PRINTED: 09/11/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
345471		B. WING			C 08/05/2015		
NAME OF PROVIDER OR SUPPLIER  MECKLENBURG HEALTH & REHABILITATION CENTER				24	TREET ADDRESS, CITY, STATE, ZIP CODE 115 SANDY PORTER ROAD HARLOTTE, NC 28273	1 00/	03/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	:	F	000			
F 000	provided to the facility typographical errors to riginal 2567 report.						0/00/45
F 280 SS=D	483.20(d)(3), 483.10( PARTICIPATE PLAN	K)(2) RIGHT TO NING CARE-REVISE CP	F 2	280			8/29/15
	incompetent or other incapacitated under the participate in planning changes in care and A comprehensive car within 7 days after the comprehensive assessinter disciplinary teams physician, a register of the resident, and disciplines as determinant, to the extent pratter resident, the resident, the resident incapacity in the second secon	the laws of the State, to g care and treatment or treatment.  e plan must be developed be completion of the sement; prepared by an and the includes the attending and nurse with responsibility other appropriate staff in ined by the resident's needs, acticable, the participation of dent's family or the resident's					
	and revised by a tear each assessment.	and periodically reviewed  n of qualified persons after  is not met as evidenced					
ABODATODY	by: Based on observation interview, the facility to include wheel chairs a sampled residents positioning. (Resident)	ns, record review and staff failed to update a care plan r positioning devices for 1 of reviewed for wheel chair			The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state at federal regulations as outlined. To rem	nd	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

**Electronically Signed** Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 08/28/2015

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.

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				2415 SANDY PORTER ROAD		
MECKLEN	IBURG HEALTH & REHA	BILITATION CENTER		CHARLOTTE, NC 28273		
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F 280	F 280 Continued From page 1		F 280			
	The findings included:  Resident #3 was readmitted to the facility on 05/21/13 after a inoperable left femoral neck (hip) fracture. Diagnose included advanced dementia, abnormal posture, left ankle contractures and a personal history of falls, among others.  An occupational therapy discharge summary dated 09/11/14 recorded in part that Resident #3 would be discharged with a plan for wheel chair positioning to include a wheel chair with a foot buddy with a wedge underneath to increase lower extremity positioning.  Review of the care plan for Resident #3 dated			in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center; so allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.  F280 How corrective action will be accomplished for each resident found have been affected by the deficient practice; Resident # 3 Foot buddy plan on resident; so wheelchair on 8/5/2015 interventions have been care planned appropriately.	of oo ced	
	A quarterly minimum 07/16/15 assessed R impaired cognition an assistance with whee Resident #3 was obstand and 12:22 PM sea pommel wedge cus and legs hung approxithe floor without lowe for support.  An interview with nurs 08/05/15 at 1:49 PM about 1 stated that Resassistance with whee used to have 2 foot p	data (MDS) set dated esident #3 with severely d required extensive staff I chair mobility.  erved on 08/05/15 at 10:00 ated in her wheel chair with hion. The Resident's feet kimately four inches above r extremity assistive devices  se aide (NA) #1 occurred on and revealed that she had lesident #3 for over a year. sident #3 required I chair mobility and that she ledals with a cushion for her lated that she had not seen		How corrective action will be accomplished for those residents havir the potential to be affected by the same deficient practice ¿  1) Audit completed by Therapy Director 8/24/2015 of current patients to ensure they are positioned appropriate and correct devices are in place.  2) On 8/27/15 the MDS Coordinator to the audit completed by Therapy and ensured that the individual recommendations had been care plans.  Measures to be put in place or systemic changes made to ensure practice will recompleted in Point Click Care by Therapy and printed off after saving to give to Director of Nursing for distribution the appropriate Unit Manager/Unit Coordinator to be care planned and	or ly ok ned. c not will	

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		345471	B. WING			1	05/2015	
NAME OF PR	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	00/2010	
				2	415 SANDY PORTER ROAD			
MECKLEN	IBURG HEALTH & REH	ABILITATION CENTER		c	CHARLOTTE, NC 28273			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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F 280	Continued From pag	e 2	F	280				
	remembered the Res	sident did used to have them.			recommendation followed through if			
	During the interview,	a leg rest and foot buddy			appropriate. The DON, Therapy Direct	or,		
	_	n were observed on the floor			MDS and SDC educated on the proces			
	in the Resident's roo	m underneath the sink. NA			for referrals that are not Restorative			
	#1 stated, "This may	belong to her, this is the			focused by Corporate Nurse Consultar	ıt		
		ong time ago." NA #1 stated			on 8/24/2015.			
	she used a care guide and the computer to know							
	what care to provide to the residents she was				The Director of Nursing/Unit			
	assigned. Review of the care guide and nurse				Manager/MDS Coordinator or designed			
	aide computer instructions revealed it did not				will review the Restorative Referral Re	oort		
	record the use of lower extremity wheel chair devices for Resident #3.				in Point Click Care to ensure that the	_		
	devices for Resident	#3.			appropriate interventions are placed or			
	During an interview o	on 09/05/15 at 2:15 DM tha			the care-plan and will revise the care p as necessary. If the appropriate	ian		
	During an interview on 08/05/15 at 2:15 PM, the rehab manager stated Resident #3 required a				interventions are not careplanned it wil	l he		
	foot buddy with a wedge cushion underneath due				addressed at the time of the audit. The			
		and left ankle contractures.			audits will be reviewed daily (Monday			
		further stated that the lower			Friday) x 2 weeks, weekly x 2 weeks,	'		
		ould have been recorded on			bimonthly x 1 month, and monthly x 1,	for		
	the care plan.				any new referrals identified by the			
	·				Restorative Referral Process.			
	During an interview of	on 08/05/15 at 2:50 PM, the						
	director of nursing (D	OON) revealed that she						
	-	an and medical record for			How facility will monitor corrective			
	Resident #3 and con	firmed that the care plan had			action(s) to ensure deficient practice w	ill		
	·	include the occupational			not re-occur-The results of these audits	3		
		structions from 09/11/14. The			will be reviewed in Monthly Quality			
	DON stated that residents with a plan for				Assurance Meetings X4 for further			
		py services were discussed			problem resolution/revision if needed.			
		ng meeting, MDS staff were						
	present and were expected to update care plans and computer instructions for nurse aides at that							
	time.	stone for harde alded at that						
	Decision on the territory	00/05/45 -+ 4/55 DM 14D0						
	•	on 08/05/15 at 4:55 PM, MDS						
		had been at the facility since						
	_	se #1 stated she attended						
		nich included discussion of structions, but she could not						

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MECKLEN	IDUDO HEALTH & DEHA	ADII ITATION CENTED		2415 SANDY PORTER ROAD			
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F 280	Continued From page	e 3	F 28	30			
	recall if the care plan updated to include th positioning devices.						
F 318 SS=D	483.25(e)(2) INCREA IN RANGE OF MOTI	ASE/PREVENT DECREASE ON	F 31	8		9/4/15	
	resident, the facility n with a limited range of	t and services to increase or to prevent further					
	by: Based on observation interview, the facility is chair positioning devirecommendations for reviewed for wheel of #3)  The findings included Resident #3 was read 05/21/13 after a inoperfracture. Diagnose in abnormal posture, left personal history of fath An occupational there dated 09/11/14 record would be discharged positioning to include	that a sampled residents thair positioning. (Resident distribution of the facility on the sample left femoral neck (hip) coluded advanced dementia, it ankle contractures and a sample (OT) discharge summary ded in part that Resident #3 with a plan for wheel chair a wheel chair with a foot cushion underneath to		F318 How corrective action will accomplished for each resident have been affected by the deficie practice ¿Resident # 3 Foot bud on Resident¿s wheelchair on 8/5 and interventions have been car appropriately and interventions at the Kardex which is visible to the the Nurse Consultant by 8/25/15  How corrective action will be accomplished for those residents the potential to be affected by the deficient practice ¿  1) Audit completed by Therapy on 08/24/2015 of current patient ensure they are positioned approand correct devices are in place.  2) On 08/27/2015 the MDS Cootook the audit completed by The	found to ent dy placed 5/2015 e planned appear on e CNA by i. s having e same Director s to opriately ordinator		

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NAME OF D	20/4050 00 01 1001 150	343471	B. WING_	0.TDEET ADDRESS SITV STATE 7/D SOD	08/05/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	E	
MECKLEN	IBURG HEALTH & RI	HABILITATION CENTER		2415 SANDY PORTER ROAD		
		-		CHARLOTTE, NC 28273		
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F 318		e plan dated 05/26/15 revealed	F 3	ensured that the individual recommendations had been o	are planned.	
	limited physical m dependent on stat positioning. The o	ed cognition, weakness and obility, Resident #3 was for wheel chair mobility and care plan did not include the use wheel chair positioning devices		Measures to be put in place of changes made to ensure practical Re-occur: Restorative Refer be completed in Point Click Contral Therapy and printed off after give to Director of Nursing for	ctice will not ral Form will are by saving to	
	07/16/15 assessed impaired cognition assistance with what Resident #3 was of AM and 12:22 PM a pommel wedge and legs hung approximately assessed in the company of the comp	um data (MDS) set dated d Resident #3 with severely and required extensive staff neel chair mobility.  Observed on 08/05/15 at 10:00 seated in her wheel chair with cushion. The Resident's feet proximately four inches above		to the appropriate Unit Manage Coordinator to be care planned scheduled on the care plan so interventions appear on the R Kardex for the CNA¿s to ensure recommendations are followed appropriate. The DON, There MDS and SDC educated on the for referrals that are not Restored.	ger/Unit ed and to that esident ure d if apy Director, ne process orative	
	for support.  An interview with 1 08/05/15 at 1:49 F been a caregiver to	nurse aide (NA) #1 occurred on PM and revealed that she had o Resident #3 for over a year shift. NA #1 stated that		focused by Corporate Nurse on 8/24/2015.  The Director of Nursing/Unit Manager/MDS Coordinator or will review the Restorative Rein Point Click Care to ensure	designee ferral Report	
	Resident #3 requiremobility and that swith a cushion for that she had not subuddy with a wedgremembered Resident buring the interviewith a wedge cush in the Resident's ruth a stated, "this macushion she used she used a care guhat care to provi	red assistance with wheel chair the used to have 2 foot pedals her legs. NA #1 further stated een the foot pedals or foot ge cushion in a while, but dent #3 did used to have them. It was a leg rest and foot buddy nion were observed on the floor com underneath the sink. NA and belong to her, this is the a long time ago." NA #1 stated uide and the computer to know de to the residents she was of the care guide and nurse		appropriate interventions are the care-plan and intervention will appear on the Kardex so the CNA if referral is received to the care plan will be compenecessary. If the appropriate are not care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time. The audits will be reviewed downward to the care planned or on the will be addressed at the time.	placed on as scheduled t is visible to . Revisions sted as interventions e Kardex it of the audit. aily (Monday 2 weeks, athly x 1, for y the	

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F 318	record the use of low devices for Resident  During an interview of nurse #1 who worked 7AM - 3PM shift, rev Resident #3 used leg haven't seen them lad Resident #3 was dependent which was at 2:15 PM, the rehad #3 was discharged for recommendations for cushion due to a hip contractures to increpositioning. During the support. During the support. During the support where contractures manager stated that lower extremity where contractures manager alignment/positioning during the observation wheel chair and state had a history of a hip contractures, she she wheel chair with her 90 degrees as possill the leg rests and and would assist with prostill be used for Resident.	ctions revealed it did not ver extremity wheel chair #3.  on 08/05/15 at 2:12 PM, did with Resident #3 on the ealed that she recalled grests "a long time ago, but I tely." Nurse #1 stated bendent on staff for wheel and observation on 08/05/15 be manager stated Resident from OT on 09/11/14 with a factor and left ankle ase lower extremity the interview, Resident #3 was tell chair without bilateral leg observation the rehab Resident #3 should still have tell chair devices in place for tement and for proper grown of Resident #3 in her tend that because Resident #3 fracture and left ankle to of the positioned in the hips and knees as close to oble. OT #1 stated that both if foot buddy with a cushion per positioning and should	F3	318	How facility will monitor corrective action(s) to ensure deficient practice w not re-occur. The attached audit tool w be completed by the MDS coordinator or assistant daily for 4 weeks then 3 tin weekly for 4 weeks then weekly for 4 weeks to ensure all positioning devices are in place for all Residents requiring positioning devices. The results of the audits will be reviewed in Monthly Qual Assurance Meetings X4 for further problem resolution/revision if needed.  Date of Compliance September 4, 2015	ill and nes		
	discharge recommer	DON) revealed that therapy indations were discussed daily ings with MDS staff present						

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F 318	and were expected to computer instructions. The DON stated she discharge recommen. During an interview o #2 stated she last wo 7AM - 3PM shift about that at times she apprests with the foot but wheel chair of Reside that since changing to about a month ago, s devices to the wheel. During an interview on urse #2 stated she was to three times per we for the last few years. Resident #3 use lowed devices while in her was puring an interview on urse #1 stated she had July 2014. MDS nurse morning meetings who therapy discharge recould not recall if she computer used by nurse morning meetings who had so the same process.	o update care plans and a for nurse aides at that time. expected the therapy dations to be followed.  In 08/05/15 at 3:27 PM, NA rked with Resident #3 on the ut a month ago, and recalled lied one, sometimes two leg ddy and cushion to the ent #3. NA #2 further stated to the 3 PM - 11 PM shift he had not applied these chair for Resident #3.  In 08/05/15 at 3:30 PM, worked with Resident #3 one ek on the 3PM - 11PM shift and had not observed er extremity positioning	F3	318				