>ate and mild/moderate | F       | 323 | plan of correction. The following plan<br>correction constitutes the center s<br>allegation of compliance. All alleged<br>deficiencies cited have been or will be<br>completed by the dates indicated.<br>F323<br>How the corrective action will be<br>accomplished for those residents four<br>have been affected by the deficient<br>practice:<br>" On 3/20/2014 Resident # 5 at<br>approximately 12:05 a.m. was reported<br>be at the hospital. The hospital nurse<br>reported to our facility charge nurse th<br>the Police Department, reported our<br>resident walked to their station and as<br>for a ride home. The police assisted th<br>resident. They attempted to take him<br>two different locations. Both of the<br>locations were the incorrect home<br>addresses for the resident. It was at th<br>point the police realized the resident of<br>possibly confused. Emergency Medic<br>Services was called and the resident of<br>transported to the hospital. The reside<br>was evaluated by hospital ED, and it of<br>determined no trauma or injury was<br>experienced by the resident, which was<br>confirmed by facility nurse upon his re<br>(3/20/14)<br>" The Resident had a wander guar<br>applied on him upon return to the faci<br>and the Director of Nursing did every<br>minute checks from 0700 a.m. to 0600<br>p.m. on 03/20/2014. (3/20/14)<br>" On 03/21/2014 resident #5 Wand | of<br>of<br>ad to<br>d to<br>hat<br>ked<br>he<br>to<br>his<br>vas<br>cal<br>was<br>ent<br>was<br>ent<br>was<br>eturn.<br>d<br>lity<br>30<br>D<br>lering |   |

Event ID: WSX511

Facility ID: 955030

If continuation sheet Page 2 of 18

|                          | OF DEFICIENCIES                                 | MEDICAID SERVICES   |                     |    | CONSTRUCTION  |          | TE SURVEY                 |
|--------------------------|---|---|---------------------|----|---|----------|---------------------------|
|                          | CORRECTION                                      | IDENTIFICATION NUMBER:  | . ,                 |    |   | 1 Y /    | MPLETED                   |
|                          |   |   |                     |    |   |          | С                         |
|                          |   | 345471  | B. WING             |    |   | 0        | 3/29/2014                 |
| NAME OF P                | ROVIDER OR SUPPLIER                             | ·   |                     | ST | IREET ADDRESS, CITY, STATE, ZIP CODE  | -        |                           |
|                          |   |   |                     | 24 | 15 SANDY PORTER ROAD  |          |                           |
| WECKLEP                  | IBURG HEALTH & REHA                             | ABILITATION CENTER  |                     | Cł | HARLOTTE, NC 28273  |          |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                 | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG |    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | ЗE       | (X5)<br>COMPLETIO<br>DATE |
| F 323                    | Continued From page                             | e 2   | F 32                | 23 |   |          |                           |
|                          |   | by nurse #1 documented  | 1 02                |    | re-evaluated to ensure appropriate  |          |                           |
|                          |   | nentia, intermittent confusion,   |                     |    | interventions were in place. (3/21/14   | 4)       |                           |
|                          |   | ently with a walker and had   |                     |    | " Power of Attorney for Resident #5   |          |                           |
|                          |   | ng/elopement behavior.  |                     |    | decided to transfer resident #5 to a  |          |                           |
|                          | There were no wande                             |   |                     |    | different facility on 3/28/14 as previous   | sly      |                           |
|                          | interventions docume                            | ented on this assessment for  |                     |    | planned. Resident #5 is no longer in t  | he       |                           |
|                          |   | ions for the completion of  |                     |    | facility. (3/28/14)   |          |                           |
|                          |   | included "Complete with   |                     |    | " All staff was in-serviced on 3/20/2   |          |                           |
|                          | -   | ve changes. Revise/update   |                     |    | for "code orange" including elopement   | t        |                           |
|                          | the care plan as indic                          | cated."   |                     |    | procedures, patient rounding, and   |          |                           |
|                          | A purso's noto by pur                           | se #2 dated 03/06/14 03:39  |                     |    | responding to alarms. (3/20/14)<br>" On 3/20/14 maintenance director  |          |                           |
|                          | AM recorded in part,                            |   |                     |    | contacted Fire Monitoring Company w   | ho       |                           |
|                          | wandering in hallway earlier, attempting to use |   |                     |    | performed in house testing of all doors   |          |                           |
|                          | BR (bathroom) in another res (resident's) room  |   |                     |    | and alarms. All door alarms were foun   |          |                           |
|                          |   | vithout incident to his own   |                     |    | be properly working with no malfunction   |          |                           |
|                          | BR."  |   |                     |    | (Note: An event history report of the al  |          |                           |
|                          |   |   |                     |    | system showed two alarms were signa   | aled     |                           |
|                          |   | note by nurse #3 from   |                     |    | on the facility□s 100 hall. Both were   |          |                           |
|                          | -   | nift) dated 03/27/14 4:03 AM  |                     |    | accounted for). (3/20/14)   |          |                           |
|                          | -   | ring rounds this resident told  |                     |    | " As a routine practice the Maintena  |          |                           |
|                          | this writer he wanted                           |   |                     |    | Director or designee will test door alar  | ms       |                           |
|                          |   | sted to speak to his son."<br>her clarified that when asked                           |                     |    | daily. (ongoing)  | ina      |                           |
|                          |   | nce to contact his son, the   |                     |    | <ul> <li>As a routine practice, Housekeep<br/>will strip and wax hallways in halves to</li> </ul>                   |          |                           |
|                          |   | e nurse that he did not have  |                     |    | allow passage for walking rounds.   |          |                           |
|                          | a son.  |   |                     |    |   |          |                           |
|                          |   |   |                     |    | How corrective action will be   |          |                           |
|                          | An admission Minimu                             | Im Data Set and Care Area   |                     |    | accomplished for those resident havin   | g        |                           |
|                          |   | 3/11/14 assessed Resident   |                     |    | potential to be affected by the same  |          |                           |
|                          |   | npaired cognition, without  |                     |    | deficient practice:   |          |                           |
|                          | -   | and at risk for increased   |                     |    | " The Director of Nursing (DON) an  |          |                           |
|                          | •   | ted to an acute disease   |                     |    | at the facility on 3/20/14 and verified th  | nat      |                           |
|                          |   | was not care planned for  |                     |    | all residents were accounted for.   |          |                           |
|                          | the risk of wandering                           |   |                     |    | (3/20/14)<br>As a routine practice, visual round  | łe       |                           |
|                          | A nurse's note dated                            | 03/11/14 04:36 PM recorded  |                     |    | and cross shift communication will be   | 10       |                           |
|                          |   | moved on this date to a   |                     |    | done by nursing every shift to observe  | <u>,</u> |                           |
|                          | new room on the sam                             |   |                     |    | and ensure all residents are accounted  |          |                           |

Facility ID: 955030

If continuation sheet Page 3 of 18

|               | OF DEFICIENCIES        | MEDICAID SERVICES   |               | PLE CONSTRUCTION   |             | NO. 0938-039<br>TE SURVEY |
|---------------|------------------------|---|---------------|--|-------------|---------------------------|
|               | CORRECTION             | IDENTIFICATION NUMBER:                                      | . ,           | G  | · · /       | MPLETED                   |
|               |                        |   | A. DOILDIN    | J  |             | С                         |
|               |                        | 345471  | B. WING       |  |             | 3/29/2014                 |
| NAME OF P     | ROVIDER OR SUPPLIER    |   |               | STREET ADDRESS, CITY, STATE, ZIP CODE                                    |             | 5/25/2014                 |
|               |                        |   |               | 2415 SANDY PORTER ROAD   |             |                           |
| MECKLEN       | IBURG HEALTH & REH     | ABILITATION CENTER  |               | CHARLOTTE, NC 28273  |             |                           |
| (X4) ID       | SUMMARY S              | TATEMENT OF DEFICIENCIES                                    | ID            | PROVIDER'S PLAN OF CORRI   | ECTION      | (X5)                      |
| PRÉFIX<br>TAG |                        | CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) |             | COMPLETIO<br>DATE         |
| F 323         | Continued From pag     | e 3   | F 32          | 23   |             |                           |
|               |                        |   |               | for. This will be reviewed in Risk                                       | K           |                           |
|               |                        | rse #2 dated 03/12/14 02:29                                 |               | Management Meeting on a week   | -           |                           |
|               |                        | "(Resident) wandering in                                    |               | and through quarterly QA as nee  | eded.       |                           |
|               | •                      | ue to room change. Easily                                   |               | (4/21/14)  | t: <b>f</b> |                           |
|               | redirected to new roo  | om and shown where BR is."                                  |               | " On 3/20/2014, under the dir<br>DON, all current residents with a       |             |                           |
|               | A Physician's Admiss   | sion Medical Care Plan dated                                |               | guard in place were assessed for   |             |                           |
|               | -                      | Resident #5 with dementia,                                  |               | placement. All were in place. All  |             |                           |
|               |                        | versation, but able to answer                               |               | in-serviced on 3/20/2014 for "co   |             |                           |
|               |                        | e physician's assessment                                    |               | orange" including elopement pro  | cedures,    |                           |
|               | also documented that   | at Resident #5 possibly                                     |               | patient rounding, and responding   | g to        |                           |
|               | needed a closed me     | mory care unit.   |               | alarms. (3/20/14)  |             |                           |
|               |                        |   |               | " On 3/20/14 the maintenance   |             |                           |
|               |                        | rse #4 dated 03/19/14 10:24                                 |               | contacted Fire Monitoring Comp   | -           |                           |
|               | confusion in the even  | "Resident has increased                                     |               | performed in house testing of all<br>and alarms. All door alarms were    |             |                           |
|               |                        | ling.   |               | be properly working. As a routin   |             |                           |
|               | Review of the facility | 's Incident Report and                                      |               | the Maintenance Director or des  |             |                           |
|               |                        | d that Resident #5 exited the                               |               | test door alarms daily. (3/20/14   |             |                           |
|               |                        | etween 8:30 - 9:30 PM                                       |               | " On 03/21/2014 all residents  | ,           |                           |
|               | through the front doo  | ors unsupervised by staff.                                  |               | on this date, Wandering and Elo  | pement      |                           |
|               |                        | hat Resident #5 was not in                                  |               | Risk Assessments were re-evalu   |             |                           |
|               |                        | ospital called the facility at                              |               | revised as needed by the DON a   |             |                           |
|               |                        | AM on 03/20/14. Nurse #2                                    |               | Registered Nurse Minimum Data  | a Set       |                           |
|               | emergency medical      | ospital that police called                                  |               | (MDS) Coordinator. (3/21/14)<br>" On 03/27/2014 all residents            | in house    |                           |
|               |                        | to the police station on                                    |               | on this date, Wandering and Elo  |             |                           |
|               |                        | nately 10:00 PM asking for a                                |               | Risk Assessments were re-evalu   |             |                           |
|               |                        | failed attempts to take                                     |               | the DON and Registered Nurse   |             |                           |
|               |                        | he police determined that                                   |               | Data Set (MDS) Coordinator. A  |             |                           |
|               |                        | fused and called EMS for                                    |               | employee was posted in the from  |             |                           |
|               |                        | ne hospital reported to nurse                               |               | the door to monitor for any atten  |             |                           |
|               |                        | arrived to the hospital on                                  |               | any resident to exit the facility un                                     |             |                           |
|               |                        | parent injury and would be                                  |               | wander-guards were checked ar  | ום וח       |                           |
|               |                        | ne facility. Nurse #2 notified<br>g (DON) on 03/20/14 at    |               | place. (3/27/14)   | n m         |                           |
|               |                        | ement. Additionally, the                                    |               | " 03/27/2014 Initially at 05:00<br>every 15 minute visual checks w       |             |                           |
|               | -                      | ator and Resident's Power of                                |               | completed on residents that cou  |             |                           |
|               | Attorney (PoA) were    |   |               | risk based on Wandering Assess   |             |                           |

Facility ID: 955030

If continuation sheet Page 4 of 18

| CENTER                   | S FOR MEDICARE &                                | ND HUMAN SERVICES<br>MEDICAID SERVICES                 |                     |   | OMB NO       | MAPPROV<br>0. 0938-03     |
|--------------------------|---|--|---------------------|---|--------------|---------------------------|
|                          | DF DEFICIENCIES                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | PLE CONSTRUCTION G  |              | PLETED                    |
|                          |   | 345471   | B. WING             |   |              | C<br>/ <b>29/2014</b>     |
| NAME OF PI               | ROVIDER OR SUPPLIER                             | •  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | Ē            |                           |
| MECKLEN                  | IBURG HEALTH & REH                              | ABILITATION CENTER                                     |                     | 2415 SANDY PORTER ROAD  |              |                           |
|                          |   |  |                     | CHARLOTTE, NC 28273   |              |                           |
| (X4) ID<br>PREFIX<br>TAG | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE    | (X5)<br>COMPLETIC<br>DATE |
| F 323                    | Continued From page 4                           |  | F 32                | 23  |              |                           |
|                          |   |  |                     | then at 1100 p.m. an employed   | e was        |                           |
|                          |   | served in his room on                                  |                     | posted at the front door until 2  |              |                           |
|                          |   | with a wander guard to his                             |                     | when all wander-guards were   | verified to  |                           |
|                          |   | ent stated "I want to go                               |                     | be in place. (3/27/14)  |              |                           |
|                          | home", but did not re                           | ecall the events of 03/19/14.                          |                     | " On 3/27/2014 all staff wer  |              |                           |
|                          | $O_{\rm P} = 0.2/26/14$ at 5.00                 | PM, nurse aide #1 (NA #1)                              |                     | in-serviced by Director of Nurs<br>Development Coordinator, Un                                | •            |                           |
|                          |   | at she was accustomed to                               |                     | and one done by the Regional  | -            |                           |
|                          |   | nt #5 on the 3-11 PM shift,                            |                     | President of Operations on the  |              |                           |
|                          | -   | ing he left the facility. NA #1                        |                     | policies and procedures to ens  | -            |                           |
|                          |   | #5 as intermittently confused                          |                     | understanding. New hires will   |              |                           |
|                          | and independent witl                            | h ambulation. NA #1 stated                             |                     | educated during general orien   | tation. All  |                           |
|                          |   | y walked into the hallway                              |                     | staff will be in-serviced before  | returning to |                           |
|                          |   | or the bathroom and often                              |                     | work. (3/27/14)   |              |                           |
|                          | -   | o go home. NA #1 stated                                |                     | 1) Nursing Policy and Proce   |              |                           |
|                          |   | have a wander guard and                                |                     | Behavioral Assessment/Behav<br>Monitoring, which states that p                                |              |                           |
|                          | facility.                                       | vious attempts to leave the                            |                     | behavior shall be assessed an   |              |                           |
|                          | lacinty.  |  |                     | monitored. Factors influencing  |              |                           |
|                          | On 03/26/14 at 5:16                             | PM, the administrator was                              |                     | as well as management interv  |              |                           |
|                          |   | aled that he received                                  |                     | shall be evaluated and care pl  |              |                           |
|                          | notification from the                           | DON on the morning of                                  |                     | Under this policy Residents wi  | ill be       |                           |
|                          | 03/20/14 that Reside                            | -  |                     | observed by staff on all shifts a   |              |                           |
|                          |   | thout staff knowledge on                               |                     | immediately report any untowa   |              |                           |
|                          |   | the police station and was                             |                     | (untoward meaning unusual be  |              |                           |
|                          | , , ,   | ital for evaluation. The<br>he notified the Resident's |                     | behavior that is observed to a nurse. On 03/28/2014 the fac                                   |              |                           |
|                          | PoA on 03/20/14 of t                            |  |                     | immediately began in-service  |              |                           |
|                          |   | ated he contacted the police                           |                     | wandering/elopement risk ass  |              |                           |
|                          |   | med that Resident #5 walked                            |                     | form. Department Heads and  |              |                           |
|                          |   | in the parking lot of the                              |                     | Administration re-in serviced a   |              |                           |
|                          | police station reques                           | ting a ride home. Resident                             |                     | the Stop and Watch Tool whicl   |              |                           |
|                          |   | curately state his address                             |                     | by all staff in helping to identify   |              |                           |
|                          |   | ots the police determined                              |                     | communicate changes in patie  |              |                           |
|                          |   | nfused and called EMS for a                            |                     | subtle changes and communic   |              |                           |
|                          | hospital transport.                             |  |                     | changes to nursing staff imme   | -            |                           |
|                          | On 03/26/14 at 7.27                             | PM the maintenance                                     |                     | that appropriate interventions  | can be put   |                           |
|                          |   | PM, the maintenance                                    |                     | in place. (3/28/14)   | 539          |                           |
|                          |   | erview that the front door was                         |                     | 2) Policy and Procedure #1  | 539,         |                           |

Facility ID: 955030

If continuation sheet Page 5 of 18

|                          | F DEFICIENCIES   | MEDICAID SERVICES   |                     | LE CONSTRUCTION  | (X3) DATE                         | 0938-03                   |
|--------------------------|--|---|---------------------|--|-----------------------------------|---------------------------|
|                          | CORRECTION   | IDENTIFICATION NUMBER:  | . ,                 |  | . ,                               | PLETED                    |
|                          |  |   |                     |  |                                   | с                         |
|                          |  | 345471  | B. WING             |  |                                   | 29/2014                   |
| NAME OF P                | ROVIDER OR SUPPLIER                                    | •   | •                   | STREET ADDRESS, CITY, STATE, ZIP   | CODE                              |                           |
|                          | BURG HEALTH & REHA                                     | BILITATION CENTER   |                     | 2415 SANDY PORTER ROAD   |                                   |                           |
|                          | BONG HEALTH & KEHA                                     | dilitation center   |                     | CHARLOTTE, NC 28273  |                                   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OL<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETIC<br>DATE |
| F 323                    | Continued From page                                    | e 5   | F 32                | 3  |                                   |                           |
|                          |  | guard system and was  | _                   | Safety/Security Systems (  | Wandering),                       |                           |
|                          |  | d 10:00 PM each night. If a   |                     | which states Residents ide   |                                   |                           |
|                          | -  | have on a wander guard  |                     | risk for wandering away fr   | om the Center                     |                           |
|                          |  | door, the resident could exit   |                     | will have the least restricti  | •                                 |                           |
|                          |  | incident. The maintenance   |                     | device is in use. This poli  |                                   |                           |
|                          |  | ecked the wander guard  |                     | guidance to initiate safety  | -                                 |                           |
|                          | system to the front do<br>functioned and then p        |   |                     | as deemed appropriate to potential for leaving the C                         |                                   |                           |
|                          |  | rther stated he was notified  |                     | unsupervised. Per this po  |                                   |                           |
|                          |  | ident #5 left the facility  |                     | the appropriate assessme   |                                   |                           |
|                          |  | I not have a wander guard in  |                     | 3) Nursing Policy and Pi   |                                   |                           |
|                          | place at the time of exit. All other exit doors to the |   |                     | Potential Transfer/Dischar   |                                   |                           |
|                          | outside were observe                                   | ed with egress bars that  |                     | Behavior, which states Dis   |                                   |                           |
|                          | alarmed when the ba                                    | -   |                     | planning staff, in conjuncti   |                                   |                           |
|                          |  | stated the exit doors with  |                     | Administrator and designa  | -                                 |                           |
|                          | egress bars were mo                                    |   |                     | will evaluate patients who   |                                   |                           |
|                          |  | ich documented each time<br>pushed. Review of the                                     |                     | untoward behaviors. Imm<br>the Administrator, DON or                         |                                   |                           |
|                          |  | Frevealed the egress bar  |                     | Supervisor. Proper investi   |                                   |                           |
|                          |  | e 200 hall where Resident   |                     | be directed by the Adminis   | •                                 |                           |
|                          | #5 resided.  |   |                     | is reason that the patient i   |                                   |                           |
|                          |  |   |                     | self or others then a review   | -                                 |                           |
|                          | A physician's interview                                | w occurred on 03/27/14 at   |                     | record with the licensed n   | urse, CNA and                     |                           |
|                          |  | ed that when Resident #5  |                     | interview with patient/resp  |                                   |                           |
|                          |  | 12/14 the physician had   |                     | determine what triggers th   | •                                 |                           |
|                          | concerns that the Res                                  |   |                     | bath time, time of day, roc  | -                                 |                           |
|                          | -  | ed a memory care unit. The ed she did not verbally share                              |                     | noise, difficulty hearing/ur fear, unfamiliar caregivers                     | -                                 |                           |
|                          |  | but expected staff to review  |                     | surroundings). (3/28/14)   |                                   |                           |
|                          | the progress note and                                  | •   |                     | 4) Nursing Policy and P  |                                   |                           |
|                          | recommendation.  | -   |                     | Code Orange, which cove  |                                   |                           |
|                          |  |   |                     | immediate notification of a  | a missing                         |                           |
|                          | On 03/27/14 at 09:04                                   |   |                     | resident, Code Orange wi   |                                   |                           |
|                          |  | red for Resident #5 on  |                     | throughout the Center. Al  |                                   |                           |
|                          | -  | -11 PM shift. NA #2 stated  |                     | search and recover plans   |                                   |                           |
|                          |  | nt #5 in bed at the beginning   |                     | in full force to locate and s  |                                   |                           |
|                          |  | ent most of the shift in his<br>nat around 9:00 PM "out of                            |                     | resident as quickly as pos<br>will be pre-assigned and t                     |                                   |                           |
|                          | TUUTTI. INA #2 STATEU LI                               |   | 1                   |  |                                   | 1                         |

Facility ID: 955030

If continuation sheet Page 6 of 18

|                          |                                     | ND HUMAN SERVICES   |                     |  | PRINTED: 09/29/2<br>FORM APPROV                  |
|--------------------------|-------------------------------------|---|---------------------|--|--|
| TATEMENT C               | S FOR MEDICARE &<br>DF DEFICIENCIES | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:            |                     |  | OMB NO. 0938-03<br>(X3) DATE SURVEY<br>COMPLETED |
|                          |                                     |   |                     |  | с  |
|                          |                                     | 345471  | B. WING             |  | 03/29/2014                                       |
| NAME OF PF               | ROVIDER OR SUPPLIER                 |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |
|                          | IBURG HEALTH & REHA                 |   |                     | 2415 SANDY PORTER ROAD   |  |
|                          |                                     | ABILITATION CENTER  |                     | CHARLOTTE, NC 28273  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                     | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | IOULD BE COMPLETIO                               |
| F 323                    | Continued From near                 |   | <b>F</b> 000        |  |  |
|                          |                                     |   | F 323               |  |  |
|                          |                                     | stated the Resident was   |                     | critical event. (3/28/14)  | "1000  |
|                          |                                     | eaving" because he took off   |                     | 5) Nursing Policy and Procedu  |  |
|                          |                                     | himself in pants and a shirt  |                     | Search and Reporting, in the ev  |  |
|                          |                                     | nallway. NA #2 informed   |                     | resident is reported missing, all  |  |
|                          |                                     | n the hall administering sident's behavior. Nurse #4                                  |                     | find the resident as quickly as po   |  |
|                          |                                     | ncourage Resident #5 to put   |                     | Anyone that suspects or realizes   |  |
|                          |                                     | and to tell the Resident it   |                     | resident is missing must notify a  |  |
|                          |                                     | 2 then reported that she  |                     | nurse and/or the Nursing Super-  |  |
|                          | -                                   | ent back to his room, asked   |                     | immediately. A Nursing Supervi   |  |
|                          |                                     | as back on, but he refused.   |                     | duty must immediately initiate a   |  |
|                          |                                     | urse that he was in his   |                     | the Center and grounds, and at   |  |
|                          | room, but that he refu              | used to put his pajamas back  |                     | time report to the Administrator,  |  |
|                          |                                     | d she began her rounds  |                     | Director of Nursing and Nurse C  |  |
|                          | around 9:30 PM cheo                 | cking/changing residents. NA  |                     | that the resident is missing. (3/  | 28/14)   |
|                          | #2 stated she did not               | see Resident #5 for the   |                     | " On 3/27/2014 Risk Meeting  | held   |
|                          | remainder of her shift              | t which ended 11:00 PM. NA  |                     | consisting of Interdepartmental t  | eam  |
|                          | #2 also added that at               | the end of the shift she was  |                     | members, RN Nurse Consultant   | , Director                                       |
|                          | unable to walk down                 | the hall to the room of   |                     | of Nursing, Minimum Data Set R   | RN and RN  |
|                          | Resident #5 because                 | the floor was being waxed   |                     | Unit Manager and all in-house re   |  |
|                          |                                     | hall to the other. NA #2  |                     | Wandering Assessments review   | ed and   |
|                          | -                                   | port off to the oncoming NA   |                     | updated as needed. (3/28/14)   |  |
|                          |                                     | 7 AM NA assignment had  |                     | " Wander risk care plans wer   | •  |
|                          | not been completed                  | prior to her leaving shift.   |                     | to include appropriate intervention  |  |
|                          | On 02/27/14 at 00:00                | AM purpo #2 stated in   |                     | Pictures of residents at risk for e  | -  |
|                          |                                     | 2 AM, nurse #2 stated in<br>red for Resident #5 on                                    |                     | were added as needed to binder<br>nurse s station and secured be                                   |  |
|                          |                                     | 11 PM - 7 AM shift. Nurse #2  |                     | receptionist desk. All new staff   |  |
|                          | stated that she was fa              |   |                     | receive education on this binder   |  |
|                          |                                     | . She described him as  |                     | general orientation. (4/21/14)   | Same   |
|                          | •                                   | rected and independent with   |                     | " Housekeeping will strip and  | wax  |
|                          |                                     | but that he did not have a  |                     | hallways in halves to allow pass   |  |
|                          | -                                   | e. Nurse #2 stated on   |                     | walking rounds. This will remain   | •  |
|                          |                                     | 5 was moved to a new room   |                     | with no end date. (ongoing)  |  |
|                          |                                     | ch seemed to cause him  |                     |  |  |
|                          |                                     | Nurse #2 stated after the   |                     | Measures in place to ensure pra  | ictices will                                     |
|                          |                                     | nt #5 walked to the door of   |                     | not occur.   |  |
|                          | -                                   | allway and asked staff if he  |                     | " As a routine practice, visual  | rounds   |
|                          |                                     | , but he never expressed a  |                     | and cross shift communication v  |  |

Facility ID: 955030

If continuation sheet Page 7 of 18

|                          | S FOR MEDICARE &                                |  |               |  |                                      | O. 0938-03 |
|--------------------------|---|--|---------------|--|--------------------------------------|------------|
|                          | OF DEFICIENCIES                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:      |               |  |                                      | E SURVEY   |
|                          |   |  | A. BUILDING   | <u> </u>   |                                      | <u>_</u>   |
|                          |   | 345471   | B. WING       |  |                                      | С          |
|                          | ROVIDER OR SUPPLIER                             |  |               | STREET ADDRESS, CITY, STATE, ZIF                       |                                      | 3/29/2014  |
|                          |   |  |               | 2415 SANDY PORTER ROAD                                 | GODE                                 |            |
| MECKLEN                  | BURG HEALTH & REHA                              | BILITATION CENTER  |               | CHARLOTTE, NC 28273                                    |                                      |            |
|                          | SUMMARY ST                                      | ATEMENT OF DEFICIENCIES                                    | ID            | PROVIDER'S PLAN (                                      |                                      | (X5)       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                 | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG | (EACH CORRECTIVE A<br>CROSS-REFERENCED TO<br>DEFICIE   | CTION SHOULD BE<br>O THE APPROPRIATE | COMPLETIC  |
| F 323                    | Continued From page                             | e 7  | F 32          | 3  |                                      |            |
|                          | desire to leave the fa                          | cility. Nurse #2 stated that                               |               | done by nursing every sh                               | nift to observe                      |            |
|                          | although she describe                           |  |               | and ensure all residents                               |                                      |            |
|                          |   | irse's notes, she did not see                              |               | for. This will be reviewed                             | -                                    |            |
|                          |   | iring further interventions to                             |               | Management Meeting on                                  |                                      |            |
|                          |   | ecause Resident #5 was                                     |               | and through quarterly QA                               | A as needed.                         |            |
|                          | -   | se #2 described the events e came on shift and stated      |               | (4/21/14)<br>As a routine practice                     | the Maintenance                      |            |
|                          |   | uct walking rounds on the                                  |               | director or designee will t                            |                                      |            |
|                          |   | ecause the entire hall was                                 |               | daily and reviewed during                              |                                      |            |
|                          |   | #2 stated that the shift                                   |               | Meeting. (4/21/14)                                     | g treenly then                       |            |
|                          | -   | include specifics about the                                |               | " On 3/27/2014 all sta                                 | ff were                              |            |
|                          | location of Resident #                          | #5 nor a report of any new                                 |               | in-serviced by Director of                             |                                      |            |
|                          | behavior; she just assumed he was in his room.  |  |               | Development Coordinato                                 |                                      |            |
|                          | Nurse #2 began the med pass on an adjacent hall |  |               | and one done by the Reg                                |                                      |            |
|                          | and reached the hall of Resident #5 around      |  |               | President of Operations of                             | -                                    |            |
|                          |   | yet visualized him during<br>progressed down the hall of   |               | policies and procedures t<br>understanding. New hire   |                                      |            |
|                          |   | ed that her med pass was                                   |               | educated during general                                |                                      |            |
|                          |   | one call from the hospital                                 |               | staff will be in-serviced be                           |                                      |            |
|                          |   | 03/20/14. She was asked by                                 |               | work. (3/27/14)  |                                      |            |
|                          |   | nt #5 was still a Resident in                              |               | 1) Nursing Policy and F                                | Procedure #401,                      |            |
|                          | the facility and then a                         | dvised that he had been                                    |               | Behavioral Assessment/E                                | Behavior                             |            |
|                          | •   | al by EMS transport called by                              |               | Monitoring, which states                               |                                      |            |
|                          |   | tal informed nurse #2 that                                 |               | behavior shall be assess                               |                                      |            |
|                          | -   | ood condition and would be                                 |               | monitored. Factors influe                              | •                                    |            |
|                          | -   | ne facility. Nurse #2 stated it                            |               | as well as management i                                |                                      |            |
|                          |   | staff ran to the room of<br>ed he was not there. Nurse     |               | shall be evaluated and ca<br>Under this policy Resider |                                      |            |
|                          |   | 5 was returned to the facility                             |               | observed by staff on all s                             |                                      |            |
|                          |   | 05:00 AM on 03/20/14. The                                  |               | immediately report any u                               |                                      |            |
|                          |   | n completed a head-to-toe                                  |               | (untoward meaning unus                                 |                                      |            |
|                          |   | h no new findings noted,                                   |               | behavior that is observed                              |                                      |            |
|                          |   | rd on the Resident and                                     |               | nurse. On 03/28/2014 th                                | •                                    |            |
|                          | contacted the DON.                              |  |               | immediately began in-ser                               |                                      |            |
|                          | 0= 00/07/4 4 =1 44 04                           |  |               | wandering/elopement ris                                |                                      |            |
|                          | On 03/27/14 at 11:04                            |  |               | form. Department Heads                                 |                                      |            |
|                          |   | aled she completed the<br>nt Risk Assessment dated         |               | Administration re-in servi<br>the Stop and Watch Tool  |                                      |            |
|                          | wanuenny/Ei0pelliel                             | ILI NON MODEDOILICHT UALEU                                 | 1             |  |                                      | 1          |

Facility ID: 955030

If continuation sheet Page 8 of 18

|                          |                                 |   |                     |   |                                   | O. 0938-03                |
|--------------------------|---------------------------------|---|---------------------|---|-----------------------------------|---------------------------|
|                          | OF DEFICIENCIES<br>F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | . ,                 | PLE CONSTRUCTION G  | . ,                               | E SURVEY<br>IPLETED       |
|                          |                                 |   |                     |   |                                   | С                         |
|                          |                                 | 345471  | B. WING             |   | 03                                | 8/29/2014                 |
| NAME OF P                | ROVIDER OR SUPPLIER             |   |                     | STREET ADDRESS, CITY, STATE, ZIP  | CODE                              |                           |
| MECKLEN                  | NBURG HEALTH & REHA             | BILITATION CENTER   |                     | 2415 SANDY PORTER ROAD  |                                   |                           |
|                          |                                 |   |                     | CHARLOTTE, NC 28273   |                                   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                 | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETIO<br>DATE |
| F 323                    | Continued From page             | e 8   | F 32                | 23  |                                   |                           |
|                          |                                 | 1 stated she reviewed the   |                     | communicate changes in  | patients, even                    |                           |
|                          |                                 | ecord to include the hospital   |                     | subtle changes and comm   |                                   |                           |
|                          | records, but found no           | -   |                     | changes to nursing staff ir   |                                   |                           |
|                          |                                 | t behavior in the Resident's  |                     | that appropriate interventi   |                                   |                           |
|                          | medical record, thus            | interventions were not  |                     | in place. (3/28/14)   |                                   |                           |
|                          |                                 | stated she remembered that  |                     | 2) Policy and Procedure   |                                   |                           |
|                          |                                 | abit of coming out of his   |                     | Safety/Security Systems (   |                                   |                           |
|                          |                                 | f to help him locate the  |                     | which states Residents id   |                                   |                           |
|                          |                                 | n, but because he was easily  |                     | risk for wandering away fr  |                                   |                           |
|                          | redirected, this behave         | eking. Nurse #1 stated she  |                     | will have the least restricti<br>device is in use. This poli                | •                                 |                           |
|                          | -                               | in the facility on 03/19/14 on  |                     | guidance to initiate safety   |                                   |                           |
|                          | -                               | ft, but was not assigned to   |                     | as deemed appropriate to  | -                                 |                           |
|                          |                                 | and did not see him during  |                     | potential for leaving the C   |                                   |                           |
|                          | her shift.                      | 0   |                     | unsupervised. Per this po   |                                   |                           |
|                          |                                 |   |                     | the appropriate assessme  | ents. (3/28/14)                   |                           |
|                          |                                 | AM, the DON stated in   |                     | 3) Nursing Policy and P   |                                   |                           |
|                          | interview that on adm           |   |                     | Potential Transfer/Dischar  |                                   |                           |
|                          |                                 | pement by asking the  |                     | Behavior, which states Dis  |                                   |                           |
|                          | -                               | wing hospital records, the FL   |                     | planning staff, in conjunct   |                                   |                           |
|                          | -                               | ning tool) and making   |                     | Administrator and designa   |                                   |                           |
|                          |                                 | esident. The DON stated the   |                     | will evaluate patients who  |                                   |                           |
|                          | -                               | ndering/Elopement Risk<br>ally completed by the                                       |                     | untoward behaviors. Imm<br>the Administrator, DON or                        |                                   |                           |
|                          |                                 | 11 PM - 7 AM nurse. The   |                     | Supervisor. Proper investi  | -                                 |                           |
|                          | -                               | spoke to the PoA when   |                     | be directed by the Adminis  |                                   |                           |
|                          |                                 | nitted, but no history of   |                     | is reason that the patient i  |                                   |                           |
|                          |                                 | t behavior was indicated.   |                     | self or others then a revie   | •                                 |                           |
|                          |                                 | ed that she expected a  |                     | record with the licensed n  | •                                 |                           |
|                          | -                               | mplemented if there was a   |                     | interview with patient/resp   |                                   |                           |
|                          | -                               | g behavior or if a resident   |                     | determine what triggers th  | -                                 |                           |
|                          |                                 | b leave the facility. The DON   |                     | bath time, time of day, roc   |                                   |                           |
|                          |                                 | the expressed desire to   |                     | noise, difficulty hearing/ur  | •                                 |                           |
|                          |                                 | easily redirected, she would ention of a wander guard in                              |                     | fear, unfamiliar caregivers<br>surroundings). (3/28/14)                     |                                   |                           |
|                          |                                 | expect this intervention if the   |                     | 4) Nursing Policy and P   |                                   |                           |
|                          |                                 | express a desire to leave   |                     | Code Orange, which cove   |                                   |                           |
|                          |                                 | r or not the behavior was   |                     | immediate notification of a   |                                   |                           |
|                          | easily redirected. The          |   |                     | resident, Code Orange wi  | -                                 |                           |

Facility ID: 955030

If continuation sheet Page 9 of 18

|                          | OF DEFICIENCIES                                | MEDICAID SERVICES   | (X2) MULTIF         | LE CONSTR |  | OMB NO |                           |
|--------------------------|--|---|---------------------|-----------|--|--------|---------------------------|
|                          | CORRECTION                                     | IDENTIFICATION NUMBER:  | A. BUILDING         |           |  | COMPL  |                           |
|                          |  |   |                     |           |  |        | 2                         |
|                          |  | 345471  | B. WING             |           |  |        | 29/2014                   |
| NAME OF PI               | ROVIDER OR SUPPLIER                            |   |                     | STREETAD  | DDRESS, CITY, STATE, ZIP CODE  | 00/1   |                           |
|                          |  |   |                     | 2415 SAN  | DY PORTER ROAD   |        |                           |
| MECKLEN                  | NBURG HEALTH & REHA                            | ABILITATION CENTER  |                     | CHARLO    | NTTE, NC 28273   |        |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG |           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |        | (X5)<br>COMPLETIO<br>DATE |
| F 323                    | Continued From page                            | e 9   | F 32                | 23        |  |        |                           |
|                          |  | regular rounds for all  |                     |           | ghout the Center. All established  |        |                           |
|                          | residents and especi                           | •   |                     |           | ch and recover plans will be initiate  | ed     |                           |
|                          |  | t. The DON further revealed   |                     |           | I force to locate and secure the   |        |                           |
|                          | <b>.</b>                                       | e physician to provide  |                     | resid     | ent as quickly as possible. All sta  | ff     |                           |
|                          |  | bal instruction regarding   |                     | will b    | e pre-assigned and trained on the  | ir     |                           |
|                          |  | om their assessments, hand  |                     |           | s and responsibilities during this   |        |                           |
|                          |  | the new order into the  |                     |           | al event. (3/28/14)  |        |                           |
|                          | -  | also stated that nursing staff  |                     |           | Nursing Policy and Procedure #18   | 02,    |                           |
|                          |  | ysician's progress notes, but   |                     |           | ch and Reporting, in the event a   | 1.0    |                           |
|                          |  | d physician orders should be<br>staff. The DON reviewed                               |                     |           | ent is reported missing, all availab<br>urces will be utilized to search for a   |        |                           |
|                          |  | an's progress note regarding  |                     |           | he resident as quickly as possible.  |        |                           |
|                          | the recommendation of a memory care unit for   |   |                     |           | me that suspects or realizes that a  |        |                           |
|                          | Resident #5 and stated the charge nurse should |   |                     |           | ent is missing must notify a license   |        |                           |
|                          |  | nd brought it to the attention  |                     |           | e and/or the Nursing Supervisor  |        |                           |
|                          | of nurse administration                        | on for further evaluation of  |                     | imme      | ediately. A Nursing Supervisor on  |        |                           |
|                          | placement.                                     |   |                     |           | must immediately initiate a search   |        |                           |
|                          |  |   |                     |           | Center and grounds, and at the sar   | ne     |                           |
|                          |  | AM, nurse #4 stated in  |                     |           | report to the Administrator, the   |        |                           |
|                          |  | ically worked with Resident   |                     |           | ctor of Nursing and Nurse Consulta   | ant    |                           |
|                          |  | nift. She described Resident  |                     |           | the resident is missing. (3/28/14)   |        |                           |
|                          |  | cooperative. Nurse #4 stated  |                     |           | Pictures of residents at risk for  |        |                           |
|                          |  | ht he approached the<br>d 9:00 PM or 10:00 PM   |                     |           | ement were added as needed to<br>ers at each nurse⊡s station and   |        |                           |
|                          |  | his room, car keys, or the  |                     |           | red behind the receptionist desk.  |        |                           |
|                          | bathroom. Nurse #4                             |   |                     |           | 3/14) All new staff will receive   |        |                           |
|                          |  | /hen Resident #5 was moved  |                     |           | ation on this binder during general  |        |                           |
|                          | to a new room on the                           | e same hall. The nurse stated   |                     |           | tation. (ongoing)  |        |                           |
|                          |  | ily redirected and not  |                     |           | Housekeeping will strip and wax  |        |                           |
|                          |  | ing or exit seeking. The  |                     |           | ays in halves to allow passage for   |        |                           |
|                          |  | the evening of 03/19/14,  |                     |           | ng rounds. This will remain in effe  | ct     |                           |
|                          |  | is room when she came on  |                     | with r    | no end date. (ongoing)   |        |                           |
|                          |  | stayed in his room most of  |                     | How       | the facility plane to manitor and  |        |                           |
|                          |  | ated that around 9:05 PM on<br>5 walked from his room to                              |                     |           | the facility plans to monitor and re correction is achieved and  |        |                           |
|                          |  | ring pajamas and confused   |                     |           | ained.   |        |                           |
|                          |  | his room; she redirected him  |                     |           | Administrator/Director of Nursing v  | vill   |                           |
|                          |  | ered medication to him and  |                     |           | ent the results of daily and weekly  |        |                           |
|                          |  | ass. Around 9:30 PM on  |                     |           | s to the QA Committee quarterly for  |        |                           |

Facility ID: 955030

If continuation sheet Page 10 of 18

| TATEMENT (               | OF DEFICIENCIES   | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIP | LE CONSTRUCTION                               |                 | IO. 0938-03<br>TE SURVEY  |
|--------------------------|---|--|-------------|---|-----------------|---------------------------|
| ND PLAN OF               | CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING |   | CON             | <b>MPLETED</b>            |
|                          |   | 245474   |             |   |                 | С                         |
|                          |   | 345471   | B. WING     |   |                 | 3/29/2014                 |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |             | STREET ADDRESS, CITY, STATE, ZIP COE          | )E              |                           |
| MECKLEN                  | IBURG HEALTH & REHA   | BILITATION CENTER  |             | 2415 SANDY PORTER ROAD<br>CHARLOTTE, NC 28273 |                 |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CC       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE DEFICIENCY) |             |   |                 | (X5)<br>COMPLETIC<br>DATE |
| E 000                    | 0 11 15   | 10   |             | -   |                 |                           |
|                          | Continued From page   |  | F 32        |   |                 |                           |
|                          |   | tated she saw Resident #5  |             | period of at least two quarters               |                 |                           |
|                          | in his room fully dressed, no longer wearing<br>pajamas, but wearing pants, a shirt and shoes<br>and asked NA #2 to encourage Resident #5 to<br>put his pajamas back on. The nurse stated she |  |             | of continued compliance/revision needed.      | sion to plan if |                           |
|                          |   |  |             | needed.                                       |                 |                           |
|                          |   |  |             |   |                 |                           |
|                          |   | ervisor's office, closed the   |             |   |                 |                           |
|                          | •   | mplete her nurse charting.   |             |   |                 |                           |
|                          |   | that NA #2 told her that   |             |   |                 |                           |
|                          |   | is room, but refused to put  |             |   |                 |                           |
|                          |   | and she told the NA "okay."<br>remained in the supervisor's  |             |   |                 |                           |
|                          |   | report to the oncoming nurse   |             |   |                 |                           |
|                          | at 11:00 PM. Nurse #4 stated she could not  |  |             |   |                 |                           |
|                          | account for the locati  | on of Resident #5 after  |             |   |                 |                           |
|                          |   | /19/14 because she did not   |             |   |                 |                           |
|                          |   | ds at the end of shift since   |             |   |                 |                           |
|                          |   | axed. Nurse #4 further   |             |   |                 |                           |
|                          |   | ot aware that Resident #5<br>at he was leaving the facility,   |             |   |                 |                           |
|                          |   | rted to her that Resident #5   |             |   |                 |                           |
|                          | -   | n his pajamas, she should  |             |   |                 |                           |
|                          | have gone in to talk t  | o him. The nurse stated she  |             |   |                 |                           |
|                          |   | see this behavior all the  |             |   |                 |                           |
|                          |   | d Resident #5 did not have a   |             |   |                 |                           |
|                          | ÷ .   | e, nor did she assess his  |             |   |                 |                           |
|                          | room fully dressed.   | hen she noticed him in his   |             |   |                 |                           |
|                          | On 03/27/14 at 12:10  | PM, nurse #5 was   |             |   |                 |                           |
|                          |   | aled that she cared for  |             |   |                 |                           |
|                          |   | AM - 3 PM shift. She   |             |   |                 |                           |
|                          |   | 5 as confused, pretty quiet,   |             |   |                 |                           |
|                          | Nurse #5 stated that  | without a wander guard.  |             |   |                 |                           |
|                          |   | resident's she reviewed the  |             |   |                 |                           |
|                          |   | y new orders, but did not  |             |   |                 |                           |
|                          | always review the pro   |  |             |   |                 |                           |
|                          | recommendations. N  | -  |             |   |                 |                           |
|                          | physician's progress  |  |             |   |                 |                           |

Facility ID: 955030

If continuation sheet Page 11 of 18

|                          | -  | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                    |     |   | FOR              | D: 09/29/2014<br>M APPROVED<br>D. 0938-0391 |  |
|--------------------------|--|--|--------------------|-----|---|------------------|---|--|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION  | (X3) DATE<br>COM | E SURVEY<br>PLETED                          |  |
|                          |  | 345471   | B. WING            |     |   |                  | C<br>/ <b>29/2014</b>                       |  |
|                          | ROVIDER OR SUPPLIER  | ABILITATION CENTER   |                    | 2   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>415 SANDY PORTER ROAD<br>CHARLOTTE, NC 28273                            |                  |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE             | (X5)<br>COMPLETION<br>DATE                  |  |
| F 323                    | Resident #5 and state<br>reviewing the progress<br>not notice the physici-<br>placement in a memory<br>stated had she notice<br>have recommended a<br>#5 and communicate<br>consideration of place<br>On 03/27/14 at 1:46 H<br>interviewed and state<br>about 9:00 PM on 03<br>and began waxing se<br>hall about 10:30 PM.<br>he did not see Reside<br>waxing the floor.<br>On 03/27/14 at 4:30 H<br>police station reveale<br>miles away from the<br>lane, 4-way intersect<br>miles per hour.<br>The facility's Adminis<br>Nurse Consultant and<br>Operations were noti<br>on 03/27/14 at 4:55 F<br>facility provided a cre<br>compliance on 03/29<br>following intervention<br>facility to remove the<br>Credible Allegation of<br>This allegation of cor<br>compliance with appl<br>To demonstrate conti<br>applicable law, the ce<br>the actions set forth i | ed she remembered<br>as note previously, but did<br>an's recommendation for<br>ory care unit. Nurse #5<br>ed that comment, she would<br>a wander guard for Resident<br>d it to her supervisor for<br>ement.<br>PM, floor technician #1 was<br>ed that he came to work<br>/19/14, gathered supplies<br>ections of the floor on the 200<br>Floor technician #1 stated<br>ent #5 in his room while<br>PM an observation of the<br>ed it was approximately 0.8<br>facility and across from a 7<br>ion, with a speed limit of 45<br>trator, Director of Nursing,<br>d Vice President of Clinical<br>fied of Immediate Jeopardy<br>PM for Resident #5. The<br>edible allegation of<br>/14 at 3:39 PM. The<br>s were put into place by the<br>Immediate Jeopardy. | F                  | 323 |   |                  |   |  |

If continuation sheet Page 12 of 18

|   | -   | D HUMAN SERVICES<br>MEDICAID SERVICES  |  |     |  |               | FORM   | ): 09/29/2014<br>1 APPROVED |
|---|---|--|--|-----|--|---------------|--|-----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  |               | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED |                             |
|   |   | 345471   | B. WING                                |     |  |               | C<br>03/29/2014                                    |                             |
| NAME OF PF  | ROVIDER OR SUPPLIER   |  | I                                      | S   | TREET ADDRESS, CITY, STATE, ZIP  | CODE          |  |                             |
| MECKLEN   | IBURG HEALTH & REHA   | BILITATION CENTER  |  |     | 415 SANDY PORTER ROAD  |               |  |                             |
|   |   |  |  | C   | HARLOTTE, NC 28273   |               |  |                             |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG                      |     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD B |  | (X5)<br>COMPLETION<br>DATE  |
| F 323   | Continued From page   | 12   | F                                      | 323 |  |               |  |                             |
|   | constitutes the center  | 's allegation of compliance.<br>s have been or will be   |  |     |  |               |  |                             |
|   | How the corrective ac<br>for those residents for<br>by the deficient practic<br>On 3/20/2014 Re<br>12:05 a.m. was report<br>hospital nurse reporter<br>nurse that the Police I<br>resident walked to the<br>ride home. The police<br>attempted to take him<br>Both of the locations of<br>addresses for the resi<br>police realized the resi<br>confused. Emergency<br>called and the resident<br>hospital. The resident<br>ED, and it was determ<br>was experienced by th<br>confirmed by facility n<br>Power of Attorney<br>transfer resident #5 to<br>3/28/14 as previously<br>longer in the facility. | tion will be accomplished<br>und to have been affected<br>ce:<br>sident # 5 at approximately<br>ted to be at the hospital. The<br>do our facility charge<br>Department, reported our<br>eir station and asked for a<br>assisted the resident. They<br>to two different locations .<br>were the incorrect home<br>dent. It was at this point the<br>sident was possibly<br>y Medical Services was<br>at was transported to the<br>was evaluated by hospital<br>nined no trauma or injury<br>he resident, which was<br>urse upon his return.<br>y for Resident #5 decided to |  |     |  |               |  |                             |
|   | him upon return to the<br>Nursing did every 30<br>a.m. to 0600 p.m. on<br>On 03/21/2014 re  | e facility and the Director of<br>minute checks from 0700<br>03/20/2014.<br>esident #5 Wandering and   |  |     |  |               |  |                             |
|   | ensure appropriate in<br>All staff was in-se<br>"code orange" includin<br>patient rounding, and<br>On 3/20/14 main  | ssment was re-evaluated to<br>terventions were in place.<br>erviced on 3/20/2014 for<br>ng elopement procedures,<br>responding to alarms.<br>tenance director contacted<br>any who performed in  |  |     |  |               |  |                             |

Facility ID: 955030

If continuation sheet Page 13 of 18

| -   |  |   |  |  | FORM   | ): 09/29/2014<br>1 APPROVED<br>0 0938-0391   |
|---|--|---|--|--|--|--|
| (X1) F  | ROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |  |  | (X3) DATE SURVEY<br>COMPLETED  |  |
|   | 345471   | B. WING   |  | _  |  | )<br>29/2014   |
|   |  |   | STREET ADDRESS, CITY, S  | TATE, ZIP CODE   | -  |  |
| MECKLENBURG HEALTH & REHABILITATION CENTER  |  |   |  |  |  |  |
| IENCY MUST  | BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG   | (EACH CORRE<br>CROSS-REFERE  | CTIVE ACTION SHOULD BI<br>NCED TO THE APPROPRIA  |  | (X5)<br>COMPLETION<br>DATE   |
| Il doors a<br>d to be pr<br>e: An eve<br>wed two a<br>100 hall. E<br>practice f<br>nee will te<br>practice, I<br>in halves<br>ction will b<br>ving poter<br>t practice<br>of Nursing<br>and verif<br>or.<br>practice, V<br>on will be<br>eting on a<br>QA as ne<br>4, under th<br>with a wa<br>r placeme<br>ponding t<br>ne mainte<br>practice on<br>elopeme<br>ponding t<br>ne mainte<br>ponding t<br>ne mainte<br>practice on<br>elopeme<br>ponding t | operly working with no<br>ant history report of the<br>alarms were signaled<br>both were accounted<br>the Maintenance<br>est door alarms daily.<br>Housekeeping will strip<br>to allow passage for<br>be accomplished for<br>ntial to be affected by<br>:<br>g (DON) arrived at the<br>ied that all residents<br><i>v</i> isual rounds and cross<br>done by nursing every<br>all residents are<br>reviewed in Risk<br>weekly basis and<br>eded.<br>ne direction of DON, all<br>nder guard in place<br>ent. All were in place.<br>3/20/2014 for "code<br>int procedures, patient<br>o alarms.<br>nance director<br>Company who<br>of all doors and<br>re found to be properly<br>tice the Maintenance<br>est door alarms daily.<br>dents in house on this<br>ement Risk<br>uated and revised as   | F 32  | 3  |  |  |  |
|   | E & MEDI<br>(X1) F<br>(X1) F | REHABILITATION CENTER<br>RY STATEMENT OF DEFICIENCIES<br>CIENCY MUST BE PRECEDED BY FULL<br>Y OR LSC IDENTIFYING INFORMATION)<br>page 13<br>all doors and alarms. All door<br>nd to be properly working with no<br>te: An event history report of the<br>bowed two alarms were signaled<br>100 hall. Both were accounted<br>a practice the Maintenance<br>gnee will test door alarms daily.<br>practice, Housekeeping will strip<br>in halves to allow passage for<br>ction will be accomplished for<br>aving potential to be affected by<br>ht practice:<br>of Nursing (DON) arrived at the<br>4 and verified that all residents | E & MEDICAID SERVICES       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTIPL<br>A. BUILDING         345471       B. WING         345471       B. WING         REHABILITATION CENTER       ID<br>PREFIX<br>TAG         RY STATEMENT OF DEFICIENCIES<br>IENCY MUST BE PRECEDED BY FULL<br>Y OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG         page 13       F 323         all doors and alarms. All door<br>nd to be properly working with no<br>te: An event history report of the<br>powed two alarms were signaled<br>100 hall. Both were accounted<br>e practice. Housekeeping will strip<br>s in halves to allow passage for         ction will be accomplished for<br>trying potential to be affected by<br>nt practice:<br>of Nursing (DON) arrived at the<br>4 and verified that all residents<br>for.<br>practice, visual rounds and cross<br>ion will be done by nursing every<br>ind ensure all residents are<br>his will be reviewed in Risk<br>eting on a weekly basis and<br>"OA as needed.         4, under the direction of DON, all<br>with a wander guard in place<br>or placement. All were in place.<br>erviced on 3/20/2014 for "code<br>g elopement procedures, patient<br>sponding to alarms.<br>he maintenance director<br>onitoring Company who<br>ise testing of all doors and<br>alarms were found to be properly<br>utine practice to alarms daily.<br>14 all residents in house on this<br>and Elopement Risk<br>re re-evaluated and revised as | E & MEDICAID SERVICES       (X1) PROVIDER/SUPPLEVICUA<br>IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING         345471       B. WING         345471       B. WING         REHABILITATION CENTER       STREET ADDRESS, CITY, ST<br>2415 SANDY PORTER RO<br>CHARLOTE, NC 2827         RY STATEMENT OF DEFICIENCIES<br>INFOLVINGS THE PRECEDED BY FULL<br>(OR LSC IDENTIFYING INFORMATION)       PROVIDER'S<br>(EACH CORRE<br>TAG         page 13       F 323         all doors and alarms. All door<br>do to be properly working with no<br>te: An event history report of the<br>bowed two alarms were signaled<br>100 hall. Both were accounted<br>a practice He Maintenance<br>innee will test door alarms daily.<br>practice, Housekeeping will strip<br>s in halves to allow passage for       F 323         ction will be accomplished for<br>twing potential to be affected by<br>th practice;<br>of Nursing (DON) arrived at the<br>4 and verified that all residents<br>for.<br>practice, visual rounds and cross<br>ion will be done by nursing every<br>ind ensure all residents are<br>his will be reviewed in Risk<br>eting on a weekly basis and<br>QA as needed.<br>4, under the direction of DON, all<br>with a wander guard in place<br>or placement. All were in place.<br>proviced on 3/20/2014 for "code<br>g elopement procedures, patient<br>sponding to alarms.<br>he maintenance director<br>onitoring Company who<br>se testing of all doors and<br>alarms were found to be properly<br>utine practice the Maintenance<br>nee will test door alarms daily.<br>14 all residents in house on this<br>and Elopement Risk<br>re re-evaluated and revised as | E & MEDICAID SERVICES           (x1) PROVIDERSUPPLIERCLIA<br>IDENTIFICATION NUMBER:         (x2) MULTIPLE CONSTRUCTION<br>A BUILDING           345471         B. WING           345471         STREET ADDRESS, CITY, STATE, ZIP CODE<br>Zatis SANDY PORTER ROAD<br>CHARLOTTE, NC 28273           YSTATEMENT OF DEFICIENCES<br>VOR LSC IDENTIFYING INFORMATION)         ID<br>PREFX<br>TAG         PROVIDERS PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIL<br>DEFICIENCY)           page 13<br>all doors and alarms. All door<br>do to be properly working with no<br>te: An event history report of the<br>swed two alarms were signaled<br>100 hall. Both were accounted<br>practice, Housekeeping will strip<br>s in halves to allow passage for         F 323           ction will be accomplished for<br>twing potential to be affected by<br>th practice, Visual rounds and cross<br>for.         F<br>30202014 for "code<br>placement. All were in place.<br>practice, visual rounds and cross<br>for.           on will be done by nursing every<br>ind ensure all residents are<br>his will be reviewed in Risk<br>eting on a weekly basis and<br>QA as needed.<br>4, under the direction of DON, all<br>with a wander guard in place<br>or placement. All were in place.<br>projectores, patient<br>sponding to alarms.<br>he maintenance director<br>onitoring Company who<br>se testing of all doors and<br>alarms were found to be properly<br>utine practice the Maintenance<br>ever will used for alarms daily.<br>14 all residents in house on this<br>and Elopement Risk<br>re re-evaluated and revised as | 1 AND HUMAN SERVICES     FORM       2 MEDICAID SERVICES     OMB NC       (x) REVERVERUPPLERCUA     (x) |

|   |   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                   |  |  | FC              | FED: 09/29/2014<br>RM APPROVED<br>NO. 0938-0391 |  |
|---|---|--|-------------------|--|--|-----------------|---|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | EFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  |                   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |                 | (X3) DATE SURVEY<br>COMPLETED                   |  |
|   | 345471  |  | B. WING           |  |  | C<br>03/29/2014 |   |  |
| NAME OF PROVIDER OR SUPPLIER                        |   |  |                   | STR                                    | EET ADDRESS, CITY, STATE, ZIP CODE   | •               |   |  |
|   |   |  |                   | 2415                                   | SANDY PORTER ROAD  |                 |   |  |
| WECKLEP   | IBURG HEALTH & REHA   | BILITATION CENTER  |                   | CHA                                    | ARLOTTE, NC 28273  |                 |   |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | x                                      | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE        | (X5)<br>COMPLETION<br>DATE                      |  |
| F 323   | date, Wandering and<br>Assessments were re<br>Registered Nurse Mir<br>Coordinator. A facility<br>the front lobby by the<br>attempts by any resid<br>wander-guards were<br>03/27/2014 Initia<br>minute visual checks<br>residents that could b<br>Wandering Assessme<br>employee was posted<br>a.m. when all wander<br>in place.<br>On 3/27/2014 all<br>Director of Nursing, S<br>Coordinator, Unit Mar<br>Regional Vice Preside<br>following policies and<br>understanding. New<br>general orientation. | IDS) Coordinator.<br>III residents in house on this<br>Elopement Risk<br>e-evaluated by the DON and<br>himum Data Set (MDS)<br>y employee was posted in<br>door to monitor for any<br>lent to exit the facility until all<br>checked and in place.<br>Ily at 05:00 p.m. every 15<br>were completed on<br>be at risk based on<br>ent and then at 1100 p.m. and<br>d at the front door until 2:45<br>r-guards were verified to be<br>staff were in-serviced by<br>Staff Development<br>hager and one done by the<br>ent of Operations on the<br>I procedures to ensure<br>hires will be educated during<br>All staff will be in-serviced | F                 | 323                                    |  |                 |   |  |
|   | which states that prof<br>assessed and monito<br>behaviors as well as<br>shall be evaluated an<br>policy Residents will<br>shifts and during visu<br>will immediately repo<br>meaning unusual beh<br>observed to a license<br>and Nurse Administra<br>serviced all staff on 0<br>Watch Tool which is u  |  |                   |  |  |                 |   |  |

If continuation sheet Page 15 of 18

|   |  | ND HUMAN SERVICES<br>MEDICAID SERVICES                |                    |  |  | FC       | TED: 09/29/201<br>DRM APPROVE<br>NO. 0938-039 |  |
|---|--|---|--------------------|--|--|----------|---|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                    | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |          | (X3) DATE SURVEY<br>COMPLETED                 |  |
|   |  | 345471  | B. WING            |  |  |          | C<br>03/29/2014                               |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | •   |                    | STR                                    | EET ADDRESS, CITY, STATE, ZIP CODE   | •        |   |  |
| MECKLEI   | NBURG HEALTH & REHA  | ABILITATION CENTER                                    |                    |  | 5 SANDY PORTER ROAD<br>ARLOTTE, NC 28273   |          |   |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL                            | ID<br>PREFI<br>TAG | x                                      | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE                    |  |
| F 323   | ABURG HEALTH & REHABILITATION CENTER<br>SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)<br>Continued From page 15<br>to the licensed nurse, even subtle changes, and<br>communicate those changes to nursing staff<br>immediately so that appropriate interventions can<br>be put in place. On 03/28/2014 the facility also<br>began in-service for all staff on<br>wandering/elopement risk assessment form<br>which specifies the behavior of residents at risk<br>for elopement. The form provides the licensed<br>nurse with multiple interventions for residents at<br>risk of elopement including the use of wander<br>guards, frequent monitoring, use of diversion,<br>among others.<br>2) Policy and Procedure #1539, Safety/Security<br>Systems (Wandering), which states Residents<br>identified as at risk for wandering away from the<br>Center will have the least restrictive monitoring<br>device is in use. This policy gives guidance to<br>initiate safety/security devices as deemed<br>appropriate to minimize the potential for leaving<br>the Center unsupervised. Per this policy<br>complete the appropriate assessments.<br>3) Nursing Policy and Procedure #802, Potential<br>Transfer/Discharge Due to Behavior, which states<br>Discharge planning staff, in conjunction with the<br>Administrator and designated nursing staff will<br>evaluate patients who exhibit untoward behaviors.<br>Immediately notify the Administrator, DON or<br>Nursing Supervisor. Proper investigation report<br>will be directed by the Administrator. If there is<br>reason that the patient is a danger to self or<br>others then a review of the medical record with<br>the licensed nurse, CNA and interview with<br>patient/responsible party, to determine what<br>triggers the behavior (i.e. bath time, time of day,<br>room change, loud noise, difficulty<br>hearing/understanding, fear, unfamiliar<br>caregivers, unfamiliar surroundings).<br>4) Nursing Policy and Procedure # 1801, Code<br>Orange, which covers the immediate notification |   | F                  | 323                                    |  |          |   |  |

If continuation sheet Page 16 of 18

|   | STOR MEDICARE &                                     | MEDICAID SERVICES   |                     |                     | <u>0</u> M   | B NO. 0938-03             |
|---|---|---|---------------------|---------------------|--|---------------------------|
| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA<br>IND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | , ,   | PLE CONSTRUCTION    | (X3)                | (X3) DATE SURVEY<br>COMPLETED  |                           |
|   |   |   |                     |                     |  | С                         |
|   |   | 345471  | B. WING             |                     |  | 03/29/2014                |
| NAME OF P   | ROVIDER OR SUPPLIER                                 |   |                     | STREET ADDRESS, CIT | Y, STATE, ZIP CODE   |                           |
|   | BURG HEALTH & REH                                   | ABILITATION CENTER  |                     | 2415 SANDY PORTER   | ROAD   |                           |
|   |   |   |                     | CHARLOTTE, NC 2     | 8273   |                           |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC                                     | TATEMENT OF DEFICIENCIES<br>EY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (EACH CO            | DER'S PLAN OF CORRECTION<br>RRECTIVE ACTION SHOULD BE<br>ERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETIO<br>DATE |
| F 323   | Continued From page                                 | e 16  | F 3                 | 23                  |  |                           |
|   | -   | , Code Orange will be   |                     | 20                  |  |                           |
|   |   | the Center. All established   |                     |                     |  |                           |
|   |   | blans will be initiated in full   |                     |                     |  |                           |
|   |   | ecure the resident as quickly   |                     |                     |  |                           |
|   |   | will be pre-assigned and  |                     |                     |  |                           |
|   | trained on their duties and responsibilities during |   |                     |                     |  |                           |
|   | this critical event.                                |   |                     |                     |  |                           |
|   | 5) Nursing Policy a                                 | nd Procedure #1802, Search  |                     |                     |  |                           |
|   |   | event a resident is reported  |                     |                     |  |                           |
|   | -   | resources will be utilized to   |                     |                     |  |                           |
|   |   | ne resident as quickly as   |                     |                     |  |                           |
|   | -   | at suspects or realizes that a  |                     |                     |  |                           |
|   |   | nust notify a licensed nurse  |                     |                     |  |                           |
|   |   | upervisor immediately. A on duty must immediately                                       |                     |                     |  |                           |
|   |   | e Center and grounds, and   |                     |                     |  |                           |
|   |   | ort to the Administrator, the   |                     |                     |  |                           |
|   |   | nd Nurse Consultant that the  |                     |                     |  |                           |
|   | resident is missing.                                |   |                     |                     |  |                           |
|   |   | isk Meeting held consisting of  |                     |                     |  |                           |
|   |   | am members, RN Nurse  |                     |                     |  |                           |
|   | Consultant, Director                                | of Nursing, Minimum Data  |                     |                     |  |                           |
|   |   | Manager and all in-house  |                     |                     |  |                           |
|   | •   | Assessments reviewed and  |                     |                     |  |                           |
|   | updated as needed.                                  |   |                     |                     |  |                           |
|   |   | e plans were updated to   |                     |                     |  |                           |
|   |   | nterventions. Pictures of   |                     |                     |  |                           |
|   |   | elopement were added as   |                     |                     |  |                           |
|   |   | each nurse 's station and   |                     |                     |  |                           |
|   |   | eceptionist desk. All new<br>cation on this binder during                               |                     |                     |  |                           |
|   | general orientation.                                | cation on this binder during  |                     |                     |  |                           |
|   | 0   | vill strip and wax hallways in  |                     |                     |  |                           |
|   |   | age for walking rounds. This  |                     |                     |  |                           |
|   | will remain in effect v                             |   |                     |                     |  |                           |
|   |   | 014, Director of Nursing  |                     |                     |  |                           |
|   | contacted Medical Di                                | -   |                     |                     |  |                           |
|   | physician and instruc                               | -   |                     |                     |  |                           |
|   | recommendations an                                  |   | 1                   | 1                   |  | 1                         |

Facility ID: 955030

If continuation sheet Page 17 of 18

|  | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                          |                                   |   | FORM            | ): 09/29/2014<br>APPROVED<br>0. 0938-0391 |
|--|---|--|--------------------------|-----------------------------------|---|-----------------|---|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA<br>AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTI<br>A. BUILDIN |                                   | (X3) DATE SURVEY<br>COMPLETED   |                 |   |
|  | 345471  |  | B. WING                  |                                   |   | C<br>03/29/2014 |   |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                          | STREET ADDRESS, C                 | CITY, STATE, ZIP CODE   | 1               |   |
| MECKLEN  | IBURG HEALTH & REHA   | BILITATION CENTER  |                          | 2415 SANDY PORTE<br>CHARLOTTE, NC |   |                 |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | (EACH C                           | VIDER'S PLAN OF CORRECTION<br>CORRECTIVE ACTION SHOULD B<br>EFERENCED TO THE APPROPRI,<br>DEFICIENCY) |                 | (X5)<br>COMPLETION<br>DATE                |
| F 323  | Immediate jeopardy v<br>3:39 PM when intervis<br>revealed they were in<br>walking rounds each<br>with nurses revealed<br>immediately re-evalua<br>with changes in beha<br>increased risk for war<br>immediately impleme<br>Interviews with nurses<br>in-serviced to review/<br>physician progress no<br>orders/recommendati<br>Interviews with nurse<br>staff revealed they we<br>recognize even subtle<br>would place a resider<br>wandering/elopement<br>this behavior to a nur-<br>revealed they were in<br>facility's Stop and Wa | ldress orders,<br>progress notes as needed.<br>vas removed on 03/29/14 at<br>ews with nursing staff<br>-serviced to conduct visual<br>shift. Additionally, interviews<br>they were in-serviced to<br>ate and assess a resident<br>vior consistent with an<br>indering/elopement and to<br>int interventions as needed.<br>is also revealed they were<br>process any flagged<br>otes with | F 3                      | 23                                |   |                 |   |

Facility ID: 955030

If continuation sheet Page 18 of 18