PRINTED: 06/20/2018 FORM APPROVED OMB NO. 0938-0391

_	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		345471	B. WING_			05	/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
	Service Regulation, I	18, The Division of Health Nursing Home, Licensure & conducted an annual					
	Immediate Jeopardy	was identified at:					
	of K CFR 483.70 at tag F of K	726 at a scope and severity 835 at a scope and severity 880 at a scope and severity					
F 636 SS=D	removed on 5/25/18. completed.	<u> </u>	F	636			6/25/18
33-0	§483.20 Resident As The facility must con a comprehensive, ac	sessment duct initially and periodically					
	§483.20(b)(1) Resid A facility must make assessment of a resi goals, life history and resident assessment	ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, d preferences, using the instrument (RAI) specified sment must include at least					
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	1		TITLE		(X6) DATE

Electronically Signed 06/18/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345471	B. WING _			05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 636	(ii) Customary routin (iii) Cognitive patterr (iv) Communication. (v) Vision. (vi) Mood and behave (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnos (xi) Dental and nutrit (xii) Skin Conditions (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatme (xvi) Discharge plan (xvii) Documentation regarding the addition the care areas trithe Minimum Data Struin (xviii) Documentation assessment. The assinclude direct observe with the resident, as licensed and nonlice members on all shift §483.20(b)(2) When timeframes prescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmission.	demographic information i.e. ins. vior patterns. vell-being. ining and structural problems. is and health conditions. is and health conditions. is and procedures. ining. in of summary information inal assessment performed ggered by the completion of iet (MDS). in of participation in issessment process must vation and communication well as communication with insed direct care staff	F6	336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345471	B. WING _			5/25/2018	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 636	"readmission" me following a tempor or therapeutic lead (iii)Not less than of This REQUIREM by: Based on observinterviews, the fact admission Minimulary of admission reviewed for com (Resident #177). The findings included the findings includ	(For purposes of this section, cans a return to the facility carry absence for hospitalization ve.) Ince every 12 months. ENT is not met as evidenced rations, record review and staff cility failed to complete an um Data Set (MDS) within 14 in for 1 of 3 sampled residents prehensive assessments and admitted to the facility from fization on 4/27/18 with cluded multiple fractures of the re, gout, acute kidney failure,	F 6	This allegation of compliance submitted in compliance with law and regulation. To demo continuing compliance with a the center has taken or will ta actions set forth in the follow of compliance. The following allegations constitutes the ce allegation of compliance. All deficiencies have been or will completed by the dates indice F636 The plan of correcting the sp deficiency. The plan should a processes that led to the definite facility failed to ensure the completion of the Admission with ARD of 5-10-18 for residency in the assessment had not been as of 5-25-18. Analysis of the that led to the late assessment that the MDS coordinator was keep up with the assessment independently. The procedure for implement acceptable plan of corrections.	e is applicable onstrate applicable law, ake the ing allegation g credible enter salleged ll be ated. ecific address the iciency cited. mely Assessment dent #177. en completed e processes ent revealed s unable to t volume		
	Coordinator revea	/25/18 at 1:17 pm with the MDS aled Resident #177's seessment had not been not having the assistance from		specific deficiency cited. The MDSC Consultant provious to the MDS Coordinator and completion of Admission Ass the RAI Manual, completed by	IDT on timely essment, per		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRU			E SURVEY PLETED
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	ROVIDER OR SUPPLIER	BILITATION CENTER	•	2415 SAND	DRESS, CITY, STATE, ZIP CODE DY PORTER ROAD ITE, NC 28273	·	
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F 636	an unfilled MDS positions stated she had been and had hoped to have assessment complete. An interview on 5/25/Administrator reveale the comprehensive as on time. She indicate	ion. The MDS Coordinator doing the best she could by Resident #177's ed on Monday, 5/28/18. 18 at 11:07 am with the dit was her expectation for essessments to be completed ed the Staff Development in on vacation and would be	F6	The M reside The m the plasses for 4 reasses days of the review The till impler correct The M impler	ADS Consultant is responsible menting the acceptable plan of	8-18. that I that rected tory or s, 2 thly 4 sesults J. r	
	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an initial includes but is not lim (A) The attending phy	ensive Care Plans brehensive care plan must days after completion of seessment. terdisciplinary team, that sited to	F6		ction by 6-25-18.		6/25/18

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345471	B. WING			05/25/2018
	ROVIDER OR SUPPLIER	IABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	resident. (D) A member of food (E) To the extent profite resident and their resident record if the and their resident record as requested by the compression of the and assessments and assessments. This REQUIREMENT by: Based on observative resident and staff in revise/ update a carprevent decrease in Mobility for 1 of 4 record record in the and staff in review of care plan. Findings included: Resident #50 was a second record in the and staff in review of care plan.	ch responsibility for the cod and nutrition services staff. acticable, the participation of the resident's representative(s). It is included in a resident's representative is determined the development of the code the staff or professionals in mined by the resident's needs the resident. The resident revised by the interdisciplinary ressment, including both the quarterly review Solution of the resident's needs the resident. The resident resident is not met as evidenced from the record review and the record review and the resident replan in the area of increase/or Range of Motion (ROM)/or residents (Resident #50) for the sidents (Resident #50) for the dmitted to the facility on	F6	The plan of correcting the spe deficiency. The plan should ad processes that led to the deficiency are plan in the area motion and the application of a foot orthotic. Analysis of the pled to the deficient practice reverse the therapy department had not communicated the recommence the passive range of motion not orthotic to the MDS and nursing the passive range of motion of the passive range of motion of the material process.	Idress the iency cited. Iate a a of range of an ankle rocess that realed that ot dation for or the ig staff.	
	hemiplegia, unspecting muscle weakness, haffecting left domination peripheral vascular	oses included dysphagia, ified lack of coordination, nemiplegia and hemiparesis ant side, chronic pain, disease and hypertension. plan dated 3/5/2015 revealed		Resident #50 s care plan was on 6-15-18 to include his ortho The procedure for implementin acceptable plan of correction for specific deficiency cited. The Director of Rehabilitation peducation to the therapy staff of	otic. Ing the or the orovided	

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345471		B. WING _			05/25/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	•	
MECKLEN	IBURG HEALTH & REH	ARII ITATION CENTER		2415 SANDY PORTER ROAD		
WECKLEN	IBURG HEALIH & KEH	ABILITATION CENTER		CHARLOTTE, NC 28273		
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F 657	Continued From pag	e 5	F 6	57		
	limited physical mobi	Resident #50 related to lity related to stroke. No d for the left ankle/ foot brace		communicating recommendat orthotics, braces, and splints and Nursing teams and not ju documenting them; completed The facility Director of Rehabi be responsible for printing all	to the MDS est d by 6-22-18. ilitation will	
	dated 4/9/2018 reveal moderate cognitive in required extensive as transfers, total dependence supervision for eating	rly Minimum Data Set (MDS) aled that Resident #50 had mpairment. Resident #50 ssistance with bed mobility, ndence for toileting and g. Resident #50 was coded upper and lower extremities.		restorative recommendations braces, and splints and bringi the morning stand-up meeting by the nursing team. Nursing administration will assess the recommendation from therapy on the care plan for implemer nursing staff. The MDS Coor review the care plan for update	for orthotics, ng them to g for review y and place ntation by dinator will	
	Summary dated 4/17 that read in part, pati to restorative nursing extremity passive rar donning/ doffing of le Discharge status and Resident #50 to rece program/ functional r	cal Therapy Discharge 6/2018 revealed a summary ent appropriate for discharge g program for left lower age of motion and daily eft ankle foot orthotic (AFO). If recommendations were for eive restorative nursing maintenance program that of the left AFO 4 to 8 hours		with each MDS completion. To Consultant provided education Coordinators and Nursing Adithat care plans need to reflect resident status and should be with each quarterly or annual completed by 6-22-18. The monitoring procedure to the plan of correction is effect specific deficiency cited rema and/or in compliance with the requirements. The MDS Consultant or designation of the consultant or designation of the consultant or designation.	The MDS n to the MDS ministration t current e reviewed assessment; ensure that ive and that ins corrected regulatory	
	Resident #50 in bed	21/2018 at 5:16pm revealed resting with left foot bent to t was in the corner of .		audit therapy recommendation restorative programs for orthogonal splints on residents discharged therapy and remaining in the audit will review any residents.	ns for otics, braces, parged from facility. The s discharged	
	Resident #50 having	23/2018 at 1:20pm revealed lunch in his bed. His left a pillow bent to the right. n the corner.		since the last audit up to a rar sample of 5 resident care plan audit will assess if any restora programs were recommended updated/accurate on the curre plan, for 1 time per week for 4	ns. The ative d and are ent care	

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	ROVIDER OR SUPPLIER IBURG HEALTH & REHA	ABILITATION CENTER		241	REET ADDRESS, CITY, STATE, ZIP CODE 5 SANDY PORTER ROAD ARLOTTE, NC 28273			
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F 657	An interview with the 9:47am revealed that comprehensive asses. The MDS nurse furth herself and trying to hot identify who was assessments and car. An interview on 5/25/Rehab Manager reve Resident #50 receivir March to April. Physitransfers, bed mobilit placement. The Reh Resident #50 had a leshould be worn 4 to 8 observation with the lathat the blue boot wa. An interview on 5/25/Resident #50's regular revealed the resident The nurse aide further receive education regifrom therapy. The nurse aide did indicat range of motion and the second part of the second part of the second part of the nurse aide did indicat range of motion and the second part of	2018 at 9:20am with the prising revealed that she had olied to Resident #50's foot. MDS nurse on 5/24/2018 at a she completes the essments and care plans. Per revealed that she was by seep up. The MDS nurse did presponsible for quarterly replans. 2018 at 10:00am with the aled that she recalled any physical therapy from cal therapy worked on any with proper hand and foot ab Manager verbalized that reft foot/ankle brace that a hours per day. An Rehab Manager revealed is the left foot/ankle brace. 2018 at 10:47am with any assigned nurse aide does not wear that boot. For stated that she did not garding the boot application are aide verbalized that she if she knew about it. The ter that she offers passive	F		times a month for 1 month, and month for 4 months. Any issues identified on audits will be immediately corrected w coaching/discipline as needed to the M Coordinator. Results of the audits will presented in the quarterly QAPI meeti. The title of the person responsible for implementing the acceptable plan of correction. The MDS Consultant is responsible for implementing the acceptable plan of correction by 6-25-18.	the ith MDS be ng.		

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F 657		ed that he has not worn the ndicated that he would wear	F 65	7		
F 688 SS=D	at 11:51am revealed regarding care plan r plans were for the M plans with the MDS s	evision and updating care DS nurse to update care schedule or as needed. crease in ROM/Mobility	F 68	3	6/25/18	
	resident who enters to range of motion does range of motion unle	cility must ensure that a the facility without limited so not experience reduction in set the resident's clinical test that a reduction in range able; and				
	motion receives appr services to increase	lent with limited range of copriate treatment and range of motion and/or to ase in range of motion.				
	receives appropriate assistance to mainta the maximum practic reduction in mobility This REQUIREMEN by: Based on observation resident and staff into apply a left ankle/ foo	ysical therapy to be worn		The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency circle to the facility failed to ensure the application of an ankle foot orthotic. Analysis of the	ted. ation	

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	0/20/2010	
				2415 SANDY PORTER ROAD			
MECKLEN	IBURG HEALTH & REH	ABILITATION CENTER		CHARLOTTE, NC 28273			
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F 688	Continued From pag	e 8	F 68	88			
	(Resident #50) obser	ved for range of motion.		process that led to the deficien revealed that the therapy depa not communicated the recomm	rtment had		
	Findings included:			for the passive range of motion orthotic to the nursing staff. Re #50□s passive range of motion	n nor the esident		
	10/02/2015. Diagnos unspecified lack of co weakness, hemipleg	ia and hemiparesis affecting nronic pain, peripheral		orthotic needs were added to the restorative program and the can 6-15-18 for C.N.A. implementate documentation. The facility has identified and initiated a perform improvement plan for restorative programs.	he ire plan on tion and d already mance /e		
	a problem for Reside physical mobility rela identified for Resider remain free of compl including contracture included application ordered for 4 to 8 hor	of splint to left arm as urs a day and resident to be intervention was identified		The procedure for implementin acceptable plan of correction for specific deficiency cited. The facility will continue with the previously initiated performance improvement plan to improve reprogramming in the facility. The of Rehabilitation provided educe the the facility and not just documenting them completed by 6-22-18. The facility birector of Rehabilitation will be	or the ne ee estorative e Director cation to the g ng team n; cility		
	dated 4/9/2018 reveal moderate cognitive in required extensive as daily living (ADLs). Fimpairment to the up	rly Minimum Data Set (MDS) aled that Resident #50 had mpairment. Resident #50 ssistance with activities of Resident #50 was coded for per and lower extremities. ded as receiving physical		responsible for printing all there restorative recommendations at them to the morning stand-up review by the nursing team. Not administration will assess the recommendation from therapy determine which programs to it and place on the care plan for implementation. Nursing staff and aides) were provided in-se	apy and bringing meeting for ursing and will mplement staff (nurses		
	Summary dated 4/17	al Therapy Discharge //2018 revealed a summary ent appropriate for discharge		education on the facility restoral program, including documental Director of Nursing (DON); con	ative tion, by the		

	TOTA MEDIONALE OF	WEDIO/ ND CEITTICE					. 0000 000 1
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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to e control of the c	extremity passive randonning/ doffing of le Discharge status and Resident #50 to receiprogram/ functional nucluded application of per day. Review of the Therap Referral dated 4/17/2 #50 had a goal of splicorrect alignment to the eft ankle/foot. Splint per day in the morning An observation on 5/2 Resident #50 in bed in the right. A blue boot a blue boot in the correct alignment on 5/2 Resident #50 having foot was propped on Blue boot observed in An interview on 5/24/	program for left lower age of motion and daily ft ankle foot orthotic (AFO). If recommendations were for live restorative nursing maintenance program that of the left AFO 4 to 8 hours are possible to 8 hours and the left hand/wrist and the to be applied 4 to 8 hours ags. 21/2018 at 5:16pm revealed resting with left foot bent to the was in the corner of a pillow bent #50's room. 23/2018 at 1:20pm revealed lunch in his bed. His left a pillow bent to the right. In the corner.	F	688	6/22/18. Resident charts were audite for therapy restorative referrals on 6/15/18. Facility residents identified for restorative programs had the program updated in their care plan on 6-18-18. The monitoring procedure to ensure the plan of correction is effective and to specific deficiency cited remains correction in compliance with the regulator requirements. Nursing administration audit resident charts for Therapy Restorative Nursing Referral forms on residents discharged from therapy and remaining in the facility. The audit will review any residents discharged since last audit up to a random sample of 5 resident care plans. The audit will assif any restorative programs were recommended and are on the current care plan for staff implementation, for time per week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months. Any issues identified on the audits will be immediately corrected ar any staff not implementing restorative programs will receive progressive discipline. Results of the audits will be presented in the quarterly QAPI meeting. The title of the person responsible for implementing the acceptable plan of correction. The Rehabilitation Director and DON a responsible for implementing the acceptable plan of correction by 6-25-	r at hat cted ry will the ess	

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F 688	Rehab Manager reverse Resident #50 receiving March to April. Physical transfers, bed mobility placement. The Rehabshall Resident #50 had a lashould be worn 4 to 8 observation with the surveyor revealed that in the corner of the resident #50's regular revealed the resident The nurse aide further receive education regions therapy. The nurse aide indicated	2018 at 10:00am with the called that she recalled and physical therapy from ical therapy worked on y with proper hand and foot ab Manager verbalized that eft foot/ankle brace that B hours per day. An	F 6	88		
	Resident #50 reveale	2018 at 10:50am with ed that he had not worn the ndicated that he would wear ed it.				
	Administrator revealer regarding splint applipassive range of mot would be included in	2018 at 11:51am with the ed that her expectation cation and performing ion was that the information the resident's care plan, e aide, and overseen by the				

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F 726 F 726 SS=K	the appropriate comprovide nursing and resident safety and a practicable physical, well-being of each reresident assessment and considering the diagnoses of the faci accordance with the at §483.70(e). §483.35(a)(3) The fallicensed nurses have and skill sets necess needs, as identified the assessments, and definited to assessing,	Staff (4)(c) vices e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care number, acuity and lity's resident population in facility assessment required cility must ensure that e the specific competencies ary to care for residents'	F 72 F 72	6	6/25/18	
	to demonstrate comp techniques necessar needs, as identified to assessments, and de This REQUIREMENT by: Based on observation and staff interviews to training to 3 of 4 facili	cy of nurse aides. ure that nurse aides are able betency in skills and y to care for residents'		The plan of correcting the specific deficiency. The plan should address processes that led to the deficiency c	ited.	

Facility ID: 955030

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		0	5/25/2018
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	•	0.20.20.0
				2415 SANDY PORTER ROAD		
MECKLEN	IBURG HEALTH & REH	ABILITATION CENTER		CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 726	Continued From pag	e 12	F 72	26		
F 726	device used to test g was shared among s dispose of a used sa avoid cross contamir environment and to g transmission. The fa potential to affect 6 o physician ordered ble facility by exposing the cross-contamination pathogens (Resident #72, Resident #67, F #223). Immediate Jeopardy of training resulted in blood sample test stre during blood glucose top pocket comming supplies that include would be later admir a separate medication was observed not dis glucometer after each samples for blood glu- residents (Resident #74, a Immediate jeopardy when the facility proviacceptable credible a The facility remains o scope and severity o harm with potential o that is not immediate	plucose level in the blood) that is residents and on how to ample test strip (Nurse #1) to nation of the residents' prevent disease ailed practice had the of 30 residents who had good glucose monitoring in the he residents to the risk for of potential bloodborne the #47, Resident 73, Resident Resident #74, and Resident Resident #36 amonitoring in his right scrub led with clean and dirty did a nebulizer treatment that histered to Resident #47. On on pass observation Nurse #2 sinfecting a shared the use to collect blood sucose readings from 573, Resident #72, Resident	F 7:	correction initiated on 5-23-18 " As part of the root cause the deficient practice by the a a review and analysis of the frorientation for licensed nursin conducted; it was noted that the a specific skills validation for competency of nursing staff in glucometers and hand washin part of their blood borne pather training. When the staff dever coordinator was questioned, so that she gave the forms to the expected them to complete the their training nurse and return but did not validate their complete that the Director of Nursing we evaluating competency on ne nurses prior to a nurse being floor. " During the analysis of the practice of Nurse #1, the nurse to not following proper proceed placing the glucometer strip for #36 in his scrub pocket comin supplies for Resident #47. " Nurse #1 was pulled off the immediately to discuss the depractice for infection control and cross contamination. Nurse #3 sent home and no longer is an of the facility. " No other nurses were ideal placing supplies with potential pathogens comingled into scr	analysis of dministrator, acility g staff was here was not the n cleaning ng signed as ogens lopment she stated e staff and hem with n them to her oletion. also revealed as not wly hired released to de deficient he admitted flure by or Resident ngled with he cart efficient nd possible et1 was then n employee entified as I blood borne	
	place are effective reglucometers, transpo			" Nurse #2 did not clean the after the accucheck on Residuation proceeded to perform accuch	e glucometer ent #73 and	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		SURVEY PLETED
		345471	B. WING _			05	/25/2018
	ROVIDER OR SUPPLIER	BILITATION CENTER	·	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	Policies and Procedu "Training Records" re 1. The Health an maintains records wh information: a. Names of Em b. Dates of the tr c. Contents or a session d. Names and qu conducting the training e. Names and jo attending 2. Bloodborne Pa	colicy for Exposure Control res dated 5/26/2016, titled, read in part, d Rehabilitation Center ich include the following coloyees raining sessions summary of the training utilifications of persons reg to titles of all persons rathogens Orientation	F 7	726	residents # 72, 74, 67, 223. Nurse #2 was also observed not sanitizing her hands between glove changes. Nurse was immediately removed from patient care, and in-serviced. Nurse #2 did no return to patient care until a return demonstration was validated by an RN Nurse #2 is no longer employed by the facility and has been reported to the boof nursing. "Nurse #3 expressed lack of knowledge by instructing Nurse #2 to disinfect the glucometer by using the wrong cleaning supply by using alcohowipes after the completion of an accucheck. Nurse #3 was in-serviced immediately and returned to patient care as soon as she verbalized correct cleaning procedures, return demonstration, and a quiz following the education to determine knowledge retention. "During the analysis of the deficient	t pard	
	annual Administrati which is maintained a Development Co 3. All Health and training records regal are available upon re employee representa Secretary, and the examination and cop CFR 1910.20. A review of a facility p	Rehabilitation Center rding bloodborne pathogens equest to employees,			practice of Nurses #2 & #3, the nurses expressed to the direct supervisor that they knew to clean the glucometers bu also thought alcohol wipes were an appropriate alternative for cleaning. At receiving the first in-service education 5-23-18, Nurse #3 was unable to verbathe correct process when questioned by the surveyor. Nurse # 3 then received additional training with return demonstration conducted by the Regio Nurse Consultant on 5/23/18. Nurse # admitted that she knew she needed to disinfect the glucometers but did not.	t iter on ilize y	

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 _			05/	25/2018
	ROVIDER OR SUPPLIER	HABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273			
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F 726	the meter using a li accordance with ma recommendation. A review of the mare the User Instruction titled, "Maintenance Guidelines" read in should wear gloves Wash hands after to blood presents a posuggest cleaning a between patient us can be completed by	d in part, Clean the outside of nt-free cloth. Clean in	F7	726	The procedure for implementing the acceptable plan of correction for the specific deficiency cited. "The facility will continue the plan of correction initiated on 5-23-18. "Facility nursing staff are being in-serviced beginning on 5-23-18 on the policy on Patient Care Equipment including: use of PDI Sani-Wipes, and time. Facility nursing staff are being in-serviced beginning on 5-23-18 on the policy Handwashing Requirements. Facility nursing staff also acknowledge by signature the understanding of transmission precautions and that prophand washing and glucometer disinfect was required to prevent the transmission provided by the Regional Nurse	e wet e d per ting on	
				Consultant to the Director of Nursing a Unit Managers with return demonstration and then Education was provided by DON, Unit managers, and Regional Nursing Staff. New hires will be educated during general orientation by a member of nursing administration. All nursing staff will be in-serviced before returning to work. "Facility medication carts were provided with a job aide describing the steps to cleaning a glucometer as a vising reference for the staff on the competent technique to use on 5-23-18 by the Regional Nurse Consultant. "Beginning 5-24-18, current nurses have skills validation sheets completed Glucose Monitor Cleaning/Disinfecting and Blood Borne Pathogens. All news.	on urse ng g ff sual at		
	A review of a facility	y policy for Infection Control dures dated 2/01/15, Section			Beginning 5-24-18, current nurses have skills validation sheets completed		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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MECKLEN	IDIIDO UEALTU O DE	HADII ITATION CENTED		2415 SANDY PORTER ROAD			
WECKLER	IBURG HEALIH & RE	HABILITATION CENTER		CHARLOTTE, NC 28273			
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F 726	Continued From part, staff follows infection maintain patient sawill be disposed of the dispos				cills validation on ag/Disinfecting rements during urn demonstration of Nursing or the agreeased to carts. Petency before resident care, w competency training program by the to ensure that the regulatory asultant (or a validation by the regulatory weeks and then as a random audits are glucometer ing are performed as will be done 5 a times weekly x weekly x 2	DATE	
	gathered the used test strip with the b alcohol wipes, glow insulin syringe, vial Flexpen, and pen r put them in his scri	pen I brought." Nurse #1 then gloves, the clean gloves, used lood drop, the used lancet, es, the dirty glucometer, for Humalog, Levemir needle inserted with a cap and ub's top pocket. Nurse #1's		Director of Nursing, Unit Regional Nurse Consulta The nurse consultant will with the Director of Nursi Administrator who will re the QAPI committee. The Administrator w	ant or designee. I review the audits ing and the port findings to ill validate that		

Facility ID: 955030

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 726	#47, and all the all On 5/23/18 at 9:20 he walked down the and then reached administer the secondary placed the nebuliz #47 and started the medication. An interview with the revealed there waneeded. He state training before his assigned to a medication with the administered their during his first shift. An interview on 5/Administrator was revealed Nurse #1 training by the State (SDC) and had remanagement and during a medication unable to provide given to Nurse #1 During observation to 5:12pm of a medication to 5:12pm of a medicat	ebulizer treatment for Resident cove items for Resident #36. Dam Nurse#1 was observed as the hall to room for Resident #47 into his right pocket to cond nebulizer treatment. He ter face mask on to Resident the treatment using the second Nurse #1 on 5/23/18 at 9:35am is no one to ask for help when id he had received no job first shift when he was dication cart. Nurse #1 is 44 who no longer worked at the medications and he had medications to the residents if in the facility. 23/18 at 3:27pm with the conducted. The Administrator had received orientation iff Development Coordinator ceived ongoing training on time consolidating methods to use on pass. The Administrator was any evidence of specific training	F7	completed within 30-days or annually and report findings committee. "The Administrator will deach licensed nurse has received skills validation on Glucose Cleaning/Disinfecting and Hrequirements during orientate been observed with return dealidated by the Director of Unit Manager before being work on the medication cart. The title of the person responsimplementing the acceptable correction Regional Nurse Consultant, Nursing and Administrator with by 5-25-18.	confirm that beived the Monitor land washing tion and has demonstration Nursing or the released to s. Onsible for e plan of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345471	B. WING		05/25/2018
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F 726	I .	glove changes for 5 residents dent #72, Resident #67,	F 726		
	Nurse#2 was asked hands in between re new gloves on. Nur been so nervous the explained she knew her hands when tak gloves. She then sa	on 5/23/18 at 5:10pm, if she had been washing her emoving gloves and placing rse #2 stated no, she had at she had forgotten. She how essential it was to wash ing off gloves to put on new anitized her hands with the top of her medication cart.			
	Nurse #2 was obser shared glucometer w #3 instructed Nurse with an alcohol wipe	on on 5/23/18 at 5:18pm, rved asking Nurse#3 how the was to be disinfected. Nurse #2 to disinfect the glucometer e for 2 minutes. Nurse #2 cart, found alcohol wipes and cometer.			
	Nurse #2 walked to station on Hall 100 a Nursing (DON) and shared glucometer. instructed Nurse #2	on on 5/23/18 at 5:27pm, the office by the nurse's and asked the Director of UM #1 how to disinfect a Both the DON and UM#1 to use a sani wipe for 2 er walked back to the cart with			
	UM#1 and the DON Nurse #2 on how to	on on 5/23/18 at 5:27pm, were observed educating disinfect the glucometer. The as given by the DON and UM			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273		-	
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F 726	#1 to Nurse #2 was to 2 minutes with a PDI Germicidal Disposabl for 1 minute, then dry	o wipe the glucometer off for (PDI Sani Cloth Bleach le Wipe) wipe, then air dry off any leftover chemical on by the steps after every use	F7	226			
	revealed she had new a glucometer and had orientation. Nurse #2 worked at the facility used alcohol wipes to when it had been ava had just moved from	18 at 5:35pm with Nurse#2 ver been told how to disinfect d not received formal 2 explained, since she had for the last 3 weeks, she had o disinfect the glucometer illable. She explained she another state and was icometers with alcohol there.					
		18 at 5:50pm was urse Consultant who stated ne PDI wipe was 4 minutes.					
	revealed she had bee minutes ago and was 4 minutes now instea disinfect the glucome not received formal tr in the facility for 3 we only in-service she had the facility had been of	ication pass with Nurse #3, en in-serviced about 15 to 20 told to use alcohol wipes for d of 2 minutes as before to ters. She stated she had aining and had only worked eks. Nurse #3 indicated the ad received since working in on falls. Nurse #3 explained tuman Resources (HR)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTI				OATE SURVEY COMPLETED		
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F 726	5/23/18 at 7:40pm s return employee to and had not receive indicated that Nurse had all received trai how to disinfect the of their training. An interview on 5/24 Medical Director was telephone. He state control due to abserglucometers in his process-contamination Medical Director fur not know if a reside C and mandatory U be used always. The need for training for was imperative. He to set the standards nursing education in glucometers. The MSDC (Staff Develop responsible for education and weeks previous and weeks before her laget and single standards and seeks before her laget services.	with the Administrator on she revealed Nurse #3 was a the facility from 1 year ago ad formal training. She is #1, Nurse #2, and Nurse #3 ning and should have known shared glucometers as part. #4/18 at 9:19am with the facility as conducted via the ed the breach in infection ince of disinfection of the prospective was absolutely blained the risk for in was always there. The ther explained that we may inthad Hepatitis B or Hepatitis niversal precautions were to be Medical Director stated the fall nurses including new hires a explained the facility needed is from Day 1 regarding all	F7	726		
	sometimes 15 to 20 the same time nurse for not meeting prof been a bad time for Medical Director revenues of the built b	on cart due to nurse call-outs minutes prior to a shift. At es were let go by the facility essional standards. It had staffing he explained. The realed the SDC had been lding but could not train staff etting pulled to a cart. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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F 726	used for a shared g alcohol would be ac	plained a germicidal must be lucometer and the only time ceptable was if each resident meter and were individually	F 7	26			
	Corporate Nurse Co	4/18 at 11:09am with the onsultant revealed the facility gned off education for Nurse lurse #3 for any specific on records.					
	provided orientation related to bloodborr and signed by Nurs documentation coul of disinfecting a sha	opm the Nurse Consultant training acknowledgement the pathogens dated 4/18/18 the #2 and the SDC. No d be provided for the training thred glucometer for Nurse #1, three of any training for Nurse					
	was conducted via a revealed she was on returning to the f Coordinator. She in disinfection was tau Bloodborne Pathogoday of orientation. It aught during the Bl PowerPoint present and multiple times of were given written a return demonstratio training. The SDC of the same of the sa	5/18 at 9:52am with the SDC the telephone. The SDC n vacation and had planned acility in the role of a MDS adicated glucometer ght verbally during the en PowerPoint on the third Handwashing training was oodborne Pathogen ation, during infection control, during orientation. New hires and verbal education but no ns were included in the revealed she personally had th Nurse #1 and also rounded					

CENTER	S FOR MEDICARE 6	NIEDICAID SERVICES				OIVID IN	<u> </u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED			
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F 726	used blood sample SDC stated she had a small sharps container should absolutely no scrub pocket. She is the pocket, the strip container." During the indicated Nurse #2 bloodborne pathogoremember who had believed there had a she stated Nurse #3 best of her memory expected nurses to putting on new glow and then the nurses glucometer on the noresident until the 4 r PDI wipes had expirate new hire nurses recand their preceptor the floor. She continualidation form was would bring the form SDC would review a She revealed new howere considered to The SDC explained who the new nurse nursing leadership to precepted who base between the nurses Nurse #2 nor Nurse because they were	ter seen Nurse #1 transport a test strip in his pocket. The dexpected for nurses to take ainer into the room and they of put a used test strip in their reiterated, "Nothing goes in goes directly into the sharps he interview the SDC had received training on each but she could not trained Nurse #3 and of the she wash their hands before each disinfect the glucometer, should use the second hedication cart for the next minute contact time for the red. The SDC explained the eived a skills validation form checked the skills off once on mued, once the skills off once on nued, once the skills off once on nued, once the SDC and the any competencies unsigned. Aires received mentors who be the preceptor on the floor. The were no records on was trained by and the eam determined who ead on the schedule and best fit. The SDC revealed neither #3 had been rounded by her	F 7	726				
	Nurse Consultant re	evealed Nurse #4 had been						

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F 726	mentor for Nurse #2 mentor for Nurse #3	ge 22 e #1, Nurse #5 had been the 2, and Nurse #6 had been the 3. (The SDC had explained sidered to be the preceptor	F 7	26		
	Administrator reveal included UM #1 and 5/23/18 related to or glucometers due to directions to Nurse Administrator indicate facility training policiturn-over in the facility needed a successful. The ad #2 and Nurse #3 sh (rounds by the leader	on 5/25/18 at 11:07am, the led the Regional Manager had it the DON in the training on prrectly disinfecting the both giving incorrect #2 on 5/23/18. The sted she was aware of the y and explained the nurse lity had been high. She stated a solid orientation to be ministrator added that Nurse ould have been rounded ership team to ensure nurses e care) on by the UM #1.				
	revealed the facility and she had only tra Nurse #5 indicated	urse #5 on 5/25/18 at 12:25pm did not have mentors in place ained Nurse#2 for one shift. Nurse #2 had not asked her lucometer and the topic had				
	revealed she had w months and attende She indicated after DON for a few days and daily checklist f revealed there had	5/18 at 12:32pm with UM #1 orked in the facility for 2 and orientation for Day 1 only. Day 1 she followed the past reviewing the facility policies or managers. UM #1 been no training related to meter. She added, overall the				

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		· · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 726	Continued From pag		F	726			
	on 5/24/18 at 3:32pm	rmed of Immediate Jeopardy n. The Administrator ple credible allegation of					
	specific Skills Compe nurses regarding res facility assessment n	n, record review revealed the etency Validation Record for ident care located in the otebook had not been #1, Nurse #2, and Nurse #3.					
	Credible Allegation F	726:					
		g the specific deficiency. The the processes that led to the					
	practice by the admir analysis of the facility nursing staff was con there was not a spec competency of nursin glucometers and han their blood borne pat staff development co she stated that she g and expected them to training nurse and re validate their comple	id washing signed as part of hogens training. When the ordinator was questioned, lave the forms to the staff o complete them with their turn them to her but did not tion.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILITATION CENTER	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 415 SANDY PORTER ROAD CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	nurse being released Nurse #2 did not clea accucheck on Reside perform accuchecks 223. Nurse #2 was a her hands between gwas immediately remin-serviced. Nurse #care until a return de an RN; any further depractices will result in Nurse #3 expressed instructing Nurse #2 by using the wrong calcohol wipes after thaccucheck. Nurse #3 immediately and return demonstration education to determin During the analysis of Nurses #2 & #3, the indirect supervisor that glucometers but also an appropriate altern receiving the first insonurse #3 was unable process when questing #3 then received addemonstration conduction conductions when the process when each glucometers but did reconsultant on 5/23/1 she knew she needed glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometers but did reconsultant on the process when each glucometer but did reconsultant on the process when each glucometer but did reconsultant on the process when each glucometer but did reconsultant on the process when each glucometer but did reconsultant on the process when each glucometer but did reconsultant on the process when each glucometer but did reconsultant on the process when each glucometer but did reconsultant on the process when each glucometer but did reconsultant on the process when each glucometer but did reconsultant on the process when each glucomet	y hired nurses prior to a to floor. In the glucometer after the ent #73 and proceeded to on residents # 72, 74, 67, also observed not sanitizing allove changes. Nurse #2 allove from patient care, and 2 did not return to patient monstration was validated by emonstration of incompetent in immediate termination. It immediate termination. It immediates the glucometer deaning supply by using the completion of an 3 was in-serviced and a quiz following the me knowledge retention. If the deficient practice of incress expressed to the athey knew to clean the thought alcohol wipes were ative for cleaning. After the entire the correct one by the surveyor. Nurse ditional training with return acted by the Regional Nurse 8. Nurse #2 admitted that dit to disinfect the	F	726			
		the specific deficiency cited.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X	(X3) DATE SURVEY COMPLETED	
		345471	B. WING		· · · · · · · · · · · · · · · · · · ·		05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER	•	2415 SAN	DDRESS, CITY, STATE, ZIP CODE DY PORTER ROAD OTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 726	beginning on 5/23/1 Care Equipment inc Sani-Wipes, and we are being in-service policy Handwashing nursing staff also ac understanding of tra that proper hand wa disinfecting was req transmission of bloc Education was prov Consultant to the Di Managers with retur Education was prov and Regional Nurse licensed nursing sta educated during ger of nursing administr in-serviced before re Facility medication of aide describing the siglucometer as a visi the competent techn Regional Nurse Cor Beginning 5/24/18, of validation sheets co Cleaning/Disinfectin Pathogens. All new validation on Glucos Cleaning/Disinfectin requirements during demonstration valid Nursing or the Unit I released to work on To ensure staff com independent resider show competency a	are being in-serviced 8 on the policy on Patient luding: use of PDI t time. Facility nursing staff d beginning on 5/23/18 on the Requirements. Facility knowledged by signature the msmission precautions and shing and glucometer uired to prevent the d borne pathogens. ided by the Regional Nurse rector of Nursing and Unit in demonstration and then ided by DON, Unit managers, Consultant to the facility ff. New hires will be meral orientation by a member ation. All nursing staff will be eleturning to work. carts were provided with a job steps to cleaning a ual reference for the staff on nique to use on 5/23/18 by the isultant. current nurses will have skills impleted on Glucose Monitor g and Blood Borne inurses will receive the skills	F	726			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RIPLE CONSTRUCTION NG	(X3)) DATE SURVEY COMPLETED
		345471	B. WING			05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	DDE	00/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 726	ended as directed by The monitoring procof correction is effect deficiency cited remonitarity compliance with the Regional Nurse Coraudit skills validation once weekly beginn then monthly x 5 mc Beginning on 5/25/1 conducted to ensure hand washing are paudits will be done times weekly x 2 we 2 months. Audits will not will be done to the QAPI committee The Administrator wourse has a skills various and to the QAPI committee The Administrator wourse has a skills various distribution of the QAPI committee The Administrator wourse has a skills various distribution of the QAPI committee The Administrator wourse has a skills various distribution of the QAPI committee The Administrator wourse has a skills various distribution of the QAPI committee The Administrator would be a subject to the QAPI committe	edure to ensure that the plan attive and that specific ains corrected and/or in regulatory requirements. Isultant (or designee) will a worksheets for completion aing 5/24/18 for 4 weeks and onths. 8, random audits will be a glucometer cleaning and erformed per facility policy. 5 times weekly x 2 weeks, 3 eks, and then once weekly x aill be performed by Director of gers, Regional Nurse thee. The nurse consultant is with the Director of Nursing or who will report findings to be alidation completed within annually and report findings	F7	726		
	washing requirement been observed with validated by the Dire Manager before being medication carts. The title of the person implementing the acrea Regional Nurse Corrections.	eaning/Disinfecting and Hand the during orientation and has return demonstration ector of Nursing or the Uniting released to work on the on responsible for eceptable plan of correction: esultant, Director of Nursing ith completion by 5/25/18.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345471	B. WING			05/25/2018
	ROVIDER OR SUPPLIER IBURG HEALTH & REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 726	Continued From pag	e 27	F 72	26		
F 761 SS=E	6:34pm when observe review of the in-servit revealed nurses were disinfecting glucomer blood glucose test structions and blood glucose reading glucometers after earthe manufacturer's in provided by the facilit Label/Store Drugs ard CFR(s): 483.45(g)(h) §483.45(g) Labeling Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In according to have accessor in the service of the se	ch use as recommended by istructions on the wipes ty. and Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be ewith currently accepted is, and include the ry and cautionary expiration date when of Drugs and Biologicals ordance with State and ility must store all drugs and compartments under proper , and permit only authorized	F 70	61		6/25/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345471	B. WING _			05/25/2018	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 761	quantity stored is be readily detected. This REQUIREMI by: Based on observinterviews, the factor medications from addition, the facility medication cart for observed (Hall 20). The findings inclusively medication cart for observed (Hall 20). The findings inclusively medication cart for observed (Hall 20). The findings inclusively medication and in part, the factor of the factor	tribution systems in which the minimal and a missing dose can ed. ENT is not met as evidenced ations, record review and staff cility failed to remove expired 3 of 4 medication carts. In ty failed to lock an unattended or 1 of 4 medication carts (0,cart #2).	F 7	The plan of correcting the significancy. The plan should processes that led to the definition and the facility failed to remove medications from the carts and dispose of or return to pharm facility also had one nurse whock his medication cart during medication pass. The nurse medication cart unlocked is employed by the facility. The medications and unlabeled rowere immediately discarded narcotics were secured in the return and were not for paties were processed and returne pharmacy. Nursing staff were refer to the pharmacy tip shemedication storage/labeling, destructions, and product reacceptable plan of correction specific deficiency cited. The Director of Nursing province in the procedure for implementance of the pharmacy tip sheets by 6-22 administration verified that emedication cart was provide.	address the ficiency cited. expired and either macy; the who failed to ng the expired medications. The expired medications. The expired medications is they are directed to eets on product eturns. Inting the month of the month		
	expired 3/31/18 a Lorazepam 1mg t in the locked nard use.	nd an unopened sleeve of hat expired 4/30/18, both were		pharmacy tip sheets by 6-22 administration verified that e	2-18. Nursing each od with the nursing staff of ensure that		
		M Nurse #7 stated she was		specific deficiency cited rem			

Facility ID: 955030

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345471	B. WING _			05	/25/2018	
NAME OF PROVIDER OR		ABILITATION CENTER		24	TREET ADDRESS, CITY, STATE, ZIP CODE 415 SANDY PORTER ROAD HARLOTTE, NC 28273			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
unsure we She adde a clear be complete. She furth narcotics be An observed was concerned available. An intervent of the state of the st	ed she though ag and a spend, and a calliver stated that so she kept servation of ducted on 5/2 bbservation of the servation	th the expired medication. In they needed to be put in ecial form needed to be a to transport to pick it up. In at some couriers do not take at them locked in her cart. Ithe 200 Hall medication cart 23/18 at 3:53 PM with Nurse revealed an opened bottle of pired 1/2017 that was Inducted with Nurse #9 on Nurse #9 stated that all ininistered medication are sing expired medications. Inducted on 5/23/18 at 5:00 obtor of Nursing (DON). The ected the nurses to follow the lexpired medications. She because the nurses to put all a sealed clear bag with the in it, fill out the form and fax atted pharmacy will pick up all that completed faxed form. It is properly secured in a in the 200 Hall medication in the 200 Hall medication in the expected the staff to policy for disposal and	F7	761	and/or in compliance with the regulator requirements. Nursing administration conduct medication pass audits month 3 months and then quarterly to monitor proper labeling and storage of drugs of the medication cart. The facility pharmacist will also review medication carts monthly and report any concerns with labeling and storage of drugs to the Administrator and the Director of Nursi The results of the mediation pass audit and the pharmacy reviews will be reported to the QAPI committee for analysis of a patterns, trends, or need for further systemic changes. Any staff found to non-compliant with the storage and labeling of drugs will receive progressi discipline. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implement the acceptable plan of correction by 6-25-18.	will lly x r for n ne ine ing. ts orted any be		

Facility ID: 955030

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345471	B. WING _	B. WING		05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	pass on Hall 200, m #1 on 5/23/18 at 9:3 observed to prepare administration and a nebulizer treatments medication cart to R #47's room. The me unlocked and not vis members and a resi independently via a pass the cart. An interview was co 9:35am. Nurse #1 of medication unlocked	as made of a medication edication cart #2 with Nurse 1am. Nurse #1 was medications for after dispensing two different to the walked away from his esident edication cart was observed sible to Nurse #1. Staff	F7	761		
	An interview with the on 5/23/18 at 3:18pr expectation to keep while unattended by An interview with the 3:27pm revealed she cart to have been loomedication and left to resident.	e Corporate Nurse Consultant n indicated it was the facility's the medication carts locked				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345471	B. WING		05/25/2018
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 761	9:01am. A Humalog open with no opened Nurse #1 picked up a	e 31 th Nurse #1 on 5/23/18 at (insulin) vial was observed date written on the label. nother Humalog vial in his expired with an open date	F 76	1	
	revealed different nur the label that was not must had gotten torn	18 at 9:01am with Nurse #1 ses had work his cart and dated on the insulin vial off to order new insulin from #1 stated the expired en an oversight.			
	Nurse #1 discarded the insulins in his sharps observed getting a new room on Hall 200 and open date and initiale	23/18 at 9:01am revealed ne undated and expired container. Nurse #1 was we vial from the medication labeled the vial with an d his name. The sticker on ead to discard after 28 days			
F 803 SS=E	Consultant and Admir The expectations of tonce an insulin vial hould have been the open date per the should be discarded. Menus Meet Residen	18 at 3:18pm with the Nurse nistrator was conducted. The facility were indicated as ad been open for use, the nidated. Vials expired after a pharmacy guidelines, at Nds/Prep in Adv/Followed (7)	F 80:	3	6/25/18
	§483.60(c) Menus an Menus must-	d nutritional adequacy.			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345471	B. WING		05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	33.25.25.15
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 803	Continued From pag	e 32	F 80	03	
		he nutritional needs of nce with established national			
	§483.60(c)(2) Be pre	epared in advance;			
	§483.60(c)(3) Be foll	owed;			
	reasonable efforts, the ethnic needs of the r	et, based on a facility's the religious, cultural and esident population, as well as residents and resident			
	§483.60(c)(5) Be upo	dated periodically;			
	dietitian or other clini	riewed by the facility's ically qualified nutrition tional adequacy; and			
	construed to limit the personal dietary cho This REQUIREMEN by:	T is not met as evidenced			
	review of menus the ounce portion of mac macaroni and chees	on, staff interviews and facility failed to serve a 4 caroni and cheese, pureed e, pureed pinto beans, and r the menu for 4 of 11 foods eal tray line.		The plan of correcting the specific deficiency. The plan should address processes that led to the deficiency On 5-21-18, the cook used a 2-ound scoop to serve the puree and the mi and moist portions instead of a 4-ou scoop. The Dining Services Manage replaced the 2-ounce scoop with a	cited. ce inced nce
		d: :36 AM - 12:34 PM the nager (CDM) was observed		4-ounce scoop on the tray line. He as educated the cook on the importance checking the diet guide prior to setting the tray line to ensure that we are set the correct portion sizes. The Corpo	e of ng up erving

Facility ID: 955030

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345471 B. WING _				05/25/2018	
	VIDER OR SUPPLIER	HABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
ppsiotaattfopd Re4mppm Csittonmp D#hoottm	laced all foods and team table. The Clunce (#16 scoop) able for the macard and minced meats. The observation revior 70 residents on ureed diet and 3 resident. Leview of the 05/21 evealed the following ounce portion: nacaroni and chees ureed macaroni are ureed pinto beans ninced pork chop On 05/21/18 from 1 taff #1 (DS #1) was the lunch meal tray unce portion of macaroni and chees the lureed and minced pork chop to the ureed and minced pork chop to the ureed and minced that the lueer in the tray line, and foods before start and that he was the land that he was the land and that he was the land that he was the land that he was the land that he was the land that he land that	that days lunch meal and d serving utensils on the DM was observed to place a 2 serving utensil on the steam on and cheese, pureed foods. Interview with the CDM during ealed he was preparing foods a regular diet, 8 residents on a esidents on a minced foods. 1/18 lunch meal menu ing foods were to be served in see and cheese. 2:30 PM to 1:20 PM, dietary is observed to plate foods for line service. He served a 2 acaroni and cheese, pureed se, pureed pinto beans and o residents on a regular, if foods diet. 2:30 PM, DS unch tray line was set up when out place the serving utensils in the did not verify the portions tring the tray line. He stated ally serve foods for the lunch	F8	Dietitian and Dining Services reviewed scoop sizes and to ferving the correct portion dining services staff working morning of 5-22-18. The procedure for impleme acceptable plan of correction specific deficiency cited. Dining services staff receive education on scoop sizes a sizes; completed by 6-22-18. The monitoring procedure to the plan of correction is effect specific deficiency cited remand/or in compliance with the requirements. The Dining Services Manage ensure that scoop sizes are according to the diet guide weeks, then monthly x 2 managements according to	the importance on sizes with g during the conting the confor the ed in-service and portion To ensure that ective and that mains corrected the regulatory Ger will audit to e used weekly x 4 conths, then ure deficient e Corporate coop sizes on ekly facility visits ekly visit report ults of the e QAPI my patterns, systemic to be consible for le plan of		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345471	B. WING _			05/	25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER	•	24	TREET ADDRESS, CITY, STATE, ZIP CODE 115 SANDY PORTER ROAD HARLOTTE, NC 28273	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 803	utensils for the lunch day. The CDM state scoops of the foods	te 34 It up the foods and serving It meal tray line service that It that he usually served 2 It provide a 4 ounce portion, It rovide that instruction to DS	F	303	for implementing the acceptable plan correction by 6-25-18.	of	
	with the consultant re During the interview and stated that a 4 concess, pureed made pinto beans and min been served. The Re expected the cook to but since the CDM fi	d on 05/21/18 at 1:30 PM egistered dietitian (RD). the RD reviewed the menu nunce portion of macaroni and aroni and cheese, pureed ced pork chop should have D further stated that she monitor the portions served, lled in as the cook that day, e provided the oversight.					
F 806 SS=D	11:38 AM and stated made aware of the in served during lunch Administrator stated staff to follow the me to oversee this.	that she expected the dietary enu for portions and the CDM Preferences, Substitutes	F 8	306			6/25/18
	§483.60(d)(4) Food allergies, intolerance §483.60(d)(5) Appea	es and the facility provides- that accommodates resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345471	B. WING			05/25/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	.	00/20/2010	
				2415 SANDY PORTER ROAD			
MECKLEN	IBURG HEALTH & REHA	ABILITATION CENTER		CHARLOTTE, NC 28273			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 806	Continued From page	e 35	F 80	06			
	different meal choice This REQUIREMENT by:	Γ is not met as evidenced					
	Based on observation interviews and medic failed to provide regular resident's choice for	ons, family and staff cal record review, the facility alar scrambled eggs to honor or 1 of 7 sampled residents afterences (Resident #6).		The plan of correcting the spe deficiency. The plan should ad processes that led to the defici On 5-24-18, resident #6 receiv scrambled eggs instead of reg scrambled eggs, as requested	Idress the iency cited. red pureed ular on her tray		
	The findings included:			ticket. The Dining Services Ma immediately brought the reside regular scrambled eggs. The O Dietitian and Dining Services M	ent a bowl of Corporate		
	7/30/12. Diagnoses i			immediately educated the staff the importance of honoring res food preferences and sending item as requested on resident tickets. The procedure for implementir	f on duty in sident⊡s every food ⊡s tray		
	assessed Resident # rarely/never understo understands, severel required extensive st	y impaired cognition, and aff assistance with eating. sed Resident #6 required a		acceptable plan of correction for specific deficiency cited. The corporate dietician provided dining services staff with an interested to the plan of correction is effective specific deficiency cited remains and/or in compliance with the respecific deficiency with the respecific deficiency with the respecific deficiency with the respecific deficiency with the respectific deficiency with the respection.	ed facility -service on nd tray 18. nsure that ve and that ns corrected		
	nutrition care plan do had varied food intak her by staff. The CAA documented that Res and due to the Resid nutrition status, poor	sident #6 was underweight ent's risk for a decline in food intake, therapeutic diet, eed for supplements, staff		requirements The Dining Services Manager complete a tray accuracy audit weeks, then monthly x 2 month quarterly x 1 quarter to ensure practice does not recur. The C Dietitian will also conduct quar accuracy audits and include th weekly visit report to Administr	will t weekly x 4 hs, then deficient orporate terly tray is on her		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345471	B. WING _			05/	25/2018
	ROVIDER OR SUPPLIER IBURG HEALTH & REHA	BILITATION CENTER	•	24	TREET ADDRESS, CITY, STATE, ZIP CODE 115 SANDY PORTER ROAD HARLOTTE, NC 28273	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 806	maintain a stable weiner and wein	ght. order recorded Resident #6 reed texture diet.	FE	806	results of the audits will be reported to QAPI committee for analysis of any patterns, trends, or need for further systemic changes. Any staff found to I non-compliant will receive progressive discipline. The title of the person responsible for implementing the acceptable plan of correction. Dining Services Manager is responsible for implementing the acceptable plan of correction by 6-25-18.	oe e	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION IG	· ,	ATE SURVEY OMPLETED
		345471	B. WING _			05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 806	O5/24/18 at 8:20 AM Resident #6 received pureed texture break and eggs. The tray of recorded "Regular - scrambled eggs." Re eggs instead of regu "Everything she gets at the bottom of the to mornings and did no she should get the re The Certified Dietary Resident #6 with her 8:30 AM as requeste reviewed the tray car received pureed egg #6 should have rece scrambled eggs as p per the tray card. During an interview of interim Director of No would expect staff w their meal to review of items listed on the tra resident so that the r honored. The interim food item was missin to the kitchen to obta she also expected di items to the resident	served in her room on fed breakfast by RA #1. d milk, cranberry juice and a stast of sausage, oatmeal and on her breakfast tray Pureed, Send regular esident #6 received pureed lar eggs. RA #1 stated is spureed. I don't really look tray card. I feed her most to notice the tray card said egular scrambled eggs." Manager (CDM) observed breakfast meal on 5/24/18 at ed by the surveyor. The CDM and stated that Resident is and stated that Resident is and stated that Resident ived regular texture for the family request and as soon 5/24/18 at 8:35 AM, the fursing (DON) stated she ho assisted residents with the tray card and ensure all any card were available to the resident's preferences were in DON further stated that if a fing, she expected staff to go ain the missing item, but that letary staff to send all food	F8	06		

) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	FIPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED
345471	B. WING			05/25/2018
ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	<u> </u>	
MENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)		X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
AM, she stated that the ent #6 to receive regular in the tray card system exted preferences to be stated that when a not in line with the eility honored the request int/family on the exision. ARA #1 occurred on revealed Resident #6 is scrambled eggs and ate abled eggs compared to be of the pureed eggs. It is a compared to be of the pureed eggs. It is a compared to be of the pureed eggs. It is a compared to be of the pureed eggs. It is a compared to be of the pureed eggs. It is a compared to be of the pureed eggs. It is a compared to be of the pureed eggs. It is a compared to be equirements. In the state of the pureed eggs and ate abled eggs compared to be of the pureed eggs. It is a compared to be of the pureed eggs. It is a compared to be equirements. In the state of the pureed eggs and ate abled eggs compared to be of the pureed eggs. It is a compared to be of the pureed eggs. It is a compared to be equipment to be entirely be entirely entirely entirely eggs and ate and entirely eggs. It is a compared to the pureed eggs and ate and entirely eggs and ate and entir				6/25/18
	AM, she stated that the ent #6 to receive regular in the tray card system exted preferences to be stated that when a not in line with the edity honored the request int/family on the exision. AM #1 occurred on evealed Resident #6 is scrambled eggs and ate incled eggs compared to e of the pureed eggs. AP Prepare/Serve-Sanitary Equirements. A #1 occurred on evealed Resident #6 is scrambled eggs and ate incled eggs compared to e of the pureed eggs. AP Prepare/Serve-Sanitary Equirements. A pod from sources satisfactory by federal, items obtained directly be ons. The prohibit or prevent for the pure entry of the pur	A BUILDI 345471 B. WING ITATION CENTER MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) AM, she stated that the ent #6 to receive regular in the tray card system exced preferences to be stated that when a not in line with the existing honored the request int/family on the excision. ARA #1 occurred on revealed Resident #6 recrambled eggs and ate included eggs compared to be of the pureed eggs. APPrepare/Serve-Sanitary Prepare/Serve-Sanitary Figurirements. A BUILDI B. WING PREFI TAG Figure 1 Figure 2 Figure 2 Figure 3 Figure 4 Figure 3 Figure 4 Figure	A BUILDING 345471 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273 JENT OF DEFICIENCIES ISTS BE PRECEDED BY FULL DENTIFYING INFORMATION) F 806 AM, she stated that the int #6 to receive regular in in the tray card system beted preferences to be stated that when a not in line with the decision. ARA #1 occurred on evealed Resident #6 sorambled eggs compared to e of the pureed eggs. //Prepare/Serve-Sanitary F 812 PR 12 PR 12 PR 12 PR 21 A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273 ID PREFIX TAG F 806 F 806 AM, she stated that the int #6 to receive regular in the tray card system bete ded preferences to be stated that when a not in line with the decision. PR 8110 PR 21 PR 2	A BUILDING 345471 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC. 28273 AMA, She Stated that the ent #6 to receive regular in in the tray card system cited preferences to be stated that when a not in line with the sility honored the request highard and so of the pureed eggs. (Prepare/Serve-Sanitary PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) F 806 AMA, she stated that the ent #6 to receive regular in in the tray card system cited preferences to be stated that when a not in line with the sility honored the request higher than the pureed eggs and ate bled eggs compared to e of the pureed eggs. Prepare/Serve-Sanitary F 812 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) F 806 AMA, she stated that the ent #6 to receive regular in in the tray card system cited preferences to be stated that when a not in line with the sility on the cities on the pureed eggs. Prepare/Serve-Sanitary F 812 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) F 806 AMA, she stated that the ent #6 to receive regular in in the tray card system cited preferences to be stated that when a not in line with the allity benefit and the procured on everaled Resident #6 to receive regular in the tray card system cited preferences to be stated that when a not in line with the ent #6 to receive regular in the tray card system cross-REFERENCED TO THE APPROPRIATE CROSS-REFEREN

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		OATE SURVEY OMPLETED
		345471	B. WING _			05/25/2018
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 812	This REQUIREME by: Based on observe facility failed to us staff involved in for facility failed to mo peppers) for signs degrees Fahrenhe storage units obse air dry. The findings include A continuous obse department occur - 1:20 PM. The fol observed: A. On 5/21/18 fror certified dietary m for the lunch meal	entroined as evidenced ations and staff interviews, the e beard guards for 2 of 2 male od preparation. Additionally, the onitor produce (kale and bell of spoilage, store ice cream 0 eit or below for 2 of 3 cold erved and store clean dishes to ded: ervation of the dietary red on 05/21/18 from 11:36 AM lowing problems were m 11:36 AM - 12:34 PM, the anager (CDM) prepared foods tray line while wearing a beard cover his mustache or all of the	F8	The plan of correcting the sign deficiency. The plan should a processes that led to the deficiency and covering their manager and staff were educappropriate use of beard guaring service. On 5-25-18, the Din Manager and staff were educappropriate use of beard guaring include covering of the chee mustache by the Corporate of the composition of the composi	pecific address the ficiency cited. not having the nustache as g the meal sing Services cated on the ards to ks, chin, and Dietician. od items were of fresh kale d discarded the Dietitian. In an insulated of frigerator en them for Corporate ream pans and tacked and had te Dietitian	
	was not aware tha	on 5/21/18 at 12:31 PM that he at beard guards should cover all t he did not take into account		separated the pans and bow them to air dry completely. The Corporate Dietitian Services Manager reviewed storage procedures and the air-drying all pots/pans with services staff working during of 5-21-18. The Dining Servi	and Dining proper food importance of all dining the morning	
	staff #1 prepared meal tray line serv	n 12:15 PM - 1:20 PM, Dietary and plated foods for the lunch rice while wearing a beard cover his mustache or all of the		reviewed the appropriate use restraints (hairnets, hair cover beard guards) with all staff with morning of 5-25-18.	e of hair erings, and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	COMPL	ATE SURVEY OMPLETED
		345471	B. WING _			05/25/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1	00/20/2010
				2415 SANDY PORTER ROAD		
MECKLEN	IBURG HEALTH & REH	ABILITATION CENTER		CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SE	HOULD BE	(X5) COMPLETION DATE
F 812	Continued From pag	no 40	ЕО	12		
1 012			F 8	12		
	facial hair to his che	eks/cnin.		The precedure for implementing	tho	
	cooked most days a cover his beard, but			acceptable plan of correction for specific deficiency cited. Dining services staff were in-services the Dining Services Manager ar Corporate Dietician on proper for storage practices, appropriate u	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) procedure for implementing the otable plan of correction for the fic deficiency cited. To services staff were in-serviced by sining Services Manager and the orate Dietician on proper food ge practices, appropriate use of hair ints (hair nets, hair coverings, and guards), and the importance of air guall pots/pans; completed by 18. Inonitoring procedure to ensure that an of correction is effective and that fic deficiency cited remains corrected r in compliance with the regulatory rements corporate Dietitian will monitor for ation to meet regulatory standards g her weekly facility visits and include in her weekly visit report to histration. Dining Services Manager will audit priate use of hair restraints weekly x	
	C On 5/21/18 from					
	cover his beard, but not his mustache. He stated he had not been trained to cover his mustache. C. On 5/21/18 from 11:48 AM - 11:55 AM, The walkin-in refrigerator was observed with the following problems: A box of 10 bell peppers was observed, 2 of which had black/white fuzzy hair-like growth in various spots on the bell peppers. The bell peppers were discarded. A 5 pound bulging bag of kale was observed with			drying all pots/pans; completed 6-22-18.		
				The manitoring procedure to en	cure that	
		,				
	·					
		s in a brown pooling liquid		requirements	•	
	with a manufacturer	"Best by Date" of 4/17/18.				
	The kale was discar	ded.				
					and include	
		5/21/18 at 11:48 AM that he		· ·		
	_	efrigeration units daily, but did		Administration.		
	not check them over	the weekend.		The Dining Services Manager w	ill audit	
	E. On 5/21/18 at 12:	04 PM, the reach-in		4 weeks, then monthly x 2 mont	•	
		erved at 40 degrees		quarterly x 1 quarter to ensure of		
		ips of vanilla ice cream stored		practice does not recur.		
		ch, not frozen. The ice cream		·		
	was discarded.			The Dining Services Manager w		
				food storage in all refrigerators a		
				freezer weekly x 4 weeks, then		
		5/25/18 at 12:31 PM that the we been stored in the freezer.		2 months, then quarterly x 1 qua ensure deficient practice does n		
	E On 5/24/49 at 42:	OO DM two not/non storage		The Dining Services Manager w		
		00 PM, two pot/pan storage		drying procedures to ensure that and pans are air dried appropria		

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 _			05/	25/2018	
	ROVIDER OR SUPPLIER	BILITATION CENTER		24	REET ADDRESS, CITY, STATE, ZIP CODE 115 SANDY PORTER ROAD HARLOTTE, NC 28273			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 812		e 41 ans stored wet and stacked	F 8	12	weekly x 4 weeks, then monthly x 2			
	one on top of the other				months, then quarterly x 1 quarter to ensure deficient practice does not recu	RECTION HOULD BE PROPRIATE / x 2 ter to not recur. e will be e for , or need Any staff eccive ble for an of ponsible e plan of		
	12:00 PM that dishes	ian stated on 5/21/18 at were supposed to be a single layer/row to air dry.			The results of the audits and the will be reported to the QAPI committee for analysis of any patterns, trends, or nee for further systemic changes. Any staffound to be non-compliant will receive	ed		
	storage racks were so positioned so that all	/25/18 at 12:31 PM that the et to have everything items were stored slanted to were dry, then the items			progressive discipline. The title of the person responsible for implementing the acceptable plan of correction.			
F 835 SS=K	Administrator stated s	n 5/25/18 at 11:38 AM, the she expected the CDM to be Serve Safe standards.	F 8	35	Dining Services Manager is responsible for implementing the acceptable plan of correction by 6-25-18.		6/25/18	
	enables it to use its re efficiently to attain or practicable physical, well-being of each res This REQUIREMENT by: Based on observatio and staff interviews the provide oversight and to ensure policies and control practices were	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. is not met as evidenced is not met as evidenced eadministration failed to a leadership to facility nurses a training related to infection exercise ereviewed and updated to a standards of practice were no multi-use blood			The plan of correcting the specific deficiency. The plan should address th processes that led to the deficiency cite. The facility will continue the plan of correction initiated on 5-23-18. During the analysis of the deficient practice of Nurse #1, the nurse admitted to not following proper procedure by	ed. of t		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345471	B. WING _			05/2	25/2018
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, Z	IP CODE		
MECKLEN	IBURG HEALTH & REHA	BILITATION CENTER		2415 SANDY PORTER ROAD			
				CHARLOTTE, NC 28273			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE
F 835	Continued From page	e 42	F8	35			
	transporting used blo to a sharps container transmission of blood practice was observe had physician ordere and had the potential the risk for cross-compathogens (Resident Resident #72, Resident Resident #223). Immediate Jeopardy Nurse #1 was observe to transport a blood s Resident #36 during I his right scrub top po- and dirty supplies tha	od glucose test strips safely, and preventing borne pathogens. The failed d with 6 of 30 residents who d blood glucose monitoring to expose the residents to tamination of bloodborne #47, Resident #73, ent #67, Resident # 74, and began on 5/23/18 when ed during a medication pass ample test strip used on blood glucose monitoring in cket commingled with clean t included a nebulizer		placing the glucometer's #36 in his scrub pocket of supplies for Resident #4 placing the strip safely in container. " Nurse #1 was pulled immediately to discuss to practice for infection core cross contamination. Not sent home and no longe of the facility. " No other nurses we placing supplies with po pathogens comingled in " On May 23, 2018 di shift, before dinner, Nurse display the proper techn cleaning and disinfecting	comingled with 17 instead of 18 into the sharps of off the cart the deficient 18 introl and possiburse #1 was the er is an employed as tential blood bo to scrub pocket uring the evening the evening #2 failed to aique for the g of the	ole en ee orne ts.	
	Resident #47. On a sobservation Nurse #2 disinfecting a shared blood samples for bloresidents (Resident 7 #67, Resident #74, at Immediate Jeopardy when the facility provacceptable credible a The facility remains of scope and severity of harm with potential of that is not immediate education and ensure place are effective reglucometers, transpo	glucometer while collecting and glucose readings from 5 (3), Resident #72, Resident and Resident #223). The was removed on 5/25/18 ided and implemented an allegation of compliance. But of compliance at a lower at E (pattern with no actual at more than minimal harm jeopardy) to complete a monitoring systems put into		glucometer between pat #2 did not clean the gluc accucheck on Resident proceeded to perform ac residents # 72, 74, 67, a cleaning or disinfecting t Nurse #2 was immediate patient care and in-servi method for cleaning gluc regional nurse consultar given a copy of the gluc policy and procedure as washing policy, as soon practice was identified. then validated by return the appropriate steps, fo manufacturer guidelines of the glucometer, obser regional nurse consultar to patient care. Nurse # employed by the facility	cometer after the #73 and couchecks on and 223 without the glucometer. ely removed frous iced on the proposed from the was also one ter cleaning well as the harm as the deficien. Nurse #2 was demonstration of the cleaning for the cleaning roused by the int before returning is no longer.	om per so g nd t of g	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
		345471	B. WING	·		05/25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				2415 SANDY PORTER ROAD		
MECKLEN	IBURG HEALTH & REH	ABILITATION CENTER		CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 835	Continued From pag	e 43	F 83	35		
	The findings included			to the board of nursing.		
	The infamge morace	••		" Nurse #3 was asked by N	urse #2	
				which wipes were to be used t		
	1.Cross Refer to F88	0 Based on record review,		glucometer and incorrectly sta		
		an, and staff interviews the		cleaned with an alcohol wipe.		
	facility failed to trans	port a used blood glucose		was in-serviced immediately b		
	test strip safely by pla	acing the test strip in a scrub		regional nurse consultant and	returned to	
				patient care as soon as she ve	erbalized	
	test strip safely by placing the test strip in a scrub top pocket containing clean and dirty supplies for 2 of 2 residents (Resident #47 and Resident #36). In addition, the facility failed to follow safe practices for disinfecting a shared glucometer regional nurse consultant and returned to patient care as soon as she verbalized correct cleaning procedures, return demonstration, and a quiz following the education to determine knowledge					
	l '	-			•	
					-	
		washing during a medication		retention of the appropriate cle		
	I -	ents (Resident # 73, Resident		to use per manufacturer guide		
		Resident #74, and Resident ctices had the potential to		" During the analysis of the practice of Nurse #2, the nurse		
		its who had physician		being trained on the cleaning of		
		se monitoring in the facility at		glucometers despite being pre		
	_	al recertification by exposing		her signed acknowledgement		
		isk for cross-contamination		borne pathogens training on 4		
		ne pathogens (Resident #47,		nurse expressed to her direct		
	-	nt #72, Resident #67,		that she knew to clean the glue	-	
	Resident #74, and R	esident #223).		but thought alcohol wipes were		
				appropriate product for cleaning	ng. The	
				nurse also stated she was rusl	hing	
		6 Based on observation,		because the surveyor watching	-	
		cian, and staff interviews the		her feel anxious and stressed.	-	
		de training to 3 of 4 facility		review of the nurse s medicat		
		d Nurse #3) on how to		appropriate supplies were ava		
	_	er (a device used to test		were two glucometers and the		
		olood) that was shared		Sani-Wipes in a box in the bot		
		nd on how to dispose of a		of the cart for the disinfection of		
	-	p (Nurse #1) to avoid cross		glucometers. Further analysis		
		residents' environment and ansmission. The failed		that sufficient staff and supplie available to perform the proces		
	practice had the pote			policy.	aure hei	
		nysician ordered blood		" The cause of the nurses	inability to	
	-	the facility by exposing the		perform was that they were un		
		for cross-contamination of		recall their training on cleaning		
		pathogens (Resident #47.		alucometers.	,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345471	B. WING _			05/	25/2018
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				24	TREET ADDRESS, CITY, STATE, ZIP CODE 115 SANDY PORTER ROAD HARLOTTE, NC 28273		
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page	e 44	F 8	335			
	Resident 73, Resider Resident #74, and Ro	nt #72, Resident #67, esident #223).			The procedure for implementing the acceptable plan of correction for the specific deficiency cited.		
	included a facility pro of current residents h	file report that indicated 14% and infections and 32.6%			" Beginning 5-24-18, the Director of Nursing and Unit Managers will be in-serviced on nurse education and competency skill validations, including cleaning and disinfecting of glucomete by Regional Nurse Consultant.	the	
	revealed the Adminis aware of the facility to the nurse turn-over a had been high. She solid orientation to be the past DON who had oversight had not bee expectations and had	trator indicated she was raining policy and explained and retention in the facility stated the facility needed a excessful. She explained ad been responsible for the en able to execute dispense of the explained dispense of the execute dispense of			" Staff also received training on block borne pathogens as part of the skills validation, completed 6-22-18. " On 5-25-18, Director of Nursing at Unit Managers was in-serviced on performing a medication pass audit an observing accuchecks for proper technique by the Regional Nurse Consultant. " Facility nursing staff are being in-serviced beginning on 5-24-18 using	acation and ons, including the g of glucometers) sultant. raining on blood t of the skills 22-18. r of Nursing and erviced on pass audit and or proper al Nurse f are being 15-24-18 using a tion worksheet	
	Nurse Consultant we	re informed of the			skills competency validation workshee and return demonstration to ensure understanding of the training provided glucometer cleaning and disinfecting. Facility nurses will not be able care for residents until they have received the	for	
	specific Skills Compe nurses regarding res facility assessment n	n, record review revealed the etency Validation Record for ident care located in the otebook had not been #1, Nurse #2, and Nurse #3.			skills competency validation on glucometer cleaning. "New nurses hired will be given a scompetency validation worksheet that must be completed within 30 days of h training on blood borne pathogens, and	ire,	
		n, the facility provided the egation of Immediate			new hires will be observed performing accuchecks and disinfecting the glucometer with the supplies and proce recommended by the glucometer manufacturer. The nurse skills in the areas of blood borne pathogens		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	1 ' '	
		345471	B. WING			05/	25/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	415 SANDY PORTER ROAD		
MECKLEN	IBURG HEALTH & REHA	ABILITATION CENTER		c	CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
IAG			IAG		DEFICIENCY)	DIBE COMPLÉ DATE DATE DATE COMPLÉ DATE C	
F 835	Continued From page	e 45	F	835			
	The plan of correcting	g the specific deficiency. The			understanding and glucometer cleaning	a	
		the processes that led to the			and disinfection will be validated by	on (x5) D BE PRIATE COMPLETE DATE	
	deficiency cited.	and produced and roa to and			nursing administration before the nurse	۷	
					can be released from orientation to do		
	On May 23, 2018 dui	ring the evening shift, before			medication pass independently.	-	
		ed to display the proper			" Nursing staff will continue to have		
		aning and disinfecting of the			med-pass observations performed by t	COMPLETED 05/25/2018 EXAMPLE TE COMPLETED ATE COMPLETED OF COMPLETED	
	-	patient uses. Nurse #2 did			nursing administration team monthly x		
	_						
	_	proceeded to perform months and then quarterly to ease their comfort to enable them to be less anxious					
		ents # 72, 74, 67, and 223			and stressed while being observed dur	ing	
	without cleaning or d	isinfecting the glucometer.			their observation by a surveyor.		
	Nurse #2 was immed	liately removed from patient			" The facility administrator in		
		on the proper method for			conjunction with the Regional Nurse		
	cleaning glucometers	s by the regional nurse			Consultant will monitor the infection		
	consultant. She was	also given a copy of the			control program in the facility including		
	glucometer cleaning	policy and procedure as well			effective leadership by nursing		
	as the hand washing	policy, as soon as the			administration. The facility administrat	or	
	deficient practice was	s identified. Nurse #2 was			will review the facility policies, procedu	res,	
	then validated by retu	urn demonstration of the			manufacture instructions, and QAPI		
	appropriate steps, fol	llowing manufacturer			analysis of the infection control proces	s in	
	guidelines for the cle	aning of the glucometer,			the facility with the QIO; completed 6-1	3-	
	observed by the region	onal nurse consultant before			18.		
	returning to patient ca	are. Any further			" The facility will not tolerate breach	es	
	demonstration of inco	ompetent practices by nurse			of the infection control polices and		
	#2 will result in imme				expectations; staff will be disciplined us	sing	
		by Nurse #2 which wipes			the progressive discipline process.		
		ean the glucometer and					
	•	as cleaned with an alcohol			The monitoring procedure to ensure th		
		in-serviced immediately by			the plan of correction is effective and the		
	_	onsultant and returned to			specific deficiency cited remains correct		
	·	as she verbalized correct			and/or in compliance with the regulator	у	
		return demonstration, and a			requirements.		
	quiz following the edu				" Regional Nurse Consultant (or		
	_	of the appropriate cleaning			designee) will audit skills validation		
	agent to use per mar				worksheets including glucometer		
	, ,	of the deficient practice of			cleaning, for completion once weekly		
		denied being trained on the			beginning 5-24-18 for 4 weeks and the	n	
	l cleaning of glucomet	ers despite being presented	1		monthly x 5 months.		1

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345471	B. WING _	B. WING			25/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MEOKIEN	IDUDO UEALTU O DEUA	DU ITATION OFNITED		24	15 SANDY PORTER ROAD		
MECKLEN	IBURG HEALTH & REHA	ABILITATION CENTER		CH	HARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	_	owledgement of blood borne	F 8	335	" Administrator (or designee) will rev		
	pathogens training or expressed to her dire to clean the glucomed wipes were the approach. The nurse also stated surveyor watching he stressed. Upon revie cart, the appropriate sthere were two glucon in a box in the bottom disinfection of the gluconfirmed that sufficie available to perform to the cause of the nurse that they were unable cleaning of glucometer. The procedure for implan of correction for	a 4/18/18. The nurse ct supervisor that she knew ters but thought alcohol priate product for cleaning. It was rushing because the remade her feel anxious and w of the nurse's medication supplies were available; meters and the Sani-Wipes a drawer of the cart for the cometers. Further analysis ent staff and supplies were the procedure per policy. See' inability to perform was a to recall their training on ters.			medication pass observation workshee for completion monthly x12 months dur the monthly QAPI meeting. "Facility pharmacy nurse consultan will monitor a sample of medication car during his monthly visits for supplies ar glucometer cleaning techniques. "The medical director will review the monitoring for trends and patterns during the quarterly QAPI meetings. "The director of nursing reported Nurse #2 to the board of nursing on 5-218; Nurse # 2 is no longer employed by the facility. The title of the person responsible for implementing the acceptable plan of correction. Director of Nursing, Regional Nurse Consultant, Pharmacist, and Administrations.	ts ing t ts ad e ang	
	Unit Managers will be education and competincluding the cleaning glucometers) by Regi On 5/25/18, Director of Managers was in-sermedication pass audi for proper technique I Consultant. Facility nursing staff a beginning on 5/24/18 validation worksheet ensure understanding glucometer cleaning a	onal Nurse Consultant. of Nursing and Unit viced on performing a t and observing accuchecks by the Regional Nurse are being in-serviced using a skills competency and return demonstration to g of the training provided for and disinfecting. Facility e care for residents until			with completion by 5-25-18.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345471	B. WING			05/	25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		241	REET ADDRESS, CITY, STATE, ZIP CODE 15 SANDY PORTER ROAD IARLOTTE, NC 28273	1 00	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	completed within 30 blood borne pathoge observed performing the glucometer with recommended by the The nurse's skills in pathogens understate cleaning and disinfernursing administration released from orient independently. Nursing staff will corrobservations perform administration team quarterly to ease the be less anxious and observed during their The facility administration team quarterly to ease the be less anxious and observed during their The facility administration team quarterly to ease the bear of the facility administration team quarterly to ease the bear of the facility administration team quarterly to ease the bear of the facility administration control progent facility administration control progent facility with the facility will not to infection control policy will be disciplined us process. The monitoring procoff correction is effect deficiency cited remains and process. Regional Nurse Control Policy with the Regional Nurse Control Policy Control Poli	Il be given a skills on worksheet that must be days of hire, training on ens, and all new hires will be accuchecks and disinfecting the supplies and process a glucometer manufacturer. The areas of blood borne anding and glucometer ection will be validated by on before the nurse can be action to do a medication pass are do by the nursing monthly x 3 months and then air comfort to enable them to stressed an in being robservation by a surveyor. The actor in conjunction with the sultant will monitor the gram in the facility including by nursing administration. The actor will review the facility manufacture instructions, and the infection control process a QIO. Solerate breaches of the ces and expectations; staffing the progressive discipline	F	835			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		345471	B. WING		05	/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 835	beginning 5/24/18 for 5 months. Administrator (or des pass observation wor monthly x12 months meeting. Facility pharmacy nursample of medication visits for supplies and techniques. The medical director trends and patterns of meetings. The director of nursing board of nursing on 5 The title of the persor implementing the according to the person implementing the ac	for completion once weekly 4 weeks and then monthly x ignee) will review medication ksheets for completion during the monthly QAPI rese consultant will monitor a carts during his monthly diglucometer cleaning will review the monitoring for luring the quarterly QAPI reg reported Nurse #2 to the 1/25/18.	F 83			
F 867 SS=E	6:34pm when observ revealed nurses were disinfecting glucomet practices, and transp test strips safely to a demonstrated how to readings and disinfectuse as recommended instructions on the with QAPI/QAA Improvem CFR(s): 483.75(g)(2)	e knowledgeable about ers, handwashing safe orting used blood glucose sharps container. Nurses obtain blood glucose ting glucometers after each d by the manufacturer's pes provided by the facility. ent Activities	F 86	57		6/25/18

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345471	B. WING _			05/	25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER	·	24	TREET ADDRESS, CITY, STATE, ZIP CODE 115 SANDY PORTER ROAD HARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867		uality assessment and	F	367			
	assurance committe (ii) Develop and implaction to correct ider This REQUIREMEN by: Based on record rev facility's Quality Asse Committee failed to procedures and mor the committee put in was for three recited originally cited in Jur recertification survey recited in May 2018 survey. The deficier drug records, label/s increase/ prevent de mobility, and food Pr serve- sanitation. Th facility during two fee	e must: lement appropriate plans of ontified quality deficiencies; T is not met as evidenced view and staff interview the essment and Assurance maintain implemented of the place in June 2017. This deficiencies which were the 2017 during a vand were subsequently on an annual recertification oncies were in the areas of storage and biologicals, crease in range of motion/recurement, store/ prepare/ the continued failure of the deral surveys of record show ties inability to sustain an urance Program.			The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cite. "The facility failed to ensure expired medications were removed from the cast the facility had previously been deficient securing a storage room with nursing supplies. The facility performance improvement plan to ensure secure storage of medications was successful and not a repeated issue; the medication were secure but not removed from the cart during the survey. "The facility failed to apply an orthous for one resident, the facility had previous been deficient in restorative programm. The facility had identified the restorative concern and the QAPI committee had already initiated a performance improvement plan prior to survey. "The facility failed to ensure food storage and use of beard guards met the guidelines. The facility QAPI committee has been working on these dietary are and has soon improvement in the health and the process of the proces	ed. d int, nt in ons tic usly ing. e	
	on observations, rec interviews, the facilit medications from 3 o	y failed to remove expired f 4 medication carts.			and has seen improvement in the heal inspection sanitation scores. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The Administrator met with the Quality Improvement Organization on 6-13-18		
	An interview with the	Administrator and Regional			review facility QAPI activities.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
	345471	B. WING			05/	25/2018
ROVIDER OR SUPPLIER IBURG HEALTH & REH	ABILITATION CENTER		24	115 SANDY PORTER ROAD	, 00.	20,2010
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
Nurse Consultant or that medication storaduring last year's sur Consultant stated duwas in the process of storage rooms. The verbalized that expiricant and they should resident and state to apply a left ankle/ recommended by proceeding for up to 8 hour (Resident #50) observed and resident and state to apply a left ankle/ recommended by proceeding for up to 8 hour (Resident #50) observed and interview with the 2:57pm revealed that not functional at this stated that the team developed a Perform (PIP) to address this result for 2 of 2 male staff additionally, the facility of the storage of the staff additionally, the facility of the storage of the staff additionally, the facility of the storage of the staff additionally of the staff additiona	in 5/25/18 at 2:55pm revealed age was a building issue rvey. The Regional Nurse uring that survey, the building of relocating the medication Regional Nurse Consultant red medications were on the Inot have been. The Decrease in ROM/ observations, record review of interviews the facility failed foot orthotic (AFO) hysical therapy to be worn res for 1 of 4 residents reved for range of motion. The Administrator on 5/25/18 at a set the restorative program was a time. The Administrator just met (May 2018) and hance Improvement Plan area. The Administrator on the interview of the i	F	867	QAPI committee on Performance Improvement Plans and the expectation for continued improvement in areas be expectation. The current performance improvement plans for Restorative and Dietary storage and serving were revise to add the concerns identified during the survey during the 6-15-18 QAPI meeting. The QAPI committee agreed that the medication was stored securely as identified in the previous plan, but initiated a new Performance Improvement Plans include the discarding of expired medications. The QAPI committee will continue to use audits and data to determine areas below expectation and implement Performance Improvement Plans as indicated. The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements. The Administrator will continue to work with the Quality Improvement Organization on best practices for QAPI and Performance Improvement. The administrator will set the minutes of the QAPI committee meetings to the corporate quality assurance nurse for review and recommendations. The title of the person responsible for implementing the acceptable plan of correction.	n low ed e e ng. ted to	
An interview with the	e Administrator on 5/25/18 at			The Administrator is responsible for implementing the acceptable plan of		
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OR SUPPLIER) Continued From page Nurse Consultant or that medication storaduring last year's su Consultant stated duwas in the process of storage rooms. The verbalized that expiricant and they should resident and state to apply a left ankle/recommended by proceeding for up to 8 hours (Resident #50) observed and resident and state to apply a left ankle/recommended by proceeding for up to 8 hours (Resident #50) observed for the team developed a Perform (PIP) to address this stated that the team developed a Perform (PIP) to address this	CORRECTION IDENTIFICATION NUMBER:	ROVIDER OR SUPPLIER BURG HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 Nurse Consultant on 5/25/18 at 2:55pm revealed that medication storage was a building issue during last year's survey. The Regional Nurse Consultant stated during that survey, the building was in the process of relocating the medication storage rooms. The Regional Nurse Consultant verbalized that expired medications were on the cart and they should not have been. F688 Increase/ prevent Decrease in ROM/ Mobility: Based on observations, record review and resident and staff interviews the facility failed to apply a left ankle/ foot orthotic (AFO) recommended by physical therapy to be worn daily for up to 8 hours for 1 of 4 residents (Resident #50) observed for range of motion. An interview with the Administrator on 5/25/18 at 2:57pm revealed that the restorative program was not functional at this time. The Administrator stated that the team just met (May 2018) and developed a Performance Improvement Plan (PIP) to address this area. F812 Food Procurement, Store/ Prepare/ Serve-Sanitary: Based on observations and staff interviews, the facility failed to use beard guards for 2 of 2 male staff involved in food preparation. Additionally, the facility failed to store clean dishes to air dry, monitor produce (kale and bell peppers) for signs of spoilage, and store ice cream 0 degrees Fahrenheit or below for 2 of 3 cold storage units observed.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 Nurse Consultant on 5/25/18 at 2:55pm revealed that medication storage was a building issue during last year's survey. The Regional Nurse Consultant stated during that survey, the building was in the process of relocating the medication storage rooms. The Regional Nurse Consultant verbalized that expired medications were on the cart and they should not have been. 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A BUILDING 345471 345471 345471 345471 345471 345471 345471 35TREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273 SUMMARY STATEMENT OF DESICIENCIES (EACH DEFICIENCY MIST ER PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 Nurse Consultant on 5/25/18 at 2:55pm revealed that medication storage was a building issue during last year's survey. The Regional Nurse Consultant stated during that survey, the building was in the process of relocating the medication storage was a building issue during last year's survey. The Regional Nurse Consultant stated during that survey, the building was in the process of relocating the medication storage was a building issue during last year's survey. The Regional Nurse Consultant verbalized that expired medications were on the cart and they should not have been. F688 Increase/ prevent Decrease in ROM/ Mobility: Based on observations, record review and resident and staff interviews the facility failed to apply a left ankle/ foot orthotic (AFO) recommended by physical therapy to be worn daily for up to 8 hours for 1 of 4 residents (Resident #50) observed for range of motion. An interview with the Administrator on 5/25/18 at 2:57pm revealed that the restorative program was not functional at this time. The Administrator stated that the team just met (May 2018) and developed a Performance Improvement Plan (PIP) to address this area. F812 Food Procurement, Store/ Prepare/ Serve-Sanitary: Based on observations and staff involved in food preparation. Additionally, the facility failed to use beard guards for 2 of 2 male staff involved in food preparation. Additionally, the facility failed to store clean dishes to air dry, monitor produce (kale and bell peppers) for signs of spoilage, and store ice cream 0 degrees Fahrenhete to below for 2 of 3 cold storage units observed. The Administrator is responsible for implement performance improvement produce (kale and bell peppers) for signs of spoilage, and store ice crea	A BUILDING 345471 B. WIMG STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 50 Nurse Consultant on 5/25/18 at 2:55pm revealed that medication storage was a building issue during last year's survey. The Regional Nurse Consultant stated during that survey, the building was in the process of relocating the medication storage rooms. The Regional Nurse Consultant verbalized that expired medications were on the cart and they should not have been. F888 Increase/ prevent Decrease in ROM/ Mobility: Based on observations, record review and resident and staff interviews the facility failed to apply a left ankle/ foot orthotic (AFO) recommended by physical therapy to be worn daily for up to 8 hours for 1 of 4 residents (Resident #50) observed for range of motion. An interview with the Administrator or 5/25/18 at 2:57pm revealed that the restorative program wes not functional at this time. The Administrator stated that the team just met (May 2018) and developed a Performance Improvement Plan to include the discarding of expired medications. The Administrator will continue to use audits and data to determine areas below expectation and implement Performance Improvement Plan (PIP) to address this area. F812 Food Procurement, Store/ Prepare/ Serve-Sanitary: Based on observations and staff interviews, the facility failed to use beard guards for 2 of 2 male staff involved in food preparation. Additionally, the facility failed to store clean dishes to air dry, monitor produce (kale and bell peppers) for signs of spoilage, and store ice cream 0 degrees Fahrenheit or below for 2 of 3 cold storage units observed. The Administrator is responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345471	B. WING		05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 867	some of the areas reg	the facility has addressed garding the kitchen and this aprovement in recent health	F 80	correction by 6-25-18.	
F 880 SS=K	3:00pm verbalized the corrections from the purchase from the purch	any new areas identified. & Control (2)(4)(e)(f) Introl blish and maintain an and control program a safe, sanitary and ment and to help prevent the ensmission of communicable ins. prevention and control blish an infection prevention (IPCP) that must include, at	F 8	30	6/25/18

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345471	B. WING		05/25/2018	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	, 00:20:20:0	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 880	§483.80(a)(1) A system or reporting, investigat and communicable staff, volunteers, visproviding services userrangement based conducted accordinaccepted national services for the procedures for the put are not limited to (i) A system of survery possible communication infections before the persons in the facility (ii) When and to who communicable diserreported; (iii) Standard and trato be followed to pre (iv) When and how is resident; including to (A) The type and dudepending upon the involved, and (B) A requirement the least restrictive posticicumstances. (v) The circumstances. (v) The circumstance must prohibit emploid disease or infected contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact with resider contact will transmit (vi) The hand hygier by staff involved in other contact with resider contact will transmit (vi) The hand hygier by staff involved in other contact with resider contact will transmit (vi) The hand hygier by staff involved in other contact with resider contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff involved in other contact will transmit (vi) The hand hygier by staff in	them for preventing, identifying, ing, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment g to §483.70(e) and following tandards; en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a put not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ese under which the facility eyees with a communicable skin lesions from direct atts or their food, if direct	F 880			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		TE SURVEY MPLETED	
		345471	B. WING _			5/25/2018	
	ROVIDER OR SUPPLIER BURG HEALTH & RE	EHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COI 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	1 03/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	\$483.80(e) Linens Personnel must ha	e facility's IPCP and the taken by the facility.	F 8	880			
	IPCP and update to This REQUIREMED by: Based on record and staff interview practices for disinful and performing has pass for 5 of 5 resultant for the staff interview practices for disinful and performing has pass for 5 of 5 resultant for the staff in a scrul and dirty supplies that and Resident observed with 6 of physician ordered had the potential that the potential th	review. Induct an annual review of its their program, as necessary. INT is not met as evidenced review, observations, physician, as the facility failed to follow safe fecting a shared glucometer indwashing during a medication idents (Resident # 73, Resident 7, Resident #74, and Resident 4, the facility failed to transport a retest strip safely by placing the process to the facility failed practices were from a for 2 of 2 residents (Resident #36). The failed practices were from a for 2 of 2 residents who had blood glucose monitoring and of expose the residents to the amination of bloodborne for #47, Resident #73, sident #67, Resident #74, and for the facility and the facility an		The plan of correcting the spreadeficiency. The plan should a processes that led to the defi "During the analysis of the practice of Nurse #1, the nurse to not following proper procesplacing the glucometer strip for #36 in his scrub pocket comisupplies for Resident #47. "During the analysis of the practice of Nurse #2, the nurse being trained on the cleaning glucometers despite being proper her signed acknowledgement borne pathogens training on nurse expressed to her direct that she knew to clean the glucometer borne pathogens training on nurse expressed to her direct that she knew to clean the glucometer borne pathogens training on nurse expressed to her direct that she knew to clean the glucometer broduct for clean review of the nurse smedic appropriate supplies were avwere two glucometers and the Sani-Wipes in a box in the boof the cart for the disinfection glucometers. "During the analysis of the	address the iciency cited. e deficient se admitted dure by for Resident ngled with e deficient se denied of resented with t of blood 4-18-18. The t supervisor ucometers ere the ning. Upon ation cart, the railable; there are to of the		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		345471	B. WING _			05/25/2018
NAME OF PI	ROVIDER OR SUPPLIER		_	STREET ADDRESS, CITY, STATE, ZIP CO	•	00:20:20:0
				2415 SANDY PORTER ROAD		
MECKLEN	IBURG HEALTH & REH.	ABILITATION CENTER		CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	observation Nurse # disinfecting a shared blood samples for blood, Resident #74, a Immediate Jeopardy when the facility provacceptable credible and the facility remains a scope and severity of harm with potential of that is not immediate education and ensurplace are effective reglucometers, transposition of the facility provacce and preventing pathogens. Findings included: 1. A review of a facility a facility following a line accordance with man recommendation. A review of the manual facility for the meter using a line accordance with manual facility for the meter using a line accordance with manual facility for the meter using a line accordance with manual facility for the f	separate medication pass 2 was observed not diglucometer while collecting ood glucose readings from 5 73, Resident #72, Resident and Resident #223). The was removed on 5/25/18 wided and implemented an allegation of compliance. Oout of compliance at a lower of E (pattern with no actual of more than minimal harm be jeopardy) to complete the monitoring systems put into the elated to disinfecting orting supplies exposed to g transmission of bloodborne with policy for Patient Care 1/26/17, Section 13, titled, in part, Clean the outside of t-free cloth. Clean in	F 8		expressed to the knew to be even patients, were a was noted to colood sulin during a bass. After the ecked, Nurse more insulin eeded to included: rip, gloves, insulin pen cohol prep in all into his a winfection esidents have by the deficient ents #72, 74, the facility of cleaning the Resident #73 and during her also observed tween glove mediately	
	titled, "Maintenance, Guidelines" read in p should wear gloves of Wash hands after tal blood presents a pot suggest cleaning and between patient use can be completed by	Cleaning and Disinfecting part, Healthcare professionals when cleaning the meter. king off gloves. Contact with cential infection risk. We disinfecting the meter. Cleaning and disinfecting vasing a commercially ered disinfectant detergent or		in-serviced; nurse #2 is no employed by the facility and to the board of nursing. " Nurse #3 expressed kr wrong cleaning supply by u wipes after the completion accucheck. Nurse #3 was immediately and returned to as soon as she verbalized.	longer d was reported nowledge of the sing alcohol of an in-serviced o patient care	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION (X			(X3) DATE SURVEY COMPLETED	
		345471	B. WING _			05/	25/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
MECKLEN	IBURG HEALTH & REHA	BILITATION CENTED		24	415 SANDY PORTER ROAD			
WECKLEN	IBUNG HEALTH & KEHA	BILITATION CENTER		С	HARLOTTE, NC 28273			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880	Continued From page	e 55	F8	380				
	germicide wipe. A review of the PDI S Disposable Wipe mar part, to disinfect: unforthoroughly wet surfact remain visibly wet for additional wipe(s) if n 4 minute wet contact A review of a facility prequirements dated	ani Cloth Bleach Germicidal nufacturer guidelines read in old a clean wipe and se. Treated surface must a full 4 minutes. Use an eeded to assure continuous			cleaning procedures, return demonstration, and a quiz following the education to determine knowledge retention. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The facility will continue the plan of correction initiated on 5-23-18. Facility nursing staff are being			
	require hand hygiene any invasive procedu sampling). a. A review of the adr	: before and after performing re (e.g. fingerstick blood mission MDS dated 5/8/18			in-serviced beginning on 5-23-18 on th policy on Patient Care Equipment including: use of PDI Sani-Wipes, and time. Facility nursing staff are being in-serviced beginning on 5-23-18 on th	wet		
	making. Diagnoses of paranoid schizophren	ive skills for daily decision coded included diabetes and iia.			policy Handwashing Requirements. Facility nursing staff also acknowledge by signature the understanding of transmission precautions and that prophand washing and glucometer disinfec	er ting		
	order dated 5/11/18 the sample to rule out C I a bacteria that causes colon. The bacteria secontaminated object of A physician order for order dated 5/12/18 the (Flagyl, used to treat times daily until 5/23/14 A review of a critical I	Difficile (clostridium difficile, s an inflammation of the spreads by contact with a or surface). Resident #73 revealed an hat read, Give Metronidazole C Difficile) 500mg three			was required to prevent the transmission of blood borne pathogens. Education of provided by DON, unit managers, and Regional Nurse Consultant. New hires will be educated during general orientate by nursing administration, which will be confirmed by the administrator before to can independently provide glucose checks. Nursing staff will be in-service before returning to work "The medical director, and physicial for Residents #73, 72, 74, 67, and 223 was notified on 5-23-18 of the deficient practice of the	was stion e hey ed		
	Resident #73 reveale difficile.	a aetectea toxigenic C.			5-23-18 of the deficient practice of the nurses by the Administrator and the Regional Nurse Consultant. RN			

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CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				CIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345471	B. WING_			05/	25/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	FREET ADDRESS, CITY, STATE, ZIP CODE		
				24	115 SANDY PORTER ROAD		
MECKLEN	IBURG HEALTH & REH	ABILITATION CENTER			HARLOTTE, NC 28273		
				_	·		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFI	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	^	CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 880	Continued From page	e 56	F	380			
		pass observation on 5/23/18			assessment of all five residents has no	t	
		stated she had obtained the			shown any change in condition potenti	ally	
		od glucose monitoring from			caused by the deficient practice of the		
	Resident #73 in her r				nurses. The physician agreed to order		
		glucometer with a blood			Hepatitis and HIV panels on all five		
	•	ad 223. Nurse #2 then			residents to rule out the diagnosis of a	ny	
	1	blood thinner injection) and a			new blood borne pathogens; all five		
	,	ed to treat diabetes) syringe			residents refused to comply with the		
		Resident #73. Nurse #2			physician orders and would not permit	tne	
	was observed to place	_			labs to be drawn. Each resident was		
	' '	edications and then removed			educated, re-approached, and still refu		
	_	tering Resident #73's room.			the testing. The health department wa notified and reviewed the national	S	
		ced on for administering the dent #73 and then removed			database for Hepatitis and HIV and for	ınd	
		om. Nurse #2 walked back to			no indications of previous infection by		
	_	and placed new gloves on for			of the five residents. The health	arry	
	the next resident, Re				department was notified, of the second		
		ood glucose monitoring.			refusal by three of the residents and th		
		neters observed sitting on the			discharge of two of the residents, and		
		the same glucometer was			stated the facility did not need to pursu	е	
	chosen to be used fo	or the next assigned resident,			the labs since the database was negat	ive.	
	Resident #72. No ha	andwashing or disinfecting			The facility will notify the health		
	the glucometer was of	observed.			department if any signs or symptoms of	f	
					Hepatitis or HIV presents in any of the		
		mission MDS dated 1/16/18			patients by November 2018.		
		Resident #72 had intact			" Nurse #1 was pulled off the cart		
		s coded included diabetes			immediately to discuss the deficient		
	and brain stem stroke	e syndrome.			practice for infection control and possil		
		20/40 / 4.50			cross contamination. Nurse #1 was th		
	An observation on 5/				sent home and no longer is an employ	ee	
		e gathered an alcohol swab,			of the facility.		
		the shared glucometer used			INO Other Hurses were luchtimed as		
		n her medication cart on Hall			placing supplies with potential blood be		
	· ·	d a new test strip in the			pathogens comingled into scrub pocke		
		nd went into the room where I to collect a blood sample			" The responsible parties were notif of the deficient practice by the nurses in		
		nitoring. The glucometer			the performance of the care of the six	11	
	-	eft the room and read the			residents on 5-25-18.		
		an order from the Electronic			" The facility contacted the QIO on a	5-25	
	Shamig Sould priyoloid	5. 501 110111 1110 11101101110	1		The facility contacted the QIO off	,	

Facility ID: 955030

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			TE SURVEY MPLETED
		345471	B. WING			5/25/2018
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	•	3/23/2010
				2415 SANDY PORTER ROAD		
MECKLEN	IBURG HEALTH & REH	ABILITATION CENTER		CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	Continued From pag	e 57	F 88	80		
F 880	Medication Administrunits were needed. It disinfecting the gluco observed removing he blood glucose check for the next resident, scheduled to have blood the medication cart and to chosen to be used for Resident #67. No have considered the mass coded indicating cognitive patterns. Endiabetes, hemiplegia cerebral infarction affiside. An observation on 5/#2 revealed she gath lancet, test strip, and for Resident #72 from 100. Nurse #2 place glucometer and went #67 to collect a blood monitoring. The glucoleft the room and real Novolog from the eM would need 4 units on Humalog administered observed disinfecting observed taking off the blood sugar check ar prepare both insulins administered the insulance.	ation Record (eMAR), O Nurse #2 was not observed meter. Nurse #2 was ler gloves used during the and placing new gloves on Resident #67, who was lood glucose monitoring. leters observed sitting on the the same glucometer was in the next assigned resident, andwashing was observed. In the left had moderate biagnoses coded included and hemiparesis following a fecting the left non-dominant 23/18 at 4:57pm with Nurse lered an alcohol swab, the same glucometer used in her medication cart on Hall	F 8i	-18 to request additional trainfection control and blood pathogens for facility staff; representative for the Charagreed to meet with the facility however, the meeting was rescheduled. The Adminismet with the QIO represent 18. "The director of nursing Nurse #1 and Nurse #2 to department and the board 25-18; both nurses are not employed by the facility. The monitoring procedures the plan of correction is effective deficiency cited reand/or in compliance with the requirements. "Education was provided Regional Nurse Consultant of Nursing and Unit Managedemonstration on the clear disinfecting process for glumanufacturer guidelines or. The Administrator spothealth department on 5-29-the glucometer breach; the further recommendations. also met with the local heat at the facility on 6-7-18 to reglucometer breach and the correction with no further recommendations provided department except to notify department if any signs or	borne the QIO rlotte area cility on 5-29- vas trator and DON tative on 6-13- greported the local health of nursing on 5- longer to ensure that ective and that mains corrected he regulatory ed by the to the Director ers with return hing and cometers per n 5-24-18. ke with the local -18 regarding re were no Administrator lth department eview the plan of I by the health of the health	
	blood sugar check ar prepare both insulins administered the insu injection in the reside room and removed h	nd placing new gloves on to for Resident #67. Nurse #2 ulins via subcutaneous		correction with no further recommendations provided department except to notify	I by the health the health symptoms of any of the	

Facility ID: 955030

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345471	B. WING			5/25/2018
NAME OF PI	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CO	•	0/20/2010
				2415 SANDY PORTER ROAD		
MECKLEN	IBURG HEALTH & REHA	ABILITATION CENTER		CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	Continued From page	e 58	F 88	30		
F 88U	#74, who was schedimonitoring. There we sitting on the medicar glucometer was chost assigned resident, Richandwashing was obtained. Resident #74 was diagnosis that include past medical history diabetes, and pulmor During an observation Nurse #2 gathered at strip, and the same is Resident #73, Resident #73, Resident #74 to collect a blood monitoring. The glucometer and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring. The glucomater and went #74 to collect a blood monitoring and went #75 to collect a blood monitoring. The glucomater and went #75 to collect a blood monitoring and went #75 to collect a	alled to have blood glucose are 2 glucometers observed atton cart and the same are to be used for the next resident #74. No asserved. admitted on 5/17/18 with red altered mental status and red for dementia, hypertension, mary hypertension. In on 5/23/18 at 5:06pm, and alcohol swab, lancet, test thared glucometer used for rent #72, and Resident #67. The st strip in the shared at to the room for Resident at sample for blood glucose cometer read 268. Nurse #2 retion cart to read the sliding at the order read to lurse #2 was not observed and the sliding at the order read to lurse #2 was not observed and the sliding at the blood sugar clean gloves before the insulin needed for a #2 administered the insulins rection in the resident's room. The mand removed her gloves.	F 88	"Beginning on 5-25-18, will be conducted to ensure cleaning is performed per fa and manufacturer instruction be done 5 times weekly x 2 times weekly x 2 weeks, and weekly x 2 months. Audits performed by Director of Numanagers, Regional Nurse designee. The nurse consureview the audits with the Director of the QAPI. The title of the person responsible menting the acceptable correction. Director of Nursing and Inference of Nursing Inference o	e glucometer acility policy ons Audits will e weeks, 3 ad then once will be ursing, Unit Consultant or ultant will Director of tor who will committee. onsible for le plan of	
	nervous that she had indicated she knew h					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		\ , ,	E SURVEY IPLETED		
		345471	B. WING _		0:	5/25/2018
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	hand gel stored on put on new gloves #223, who was sch monitoring. There is sitting on the medic glucometer was ch assigned resident, e. Resident #223 widiagnoses that incl Alzheimer's diseas. During an observat Nurse #2 gathered strip, and the same used for Resident #67, and Resident strip in the shared room for Resident for blood glucose in read 169. Nurse # cart and threw awa container and begat glucometer back in #2 was not observed during the blood su was observed after During an interview #2 stated she had glucometer used do for the blood glucos #73, Resident #72, and Resident #223 was to disinfect the supplies were available.	canitized her hands with the top of her medication cart and for the next resident, Resident neduled to have blood glucose were 2 glucometers observed cation cart and the same osen to be used for the next	F8			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345471	B. WING		05/25/2018
	ROVIDER OR SUPPLIER	HABILITATION CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	, 00/20/20 10
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICS)	D BE COMPLETION
F 880	worked on Monday assignment during have alcohol wipes disinfect the glucon residents on that ni During an observat Nurse #2 was obseshared glucometer #3 instructed Nurse with an alcohol wip walked back to her wiped the used glu During an observat Nurse #2 walked to station on Hall 100 Nursing (DON) and disinfect a shared gand UM#1 instructed	Nurse #2 stated she had , 5/21/18, on the same the shift of 3-11pm and did not on the cart so she did not neter for any of her assigned ght either. ion on 5/23/18 at 5:18pm, erved asking Nurse#3 how the was to be disinfected. Nurse e #2 to disinfect the glucometer the for 2 minutes. Nurse #2 cart, found alcohol wipes and cometer. ion on 5/23/18 at 5:27pm, to the office by the nurse's and asked the Director of I Unit Manager (UM) #1 how to glucometer. Both the DON the did Nurse #2 to use a sani wipe together walked back to the	F 880		
	UM#1 and the DON Nurse #2 on how to sani wipes were ob bottom drawer of the observed instruction #1 to Nurse #2 was 2 minutes with a PI Germicidal Disposation 1 minute, then of the device and to for of the shared gluco both the DON and Nurse #2 regarding	ion on 5/23/18 at 5:27pm, If were observed educating to disinfect the glucometer. The served to be located on the the medication cart. The thins given by the DON and UM to wipe the glucometer off for DI (PDI Sani Cloth Bleach the ble Wipe) wipe, then air dry thry off any leftover chemical on the obliow the steps after every use the meter. During the education UM #1 gave reminders to the washing hands between the diputting on new gloves.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		345471	B. WING _			05/25/2018	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	3572572010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	revealed she had ne a glucometer and ha orientation. Nurse # worked at the facility used alcohol wipes to when it had been avishe had just moved taught to disinfect gli. An interview on 5/23 Consultant revealed nurses on the correct glucometers right aft observation with Nur Consultant indicated wipes were located of available stock was contact time for the II. An interview on 5/23 observation of a mere revealed she had be minutes ago and way a minutes ago and way a minutes now instead infect the glucome used chlorhexidine with facility did not have available, alcohoshe had not received worked in the facility the only in-service slieved working in the facility explained she had reglucometers.	ver been told how to disinfect d not received formal 2 explained, since she had for the last 3 weeks, she had o disinfect the glucometer ailable. Nurse #2 indicated from another state and was ucometers with alcohol there. V18 at 5:50pm with the Nurse she had in-serviced all of the ext procedure for disinfecting for the medication pass are #2. The Nurse the nurses knew the PDI on their medication carts and on hand. She stated the PDI wipe was 4 minutes.	F8	80			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345471	B. WING _			05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	return employee to the and had not receive indicated that Nurse had all received train correct handwashing disinfect the shared training. An interview on 5/24 Medical Director was telephone. During the Director revealed a stomabsence of disinfers his prospective was Universal Precaution if a resident such as or not. He explained cross-contamination Medical Director furnot know if a resident C and mandatory probables as the form of C Difficile as th	he revealed Nurse #3 was a he facility from 1 year ago d formal training. She #1, Nurse #2, and Nurse #3 hing and should have known g procedures and how to glucometers as part of their when the interview, the Medical breach in infection control due bection of the glucometers in absolutely concerning. In swere to be used regardless Resident #73 had C Difficile	F8	30		

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345471	B. WING_			05/25/2018
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CO 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	notice 2 to 3 weel the last 5 to 6 weel facility, she was provided in the last 5 to 6 weel facility, she was provided in the last 5 to 6 week facility, she was provided in the last 5 to 6 week facility for not 1 thad been a badd. The Medical Direct physically in the because she kept as Nurse #2 and versus a germicid between residents. The Medical Direct be used for a shat time alcohol woul resident had their individually bagged disinfecting supply the staff in order to the staff in order to the coordinator. She disinfection was to pathogen Powerforientation. Hand during the Bloodb presentation, duritimes during orien written and verbad demonstrations with She indicated rou Department head handwashing tech	page 63 as previous and had given her as before her last day. During leks while the SDC worked in the bulled to a medication cart due to a metimes 15 to 20 minutes prior same time nurses were let go by meeting professional standards. It time for staffing he explained. It come to revealed the SDC had been building but could not train staff a getting pulled to a cart. As far Nurse #3 using alcohol wipes lal for a shared glucometer s, was an important distinction. It comes an important distinction where end and labeled. He added, lies have to be made available to to take care of the residents. In the telephone. The SDC as the telephone. The SDC as the telephone. The SDC as the telephone and had planned be facility in the role of a MDS and indicated glucometer aught during the Bloodborne coint verbally on the third day of the share to be made available to the residents. In the role of a made are all the power Point and infection control, and multiple thation. New hires were given a deducation but no return the remaining of the share and real time education and real time education and real time education and registive observations.	F	380		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345471	B. WING		05/25/2018
	ROVIDER OR SUPPLIER	HABILITATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	, 0520200
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 880	The SDC stated she #2 or Nurse #3 sind The SDC stated she their hands before published the published their hands before published the published their hands before published the published their hands before published the published the published their hands before published the published th	e had not rounded on Nurse e both were new employees. e expected nurses to wash outting on new gloves, neter, and then the nurse and glucometer on the the next resident until the 4 for the PDI wipes had on 5/25/18 at 11:07am, the dit was her expectation for the ry policy and manufacturer s to disinfecting shared andwashing after the removal aninistrator revealed the had included UM #1 and the related to correctly cometers due to both giving to Nurse #2 on 5/23/18. lity policy for Infection Control dures dated 2/01/15, Section Unit Managers assure that n control procedures to fety. Section C, 6., Equipment for properly disinfected. dmission Minimum Data Set of or Resident #47 was coded ive status and her staff that status could not be ses coded included diabetes, espiratory failure with hypoxia, disorder. Resident #47 was	F 880		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		TE SURVEY MPLETED
		345471	B. WING _			,	05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		2415	ET ADDRESS, CITY, STATE, ZIP CODE SANDY PORTER ROAD RLOTTE, NC 28273	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	his scrub's to be adr On 5/23/18 at 9:20a he reached into his is scheduled nebulizer to Resident #47. He mask on Resident # using the nebulizer to pocket. The nebulizer to pocket. The nebulizer to pocket. The nebulizer to pocket. The nebulizer to with used gloves, cle with a blood specim- wipes, gloves, the di syringe, a vial for Hupen needle inserted b. A review of the ar Resident #36 was coindependent with act Diagnoses coded in depressive disorder. On 5/23/18 at 9:01a gather alcohol wipes glucometer, insulin so (insulin used to treat Flexpen (insulin), an placed the supplies Nurse #1 walked do room and took out the	ent #47 in the right pocket of minister at a later time. In Nurse#1 was observed as right scrub top pocket for the treatment to be administered a placed the nebulizer face 47 and started the treatment reatment from his right er was observed commingled an gloves, a used test strip en, a used lancet, alcohol inty glucometer, an insulin umalog, a Levemir Flexpen, a with a cap, and an ink pen. Inual MDS dated 1/1/18 for odded for intact cognition and tivities of daily living. Cluded diabetes, major and anxiety disorder. In Nurse #1 was observed to so, gloves, a lancet, syringe, a vial of Humalog at diabetes), a Levemir dipen needle and then in his right scrub top pocket. We hall to Resident #36's the alcohol wipes, gloves,	F	380	DEFICIENCY)		
	Humalog, Levemir F Nurse #1 then place for Resident #36. N sample to test the bl resident's forefinger of blood onto blood glucometer read the	nsulin syringe, vial of flexpen and pen needle. d the supplies on the dresser urse #1 collected a blood ood glucose from the . He then squeezed the drop glucose test strip. The blood glucose to be 282. what was his blood sugar					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	ATE SURVEY OMPLETED
		345471	B. WING _		,	05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	another Levemir Fleenough in the Flexp gathered the used gets tstrip with the bloalcohol wipes, glove insulin syringe, vial flexpen, and pen ne Nurse #1's right scruhave 1 ink pen, the Resident #47, and a Resident #36. On 5/23/18 at 9:25a grab a new Levemir room on Hall 200, lathe new pen in his riwalked back down to Once in the room fo stated he had picked did not have enough 95units of Levemir a Flexpens. Again, he them in his right poor medication cart at the top drawer of the walked back to the radministering both in Resident #36, Nurse left pocket into his ritems were stored. Cart and disposed of scrub top pocket. An interview with Nurevealed he had put right pocket includin had entered the room the store of the stor	ge 66 I, "I'm sorry I need to get xpen since I do not have en I brought." Nurse #1 then loves, the clean gloves, used bod drop, the used lancet, s, the dirty glucometer, for Humalog, Levemir sedle inserted with a cap. Ib top pocket was noted to nebulizer treatment for II the above items for II the above items for III	F8	80		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345471	B. WING _		,	05/25/2018	
	ROVIDER OR SUPPLIER	ABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	stated he had a heaver residents including 7 Nurse #1 indicated the help when needed. It job training before his assigned to a medical explained Nurse #4 verticality, pulled the meadministered on 5/23/18 Administrator indicate Nurse #1 would have his glove to keep from #1 could discard the the test strip into a shourse #1 had been transpersional provide any evident consolidating memodication pass. The provide any evident to Nurse #1. An interview on 5/25/via telephone revealed on the floor with Nurse him and had never set used blood sample to SDC stated she had a small sharps contains should absolutely not scrub pocket. She resident in the state of	to Resident #36. Nurse #2 by assignment with 26 insulin administrations. here was no one to ask for he stated he had received no as first shift when he was ation cart. Nurse #1 who no longer worked at the dications and he had dications to the residents the facility. Administrator was a at 3:27pm. The hed it was her expectation that the put the used items inside in the clean items until Nurse collected blood sample on harps container. She stated ained by the Staff	F8	380			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345471	B. WING_			05/	25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER	·	24	TREET ADDRESS, CITY, STATE, ZIP CODE 415 SANDY PORTER ROAD CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 880	Nurse Consultant we Jeopardy for F880. On 5/25/18 at 3:52pt specific Skills Componers regarding restacility assessment in completed for Nurse. On 5/25/18 at 4:32pt following Credible Al Jeopardy removal. The plan of correcting plan should address deficiency cited. During the analysis of Nurse #1, the nurse proper procedure by for Resident #36 in hwith supplies for Residenting of glucomer.	m, the Administrator and ere informed of Immediate m, record review revealed the etency Validation Record for ident care located in the notebook had not been #1, Nurse #2, and Nurse #3. m, the facility provided the degation of Immediate g the specific defiency. The the processes that led to the of the deficient practice of admitted to not following placing the glucometer strip its scrub pocket comingled	F	380	DEFICIENCY		
	pathogens training of expressed to her direct to clean the glucome wipes were the appround of the nappropriate supplies two glucometers and the bottom drawer of of the glucometers.	n 4/18/18. The nurse ect supervisor that she knew eters but thought alcohol opriate product for cleaning. urse's medication cart, the were available; there were the Sani-Wipes in a box in the cart for the disinfection of the deficient practice of					

	ATEMENT OF DEFICIENCIES O PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345471	B. WING _			05/25/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From pag	ge 69	F 8	080		
F 880	Nurse #3, she expretation she knew to cle patients, but though appropriate for clear. On 5/23/18 Nurse # resident room with kinsulin during a med After the blood gluck #1 realized that he reart. He then proce which included: gluck gloves, insulin vial, in needle, insulin pen, then placed them all Nurse #2 failed to for practices and four rebe affected by the dractices and four rebe affected by the dract	essed to her direct supervisor an the glucometers between the glucometers between the alcohol wipes were being. I was noted to enter a colood glucometer supplies and dication administration pass. Ease level was checked, nurse beeded more insulin from his eded to gather the supplies cometer, used testing strip, insulin syringe, insulin pen and alcohol prep pads. He into his scrub right pocket. Follow infection control esidents have the potential to efficient practice of Nurse #2, 67, 223. Nurse #2 violated the trol policy by not cleaning the training Resident #73 was trained during her #2 was also observed not be between glove changes. Cliately removed from patient d; any further demonstration tices will result in immediate	F 8	80		
	completion of an ac in-serviced immedia care as soon as she procedures, return of	using alcohol wipes after the cucheck. Nurse #3 was ately and returned to patient everbalized correct cleaning demonstration, and a quiz ion to determine knowledge				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345471	B. WING _			05/25/2018
	ROVIDER OR SUPPLIER	IABILITATION CENTER	-	STREET ADDRESS, CITY, STATE, ZIP (2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	plan of correction for Facility nursing staff beginning on 5/23/1 Care Equipment inc Sani-Wipes, and we are being in-service policy Handwashing nursing staff also accunderstanding of trathat proper hand was disinfecting was required transmission of bloce Education was provand Regional Nurse be educated during administration which administrator before provide glucose che in-serviced before retrieved before retrieved by the Administrator Consultant. RN assense has not shown any caused by the deficit The physician agree panels on all five residents. The will be notified if the that transmission of occurred.	mplementing the acceptable or the specific deficiency cited. If are being in-serviced 8 on the policy on Patient studing: use of PDI et time. Facility nursing staff d beginning on 5/23/18 on the graph Requirements. Facility sknowledged by signature the ansmission precautions and ashing and glucometer uired to prevent the end borne pathogens. ided by DON, unit managers, a Consultant. New hires will general orientation by nursing in will be confirmed by the enthey can independently excess. Nursing staff will be enturning to work	F	380		
		t practice for infection control				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		345471	B. WING _	····		05/25/2018
	ROVIDER OR SUPPLIER IBURG HEALTH & REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	Continued From pag	ge 71	F 8	380		
		contamination. Nurse #1 was no longer is an employee of				
		re identified as placing al blood borne pathogens pockets.				
	deficient practice by	ties were notified of the the nurses in the care of the six residents on				
	request additional tra	d the QIO on 5/25/18 to aining on infection control and ens for facility staff; the QIO e Charlotte area agreed to on 5/29/18.				
		ng reported Nurse #2 and I health department and the 5/25/18.				
	of correction is effect deficiency cited remains	edure to ensure that the plan tive and that specific ains corrected and/or in regulatory requirements				
	Consultant to the Dir Managers with return	ded by the Regional Nurse rector of Nursing and Unit n demonstration on the cting process for glucometers idelines on 5/24/18.				
	conducted to ensure performed per facility instructions Audits v	8, random audits will be glucometer cleaning is y policy and manufacturer will be done 5 times weekly x ekly x 2 weeks, and then				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
		345471	B. WING _			05/25/2018
NAME OF PROVIDER OR SUPPLIER MECKLENBURG HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 880	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP		